PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality & Performance Improvement (QI)
DATE: Nov. 13, 2026
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

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

Meeting Time/Date: 7:30 – 9:00 a.m., Wednesday, Nov. 18, 2026
Meeting Locations:

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

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

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

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

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

cc:
Andrews, Leigha, Regional Director, Southwest
Bjork, Sonja, JD, Chief Executive Officer
Blake, Jill, Regional Director, Auburn
Bottke, Jayme, Regional Director, Northeast
Brincko, Aaron, MHA, Director of Provider Relations
Campbell, Anna, MPH, Policy Analyst, UM Regulations
Conery, Irem, Director of Member Experience, Administration
Crosby, Zhavontia, BSN, RN, Associate Director of Population Health
Cunningham, Aryana, Policy Analyst, Care Coordination
Davis, Wendi, Chief Operations Officer
Durst, Jennifer, Senior Manager of Quality Incentive Programs, QI
Elder, Alaina, Manager of Provider Network Teams, PR
Gual, Kristine, Director of Quality Measurement, QI
Guevarra, Angela, RN, Director of Care Coordination
Hanusiak, Kenze, Assoc. Dir., Regulatory Affairs & Compliance
Harris, Vander, Senior Health Data Analyst I, Finance
Isola, Brandy, Mgt of Performance Improvement, QI (Chico/Auburn)
Katz, Rebecca, Associate Medical Director
Klakken, Vicki, Regional Director, Northwest
Kubota, Marshall, MD, Associate Medical Director
Kulkarni, Shreya, Policy Analyst, Regulatory Affairs & Compliance
Morris, Matthew, MD, Regional Medical Director, Auburn
Nakatani-Phipps, Stephanie, Manager of Provider Relations Reps
O'Leary, Hannah, MPH, Manager of Population Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Sackett, Anthony, Project Manager II. Member Experience
Smith, Christine, Community Health Needs Liaison, Pop Health
Stark, Rebecca, Regional Director, Chico
Vaisenberg, Liat, Director of Health Analytics, Finance

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

Date: Nov. 18, 2026 **Time: 7:30 – 8:55 a.m.**

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle Room
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 will 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	Announcements	Kermit Jones, MD, JD	7:30	--
2	*Approval of* Oct. 21, 2026 Quality/Utilization Advisory Committee (Q/UAC) Minutes			5 – 16
3	*Acknowledgment and acceptance of draft minutes of the* • Oct. 13 Internal Quality Improvement (IQI) Committee			17 – 26
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isaac Brown, MHA/MBA	7:37	27 – 38
2	HealthPlan Update	Robert Moore, MD, MPH, MBA	7:42	--
III.	**Old Business – None.**			
IV.	**New Business - Consent Calendar**			
Reports	Consent Calendar	All	7:50	39
	Revised Enhanced Care Management Quality Incentive Program (ECM QIP) 2027 Measure Set Proposal – *direct questions to Deanna Watson*			41 – 43
	UM Delegated Hospitals Summary – *direct questions to Tony Hightower, CPhT*			45 – 46
	G&A PULSE Report, Issue 23, November 2026 – *direct questions to Latrice Innes*			47 – 57
	2026 Timely Access Survey – *formerly 3rd Next Available Survey – direct questions to Vander Harris*			59 – 80
Health Services Policies	**Care Coordination**			
	MCCP2022 – Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services			81 – 88
	MPCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services			89 – 114
	Population Health Management			
	MPNP9006 – Doula Services Benefit			115 – 124

	Item	Lead	Time	Page #
	Utilization Management			
	MCUG3038 – Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled, or Subacute) Facilities			125 – 137
	MCUP3003 – Guidelines for Acute Rehabilitation Services – **NEW TITLE**			139 – 144
	MCUP3102 – Vision Care			145 – 147
	MCUP3106 – Waiver Programs			149 – 154
	MPUP3144 – Residential Substance Use Disorder Treatment Authorization			155 – 160
Non-HS Policies	**Transportation**			
	MPTP2501 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)			161 – 172
	MPTP2502 – Emergency Medical Transportation			173 – 175
V.	**New Business – Discussion Policies**			
Health Services	Synopsis of Changes		--	177 – 180
	Care Coordination			
	MPCP2034 – Transitional Care Services (TCS)	Alyssa Beard, RN	7:55	181 – 196
	Utilization Management			
	MCUP3125 – Gender Dysphoria/Surgical Treatment	Tony Hightower, CPhT	8:02	197 – 201
	MPUP3116 – Positron Emission Tomography (PET and **Brain SPECT** Scans) – **NEW TITLE**		8:09	203 – 206
Non HS	**Provider Relations**			
	MPPR210 – Long-Term Services and Supports Liaison – **NEW TITLE -** *CLEAN copy begins on p. 211*	Alaina Elder	8:16	207 – 214
VI.	**Presentations**			
1	2025 Managed Care Accountability Set (MCAS) Healthcare Effectiveness Data Information Set (HEDIS®) v. Primary Care Provider Quality Incentive Program (PCP QIP) Crosswalk	Robert Moore, MD, MPH, MBA	8:23	215
2	Member (Patient) Experience CAHPS® MY2025/RY 2026	Irem Conery/Anthony Sackett	8:30	215 – 233
VII. FYI	2027 QI Committee Meeting Dates – *direct questions to Leslie Erickson*			235
	2027 IQI & Q/UAC Presentations Calendar – *direct questions to Leslie Erickson*			236
	Adjournment scheduled by 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Jan. 20, 2027			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

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

Wednesday, Oct. 21, 2026 / 7:33 a.m. – 9:00 a.m.

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

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

Partnership *Ex-Officio* Members Present:	Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Bontrager, Mark, Senior Director of Behavioral Health	Newman, Rachel, RN, BSN, Assoc. Dir., Credentialing
Brown, Isaac, MBA/MHA, Senior Director of Q & P Improvement	O'Connell, Lisa, Director, Enhanced Health Services
Cox, Bradley, DO, Regional Medical Director (Northeast)	Randhawa, Manleen, Senior Health Educator, Population Health
Glickstein, Mark, MD, Associate Medical Director	Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)	Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination	Thornton, Aaron, MD, Associate Medical Director
Krznarich, Jackie, RN, Mgr, Member Safety – Quality Inspections	Townsend, Colleen, MD, Regional Medical Director (Southeast)
Leung, Stan, Pharm.D, Director of Pharmacy Services	Ward, Lisa, MD, Regional Medical Director (Southwest)
Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair	Watkins, Kory, MBA-HM, Director, Grievance & Appeals
Partnership *Ex-Officio* Members Absent:	Guillory, Ledra, Senior Manager of Provider Relations Representatives
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Hightower, Tony, CPhT, Associate Director, UM Regulations
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI	Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Srvcs
DeVido, Jeff, MD, Behavioral Health Clinical Director	Katz, Dave, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Spiller, Bettina, MD, Associate Medical Director
Guests:	Gual, Kristine, Director, Quality Measurement, QI
Beard, Alyssa, RN, Manager of CC Regulatory Performance	Hendrix, Hillary, Executive Assistant, Population Health
Bottke, Jayme, Regional Director (Northeast)	Kubota, Marshall, MD, Associate Medical Director
Brincko, Aaron, Director of Provider Relations	Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
Campbell, Anna, Health Policy Analyst, UM Regulations	Morris, Matthew, MD, Regional Medical Director (Auburn)
Crosby, Zhavontia, BSN, RN, Associate Director, Population Health	O'Leary, Hannah, MPH, Manager of Population Health
Devan, James, Director of Quality Management	Quichocho, Sue, Manager of Quality Measurement, QI
Durst, Jennifer, Senior Manager, Quality Incentive Programs, QI	Rednic, Hanny, Program Manager I, Utilization Management
Elder, Alaina, Manager of Provider Network Services, Provider Relations	Shamoiel, Shantal, County Child Welfare Liaison, Behavioral Health
Frankovich, Terry, MD, Associate Medical Director	Stites, Jaylyn, Program Manager II, Provider Relations
George, Michael, MD, Associate Medical Director	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Approval/ Acceptance of Minutes Introductions	Committee Vice Chair and Medical Director for Quality Mrk Netherda, MD, sitting in Fairfield called the meeting to order at 7:33 a.m. • The Sept. 16 Q/UAC Minutes were approved without any corrections. • *Acknowledgment and acceptance of draft meeting minutes of the* o Sept. 8 Internal Quality Improvement (IQI) Committee o Sept. 15 & July 21 Quality Improvement Health Equity Committee (QIHEC) o Sept. 24, June 18, & Feb. 5 Substance Use Internal Quality Improvement (SUIQI) Committee o Aug. 27 Member Grievance Review Committee (MGRC) • Introductions: o Dr. Netherda welcomed new Associate Director of Population Health Zhavontia Crosby, RN, to her first Q/UAC meeting. She joined Partnership at the end of September.	Motion to **approve the Q/UAC minutes:** Steven Gwiazdowski, MD Second: Brian Montenegro, MD *Approved unanimously* Motion to **accept other minutes:** Steve Gwiazdowski, MD Second: Randy Thomas, MD *Accepted unanimously*

II. Standing Updates

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

- Organizations will soon be sent contract amendments for signature to participate in the Calendar Year 2027 Quality Incentive Programs (QIPs).
- DataLink is quickly scaling up. DataLink is able to go in and extract data from the electronic health record that is critical for proving the work was done by our clinicians. We are up to 246,714 members that are currently being represented in the data. Six of our counties have reached their target of 33%.
- Our Quality Management Score Improvement (QMSI) work groups work cross functionally on different measures to try to improve scores. One of their new activities is building out some measure specific toolkits to help different providers focus on specifics. We will be sharing these in the coming months.

There were no questions for Isaac.

Health Plan Update – *Robert Moore, MD, MPH, MBA – Chief Medical Officer*

Dr. Moore announced that he is about eight months from retirement. Until that time, Kermit Jones, MD, and Mark Netherda, MD, will rotate chairing the monthly meetings of this committee while Dr. Moore provides coaching support.

- Partnership has established what we call the Hospice Quality Network. Our hospice provider network is a smaller group of high quality providers that are largely not-for-profit in an effort to ensure individuals get what they need. That's going pretty well. We are updating our Provider Directory.
- The Primary Care Provider Quality Incentive Program (PCP QIP) for the coming year will pay increased attention to potentially preventable admissions, previously known as the ambulatory care sensitive admissions. We are going through this at our PCP advisory group meeting with external advisors later this morning. The bottom line is that this is the second biggest penalty from the State in terms of quality penalties, and it is related to admissions that are felt to be preventable across several disease states. Congestive heart failure is the biggest one. Complications of diabetes is a close second. We are committed to building out infrastructure to really communicate much more closely in real time to the PCPs who are their patients admitted to the hospital or even seen in the emergency room. We are striving to have that up and running by January to help PCPs monitor and more closely case manage the folks that are utilizing those services.
- We are looking at the drivers for current financial challenges: what is different between 2024 and 2025? Partnership in 2025 hit its highest ever number of PCP visits per member per year and also the highest ever specialty visits per member per year. This is not a bad thing, although it does drive expenses a little. I dare say it is not the adequate network that we are looking for across the board: we have really good access in some areas and others not so good.
- About the loss of part of the Wellness & Recovery Program that was Partnership's contract with seven of our counties to take on their drug Medi-Cal organized delivery system, the State changed the regulatory framework to make it impossible for the counties to contract with us for that. So, that will end as of Dec. 31. Solano and Mendocino counties are going to run their own organized delivery system. The other five small counties are going to work parts of managing the

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

delivery system. This is still in development.

- Big picture, the State for many years was moving services from fee-for-service Medi-Cal over to managed care. This peaked in 2024. The State now has new challenges, one of which is what to do with the individuals with uncertain or unsatisfactory immigration status (UIS). Then there is also a federal government prohibition against providing gender affirming care to non-adults. The State has decided to take those services back in-house, which I think reflects a bit of new blood at the Department of Health Care Services (DHCS) who have no idea what it is like to run a delivery care system. As of Jan. 1, the entire UIS population, including kids and pregnant women will cycle over to DHCS. There is a solid probability that they are going to ask us in December to continue to provide services for a few more months because they will not have their delivery system up and running. There is a history of that with the pharmacy benefit. For the gender affirming care, on Sept. 30 with two weeks' notice, DHCS notified the health plans that they would no longer be allowed to pay for gender affirming care for any non-adult; on the other hand, statutorily, the California Legislature mandated that that care be covered. DHCS felt overwhelmed with the UIS population and asked if anyone else could take this. So HCAI (California Department of Health Care Access and Information), which has never provided care delivery or paid bills before, will run that service. HCAI has yet to develop agreements with providers, and we had to notify our members and our providers that are providing care for them not to bill us anymore or we will be denying those claims. It's not that members will be denied care: the care is going to be paid for by HCAI.
  - *Regional Medical Director Jeff Ribordy, MD, said "those of us that actually practiced in the fee-for-service world, there is no network., no system, any kind of care coordination or help. The patient is the provider's responsibility, so most of these things are going to fall on our provider network." Dr. Moore acknowledged this was true but that things are changing with the standing up of call centers and contracts with others to provide care coordination services, adding HCAI is attempting to put together services similar to those provided by managed care plans. "That's the rub," he said. "Probably the Finance people thought 'we're going to save a bunch of money moving back to the State.' But if the State turns around and contracts for all these services, the cost saving will disappear."*
  - *Regional Medical Director Colleen Townsend, MD, commented "thinking about pregnancy care, with the new All Plan Letter (APL) that came out this year, there is a strong emphasis on the health plan or health plan entity to provide a high level of care coordination that connects people, particularly high-risk individuals with any people, and pregnant people after they leave the hospital. I haven't heard that they have their own system in place to make themselves accountable to or comply with their own DHCS policy."*
  - *Dr. Netherda asked Dr. Moore to explain who HCAI is. Dr. Moore responded that HCAI works on workforce and also runs the Rural Health Transformation grant program. "They are a master data collector for the hospitals. They collect a lot of the data for hospital quality. But (a history of) delivering care is not there."*

There were no other questions for Dr. Moore.

III. Old Business – None.

IV. New Business – Consent Calendar (Committee Members as Applicable)

Primary Care Providers Quality Incentive Program (PCP QIP) CY 2025 Evaluation – *direct questions to Athena Beltran – Nampraseut* Q1/Q2 2026 Prior Authorization Metrics Report by Partnership County 2026 Annual Oversight: Carelon – Notice of Final Audit Results CY 20025 **Health Services Policies** <u>Behavioral Health</u> MCBP8015 – Coordination of Care for Child Welfare-Involved Members MPBP8007 – Screening and Treatment for Substance Use Disorders MPBP8013 – Eating Disorder Management Policy	*Q/UAC voters posed no questions.* Motion to **approve the slate as presented:** John Murphy, MD Second: Meagan Mulligan, FNP *Approved unanimously*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Quality Improvement MCQP1021 – Initial Health Appointment [1] Utilization Management MCUG3032 – Orthotic and Prosthetic Appliances Guidelines MCUP3020 – Hospice Services MCUP3114 – Physical, Occupational and Speech Therapies MCUP3128 – Cardiac Rehabilitation MCUP3130 – Osteopathic Manipulation Treatment MPUP3116 – Positron Emission Tomography Scans (PET Scans) **Non-Health Services Policy** Member Services MP316 – Provider Request to **Reassign** Member & Assistance with Inappropriate Member Behavior – **NEW TITLE**		Next Steps: Nov. 4 Physician Advisory Committee (PAC)

V. New Business – Discussion Policies (Committee Members as Applicable)

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

MPQG1005 Adult Preventive Health Guidelines

Policy Owner: Quality Improvement – *Mark Netherda, MD, Medical Director for Quality*

☐ 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	

This policy is updated to align with All Plan Letters (APLs) 26-014 (Cognitive Health) **and 26-015** (Immunization Requirements).

Section III. – Partnership Advantage definition updated.
Section VI.A.8 is added: For Members who are dually eligible for Medi-Cal and Medicare, Partnership will adhere to the IHA requirements in the PHM Policy Guide and MCP Contract.
Section VI.B.2 is modified: Providers must ensure timely provision of immunizations to *adult* Members in accordance with *a recommendation from the CDC/ACIP (*Advisory Committee on Immunization Practices), *ACOG, AAP, or any modification or supplement to that recommendation adopted by the California Department of Public Health (CDPH)* regardless of the Member's age, sex, or medical condition, including pregnancy. Providers must document each *adult* Member's need for immunizations as part of all regular health visits. All provided immunizations must be documented in the California Immunization Registry (CAIR2).

Q/UAC voters posed no questions.

Motion to **approve as presented:** Steven Gwiazdowski, MD
Second: Meagan Mulligan, FNP
Approved unanimously

Next Steps:
Nov. 4 PAC

[1] MCQP1021 Attachment A – Provider's Sample Welcome Letter to New Members – is now available in Punjabi.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Section VI.B.3 is modified: Partnership, per APL 26-014, is no longer required to verify whether providers have completed DHCS Dementia Care Awareness cognitive health assessment training. Providers are no longer required to complete this training prior to billing for annual cognitive assessments. Providers will perform the annual cognitive health assessment as a part of an Evaluation and Management (E&M) visit *including, but not limited to, an office visit, consultation, or preventive medicine service. (Elements of the cognitive health assessment can be conducted by non-billing team members acting within their scope of practice and under the supervision of the billing Provider.)* Providers must have readily available documentation based on APL 26-014 guidelines in the Member's medical record. **Section VI.B.3.a is added** to address DHCS Additional Information Request (AIR): On or after June 30, 2025, Partnership is no longer required to verify whether Providers have completed cognitive assessment training to be eligible for reimbursement for conducting a Medi-Cal annual cognitive health assessment for eligible members. **Attachment A:** A line detailing Cognitive Health Assessment for members 65 years and older is added to the Behavioral Conditions section.		
MCUP3013 Durable Medical Equipment (DME) Authorization **Policy Owner: Utilization Management –** *Hanny Rednic, Program Manager I, UM* ☒ **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): We need to determine the process for how IPNs are approved and when they are published so that we do not see misalignment between policies and IPNs.*** ☐ Configuration of HRP and/or Claims Editor System (CES) ☐ Configuration of Essette/Jiva		
Section I.F. - Policy MPUP3139 – Criteria and Guidelines for Utilization Management was added as a Related Policy. **Section III.B. -** The DHCS definition of DME was added **Section VI.A.1. –** This paragraph regarding the information required on a DME prescription was moved to the top of the policy. Note was also added to that a prescription can be written or the "electronic equivalent." **Section VI.A.2. –** The list of criteria we consider when authorizing DME was modified to include our policy MPUP3139 – Criteria and Guidelines for Utilization Management in lieu of "InterQual." Policy MPUP3139 provides a more thorough description of all criteria that Partnership would consider, including InterQual. **Section VI. F.2.b**. – This section regarding bathroom equipment was updated to say "When a TAR is required" because an IPN has been posted which now states that No TAR is required for several bathroom equipment items. **Section VI. F.3.and VII.G**. – This section regarding Compression Garments was removed and transferred to a different policy, MCUG3032 Orthotic and Prosthetic Appliances Guidelines, to be in alignment with where the criteria is shared in the DHCS Provider Manual. The Reference to the BREW form for Compression Garments at VII.G. was also removed and transferred to the other policy. **Attachment A:** The only change to this document was on page one to update policy reference to section VI.B. for Rental Only with a 10-month limit. **Attachment B:** Codes E0658 and E0659 were added to the list of Lymphedema pumps/compression devices, and a policy reference was updated to VI.E. for information on DME provided to disabled parents or guardians.		*Q/UAC voters posed no questions.* Motion to **approve as presented:** Randy Thomas, MD Second: Brian Montenegro, MD *Approved unanimously* Next Steps: Nov. 4 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

MCUG3118 Prenatal & Perinatal Care

Policy Owner: Utilization Management – *Colleen Townsend, MD, Regional Medical Director (Southeast)*

☐ 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):* ***Provider Contracting to use updated Attachment A document as Contract Addendum***
☒ Configuration of HRP and/or Claims Editor System (CES)	☐ Configuration of Essette/Jiva	

This policy was updated to align with APL 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members.

Section I – Policy numbers were updated as necessary. Policy MCQG1015 Pediatric Preventive Health Guidelines was removed from the Related Policies list and policy CLPM31 Obstetrical Services was added at I.K.
Section III.I – Definition for Professional Organization was added to describe those recognized by DHCS for clinical guidance as per APL 26-005.
Section VI.B. – Statement added to say, "No prior authorization is required for standard prenatal, maternal, and preventive services and care as defined by the most current clinical standards or guidelines of ACOG, AAFP, ACNM, NACPM and CPSP, as applicable."
Section VI.C.3. – Paragraph updated to clarify requirements for different types of perinatal services programs.
Section VI.C.4.c.3)b)i. – "Comprehensive Assessments" was added as a specific measure to be evaluated in quality monitoring of PHPS providers
Section VI.C.5.b. – Statement added to say "Members may choose a midwifery provider outside of their capitated facility if that facility does not offer midwifery services for delivery."
Section VI.C.8. and 9. – Regulatory requirement sources for perinatal services were updated to reference APL 26-005 and links to CPSP information were updated. Screening required by various agencies were separated into section VI.C.9
Section VI.C.10. - Statement added to say "Claims for PHPS services should be submitted using the codes defined by DHCS for CPSP services. These Z-codes should be used by all PHPS programs, both CDPH-recognized CPSP programs and CPSP-like programs."
Section VI.C.12. – Reference was added for our policy MPNP9006 Doula Services Benefit.
Section VI.D.1.a. - Statement added in the PHPS Standards of Perinatal Case Management section to say, "The entire assessment or portions of the assessment can be completed by the clinical provider or perinatal services provider. The results for assessments must be made available to clinical and perinatal services providers caring for the Member."
Section VI.D.4. – Specified that every PHPS program "must" have a designated Clinical Director.
Section VI.D.12.b.1) b) and VI.G.2.a.-e.– In the Nutrition Education Services section and the Diabetes Care in Pregnancy section, we updated the certification title for Certified Diabetes Care and Education Specialists (CDCES).
Section VI.D.12.c.1) a)i. – Statement added to say "Patients who do not screen positive and who have risk factors for perinatal mood disorder should be provided with education on perinatal mood disorders, stress management and referred to local resources per USPSTF grade B recommendation."
Section VI.E.3.a. – Specified that standardized assessment and reassessment tools, and the individualized care plan must be updated and revised as necessary each trimester and at the post-partum visit, more frequently as needed.
Section VI.E.7.a. – Specified that Perinatal Services providers will maintain an updated list of staff working for them and their qualifications and "These will be provided to Partnership upon request and submitted with PHPS applications and updates."

Q/UAC voters posed no questions.

Motion to **approve as presented:** Jennifer Wilson, MD
Second: Brian Montenegro, MD
Approved unanimously

Next Steps:
Nov. 4 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.H.1. - Statement added to say "PHPS programs should provide basic lactation support and education during and after pregnancy and should refer to local resources as needed to meet the Member's specific needs." **Section VI.H.3.** - Statement added to say "WIC programs in each county may provide lactation services for Members. PHPS/CPSP programs that do not have Lactation Education, Support or Consultation available should refer to local WIC programs and other community-based lactation services." **Section VI.I.2.** – Added reference to policy MCUP3124 Referral to Specialists (RAF) Policy **Section VI.I.2.a.** – Statement added to say "Members requiring a referral to a Medical or Obstetrics specialist should be referred to Partnership's Care Coordination Department for Complex Care Management." **Section VII. References** - Reference C. was updated to reflect APL 26-005. Hyperlinks were updated throughout as needed. Reference I was added for USPSTF Perinatal Depression Interventions and References J. – L. were added for recommended depression screenings cited in the policy. **Attachment A** – The PHPS Application and Update Form and Contracted Provider Addendum was updated to specify that all licensed program staff must be credentialed with Partnership or with a Partnership delegate, if applicable, "prior to providing services to Partnership Members and in accordance with Partnership credentialing requirements" by July 2026. Dr. Towsend remarked we will be asking practices that participate in our Partnership HealthPlan Perinatal Services (PHPS)[2] program and anyone who offers case management during pregnancy as an obstetric practice to both apply or verify their provision of those services, reflect who are their providers in their network, and that they are compliant with the maternity care services APL from the State.	

MCUP3133 Wheelchair Mobility, Seating and Positional Components		
Policy Owner: Utilization Management – *Anna Campbell, MPH, Policy Analyst, UM,*		
☒ **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	

This policy was updated due to align with new DHCS terminology and a new benefit code K0462. **Section III.B. and C.** – The previous definition for "Custom Rehabilitation Equipment" was updated to define a new term, "Complex Rehabilitation Technology (CRT)." A new definition for a "CRT Supplier" was also added. **Section III.K. and L.** – The acronym and definition for a Qualified Health Care Professional (QHCP) was updated. The definition of a Qualified Rehabilitation Technical Professional (QRTP) was also updated. **Section VI.** - Language was updated throughout to reflect "Complex Rehabilitation Technology" or CRT in lieu of "custom rehabilitation equipment."	*Q/UAC voters posed no questions.* Motion to **approve as presented:** Steven Gwiazdowski, MD Second: Randy Thomas, MD

[2] CPSP-like services that are equivalent to, or substantially similar to, the services defined by the California Department of Public Health-defined CPSP program.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.A.3. – Statement added to say, "Replacement wheelchairs will be considered based on Medi-Cal guidelines/ frequencies. A replacement that is requested and does not meet frequency limits will be considered based on a report of the need for replacement and documentation of the cost to repair (if appropriate) vs. replacement of the device. The request must document the medical need for continued use of the device." **Section VI.D.** – In the section of Seating and Positional Component Coverage Criteria, our application of criteria 10-19 was clarified, and language was added to say "Accessories or features that do not explicitly improve function, independence and safety to complete ADLS or that do not support a medical need are not covered." **Section VI.F. –** This section regarding Loaner Rental During Repair was updated to reflect new DHCS benefit coverage instead of Partnership's previous coverage as a Benefit Review and Evaluation Workgroup (BREW) benefit. Code K0462 for rental of a power wheelchair during extended repair will now be covered with no TAR requirement for up to two one-month rental periods per year.	*Approved unanimously* Next Steps: Nov. 4 PAC

VI. Presentations

MY 2025 National Committee on Quality Assurance (NCQA) Health Plan Rating and **5-Star Strategic Plan for Quality Improvement – 2026-2029**
Kristine Gual, PMP, CPHQ, Director of Quality Measurement, Quality Improvement

Kristine presented the Healthcare Effectiveness Data Information Set (HEDIS®) outcomes for the 2025 Managed Care Accountability Set (MCAS) to this committee in July.

Today, she circled back to talk about our NCQA Health Plan Rating. (She noted the timing is a little out of sync: we do not usually hear from NCQA with our final outcomes until late August or early September.) Our final HPR is 3-Stars. We did use the Child Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey for the HPR in 2025, and our county ratings were nearly identical to 2024 (which was the first year that our 10 incoming counties joined the Plan), yet we saw a decrease from 3.5-Stars to 3-Stars. We are still working on regaining that lost ground. Everyone is encouraged to look at the white paper in today's packet under FYI for more information, including a county-level breakdown on all of the 44 measures that make up the HPR.

Neonatologist and Q/UAC voter Steven Gwiazdowski, MD, asked if there was a big factor that drove the Star rating down? Do we focus 80% of our effort on 20% of the systems to go back?

Kristine replied that one positive thing is we do have a nice alignment now between the MCAS measures set and the measures that are in the prevention population domain, although we have yet to see that result in a higher Star rating. That is such an area of focus for us: the measures like the well child visits, the vaccinations, the prenatal/postpartum care. Where we really need to improve is probably in the treatment domain: it is a little different from the MCAS measure set because it is very focused on chronic disease outcomes, behavioral health transitions of care, and care coordination. We know that we need to do more in terms of things like data completeness for our behavioral health transition of care measures. There are other chronic disease measures like statins that we are actively working on, folding those into programs like Academic Detailing.

Dr. Gwiazdowski continued: is there a way to align the provide incentives and crosswalk for the things that we want to change?

Kristine: Yes. It takes a while. It's like turning an ocean liner, but I think that is ultimately the plan. Dr. Moore added that, from a measure perspective, that is the way to think about it. If you look at it from a population or geographic perspective, basically, if you took the Bay Area counties, we would be a 4-Star plan; Bay Area plus the North, we would be a 3.5-star plan, but all three together, it is a 3.0. There's an opportunity to bring those new counties up to a higher level.

Kristine segued into the Five-Star Strategic Plan for Quality Improvement 2026-2029.

The last time we updated our strategic plan for the Quality Improvement department was in 2019. We are in a different world than we were back then, so it was definitely time for an update. There is a white paper that goes along with this presentation in the packet under FYI.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Every three years, Partnership updates its org-wide strategic plan, which looks at things much beyond the scope of quality improvement. This is in process right now with our Executive team and Board. They will come up with a set of "pillars," which have goals associated with them. The pillars are not yet defined, but in our last strategic plan we had a pillar for quality of care and health equity. We anticipate that there will be a similar pillar, and this is where we can see this QI plan located. There are many other departments' strategic plans going on now, including Health Equity and Member Experience. We all work together, and the idea is that everybody aligns; we may have different focus areas, but we are all moving in the same direction.

A little bit about the urgency of accelerating our performance at this time: we saw it in our health plan ratings that national trends in quality performance are outpacing Partnership. We are improving but not at the trajectory that we need to keep up with national Medicaid benchmarks or with performance by other California managed care plans. There is an enormous financial risk associated with this performance as well as to our members' health, which is really our mission. Finally, we want to see consistency across our network. We have a very diverse network, and performance on the quality plan is sometimes dependent on where you are located, what community you are part of, and so this is why that is related to equity.

Kristine then went through the plan's development process, which began in May with outside consultants, focus groups and interviews. We were able to develop a very comprehensive SWOT (Strengths, Weaknesses, Opportunities and Threats) as summarized in the white paper. We needed a criteria to bump that against so that we could come up with a focus plan that was achievable in three years. The criteria included member health and experience, regulatory and financial impact, and organizational capacity. We want to make sure that anything we decide to put time and effort into is sustainable, fits into our timeline and that we are able to have a regional approach. We are in the midst of our communications now and are interested in provider feedback on this plan. It will go to our Board on Oct. 28. Then we will go right into implementation, setting up tactical goals with the impacted departments and the provider network.

Kristine then went over the high-level strategic "aggressive" goals for the next three years. We can achieve these goals or make significant progress towards achieving all of them, she said. Improving member experience is actually a goal for our entire organization. Some needed metrics are getting needed care and getting care quickly. We want to perform at the 67th percentile or higher.

Our second strategic goal is around reducing avoidable utilization in things like ambulatory sensitive admissions. Our goal is to reduce by 10% or more annually plan-wide and to retain our actually high level of performance on hospital readmissions. This is where lower is better. We are currently performing at the 90th percentile. We want to retain that and keep that high performance. The final three strategic goals are around areas of preventive care: improving pediatric preventive care defined by well-child visits and immunizations, improving chronic disease outcomes like diabetes and hypertension, and improving timely access to prenatal care. This is consistent with what we shared this summer on our HEDIS® outcomes. Kristine noted our goal is to perform at the 67th percentile or higher in each of the three DHCS rating regions.

We have a special focus on our rural regions because we know this is where the need is greatest and on reducing health inequities. Composite key indicators that will show us we are moving in the right direction include our NCQA Star rating. We will start with moving from a 3-Star to a 3.5-Star and then onward up to 4 and then 5. Our second success measure is our Quality Factor Score on our MCAS measures. We don't yet have that information from DHCS to compare across California, but we will share when DHCS releases that information for 2025.

How will we focus? We have objectives and lead departments defined to move the needle on five strategic goals: access to care, provider experience, member experience, data analytics and organizational excellence and culture. In access to care, the idea is not only to strengthen our network capacity, it is also to expand alternative access models to meet the needs of the community, like telehealth and mobile units. Provider engagement is Quality's wheelhouse: building the capacity of the network towards high performance on the prior unprioritized quality measures. Our Member Experience department is focused on better understanding drivers and resolving some of the highest priority gaps in the member journey. Member engagement is focused on improving outcomes for high needs populations. for example, D-SNP, high-needs care coordination and CalAIM. Finally, we are able to provide retrospective analytics, but the idea is to include real time analytics that maximizes opportunities for closing care gaps and improving member health. Lastly, in this time of economic uncertainty, we want to make sure our resources as well directed and that we receive a return on investment for every initiative we launch.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Pediatrician and Q/UAC voter Randy Thomas, MD, asked for examples of efforts to improve chronic disease outcomes in pediatric measures. "Our family practitioners are wonderful, but as we are getting more and more obesity, more and more family practitioners are seeing children with Type 2 diabetes and sometimes think that you apply the same treatment that you do for adults to the children." Kristine expressed appreciation for his "great call out."

Kristine said this report and plan will be considered Oct.28 at the Board of Commission, after which this will be considered "final." We will then talk with our lead departments on finalizing smart goals around these different focus areas and building tactical plans. We will report annually on our progress. Kristine closed by inviting Q/UAC members to engage with our Quality Improvement Advisors and Provider Relations too, particularly on Member Experience and improving Health Equity.

Kristine said she is "thankful" for new Director of Member Experience Irem Conery and is eager to work with her to align QI and Member Experience efforts. Dr. Moore noted that Chief Executive Officer Sonja Bjork, JD, has reviewed this plan, and that her sole recommendation is that Behavioral Health be involved.

Health Equity Disparities Grand Analysis MY2025/RY2026 Summary of Performance
Mohamed Jalloh, Pharm.D., Director of Health Equity (Health Equity Officer)

Dr. Jalloh took a three-prong approach: a review of the Grand Analysis, his specific plan that Health Equity looking to do, and a preview of what our Health Equity Strategic Plan will be as well. He spoke about what we actually did well on this past year, what measures still require support, and then which to prioritize for the upcoming year.

Dr. Jalloh and team calculated these health disparities and assessed them according to both DHCS and NCQA Health Outcomes Accreditation (formerly Health Equity Accreditation) accountabilities. He then did a statistical analysis on "estimated race," one actually done at the National Institutes of Health (NIH) and other organizations. Many members do not have any race designated with their name, he said, so for some they will have the race designated as "black" or "Hispanic/ Latino" but for some, it could be "other." So, we actually did a statistical technique where we estimated a race based upon a member's zip code, their name and other factors. (Keep in mind, we did this solely for this statistical analysis; we did not put this on people's individual profile.) And then the final thing we did is compare shared measures based upon the data that we were looking at. When we looked at the MCAS sample, we compared each race group to the Minimum Performance Level (MPL). And then when we looked at our QIP data, we also looked and compared everyone to our white community.

Dr. Jalloh then talked about the health disparities seen in five organizational and Quality MCAS measures of focus. He was particularly "excited" to see that blood pressure control – below the MPL threshold for all race groups in MY2024 – improved to above the MPL for nearly all race groups in MY2025. While we didn't achieve that with our tribal community, they are trending upward. Four disparities were eliminated, four improved, and no disparities worsened. CHW-Barber Program Charter development launched in 2026 and Academic Detailing may have played a big factor here, he noted.

In HbA1c Poor Control, (where the lower number is better), we have seen improvement across all race groups and are excited to see our Asian/Pacific Islander and our Hispanic/Latino communities cross the MPL threshold.

The final one Dr. Jalloh pronounced "interesting" was postpartum care visits and the mostly positive change from the previous year. This is one where we actually had a textbook definition of health disparity where most all the race groups were actually doing very well, but then when we looked at our black community, they were not doing well in MY2024. They were not at the MPL. We did some additional work and the black community improved 6% to the 82.72 percentile, meeting the State's MY2025 threshold.

Dr. Jalloh then segued into measures where we typically see health disparities. In adolescent immunizations, Asian/Pacific Islanders and Hispanic communities have both been consistently above the State's MPL and have actually improved these past two years. Our black and our white communities have improved but still do not meet the threshold. The one community that actually worsened is our American Indian/Alaska Native or "tribal" community. They are trending downward where everyone else is trending upward.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

When we looked at timely prenatal care, all but our tribal community trended up, although only the black and Hispanic communities broke the MPL threshold. The tribal community is actually trending downward.

In the child and adolescent well care visits, we see our Hispanic community consistently (perform above the MPL. Our Asian/Pacific Islanders were not at the minimum in 2024 but now they are. Our black and white communities also trended upward, but our tribal community trended down compared to the previous year.

Dr. Jalloh included a secondary MCAS Measures of Focus for Disparities as Appendix A to his presentation about which he said there is likely a systems issue at play. For example, in cervical cancer screening, all race groups are below the MPL and actually worsened this past year. So, there may be more a systems issue that is driving this versus something specific to one race group or another. Similarly, breast cancer screening decreased in all race groups; however, Asian/Pacific Islanders and Hispanics remained above the MPL. For chlamydia screening, we improved across all race groups but none reached the MPL. When we looked at childhood immunization status, the one group that actually performed worse, where others performed better, is our black community, which is below the minimum and trended downward. With lead screening, we improved across the board, and only our tribal community is still below the MPL. Lastly, our white and tribal communities trended downward for well child visits in the first 15 months of life while the other groups trended up and met the MPL.

We did a review of our MCAS data when we did our HEDIS® assessment, and Dr. Jalloh did a review of our pay-for-performance data where we actually have a separate data set for participating organizations. We have seen this data is very robust where we are not limited by sample size, he said. We have all the measures stratified by race, but you may see that the race stratifications are different compared to the ones that we have for our HEDIS® measures.

So, one may wonder, 'well, we have so many disparities, which ones are we likely to prioritize?' Dr. Jalloh said he would be happy to say more offline, but said we essentially identified looking at two data sets, the QIP data set and the HEDIS® data set that we just reviewed. When we looked at them separately, we came up with an assessment identifying should we act on that disparity, plan upon it, monitor, or not do anything? We think there is a system issue likely driving these measures, including cervical cancer and chlamydia screenings and topical fluoride, because no race or linguistic group has met the State's MPL. So that's why we didn't really want to spend too much energy on trying to initiate targeted interventions that we would do for the other disparities.

Dr. Jalloh quantified the impact of what we have been doing as an organization. He calculated 46 disparities across 2024 measures simply by looking at how many were below the MPL. We were able to address 19 of these in 2025, which he said is "impressive" for a health plan. DHCS has bold goals they want us to meet, and we were able to meet three of them this past year. Focusing on only the top five measures that the QI team wants to focus on, 23 disparities were identified in MY 2024, and we addressed 10 of them in MY 2025.

Pop Health and Health Equity have separate work plan, Dr. Jalloh noted. Health Equity's is geared toward the health disparities themselves. (This workplan is in today's meeting packet. Pop Health's focuses on the cultural and linguistic activities that we must do for NCQA.) The Heath Equity workplan is somewhat extensive because we have our NCQA Health Outcomes Accreditation activities that we have to notate. Our entire 2026-2027 annual work plan is on pp. 355-357. Page 359 in somewhat of an overview of our health equity strategic plan. We also understand that this is a perfect time to align with our QI team, but what we ultimately did is provide a view of their mission as well as what the long term vision is for the Health Equity Strategic Plan for the organization.

We have three core strategies that we are going to implement to help as many of the health disparities as we can. The first is to increase members' health literacy and motivation to access, understand and apply accurate health information to make informed judgments regarding disease prevention and treatment. Two, we want to equip local communities, especially where they are dense with health disparities, with resources to provide basic Medi-Cal navigation, as well as to help empower them to co-design community-based solutions. Three, we want to try to focus on working with our health systems to increase access to excellent quality multilingual services and help ensure that we have diverse practitioners, ancillary staff, community health workers, doulas, helping our members in the community.

Dr Moore commented: for those measures where the Native American population is dropping, I remember that in prior years, we noted that where performance was lower in certain groups, it was often not a reflection of some group-within difference, but it was the PCP that was providing care was deficient in their quality. Dr. Jalloh replied that a preliminary assessment suggested that one provider is indeed a big driver in the tribal population, and that this is reminiscent of a past situation

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

in the African American community where when one large provider was low, thus driving down total performance.

Neonatologist and Q/UAC voter Brian Montenegro, MD, wondered if the universal improvement in A1c indicated mass use of GLP-1s? What's going on?, he asked. Dr. Jalloh relied that we recognize that when we went through the expansion, our data trended down. But today, looking at 24 counties against 24 counties? Maybe our data is improving with Datalink whereas before we relied on manual submissions.

Dr. Montenegro said it stands out for him because "it's a diet and lifestyle thing and that's very difficult to get people to change despite access." Family Medicine physician and Q/UAC voter Jennifer Wilson, MD, commented that many clinics now have access to in-house A1c testing, so one is not dependent on sending someone out to the lab to be able to get the value. So, a value, like not having an A1C, is the same as not having it controlled. She said she thought those to be details worth capturing.

Kristine Gual agreed: speaking from the data completeness perspective, one thing to remember is the rate for diabetes A1c and controlling blood pressure for people with hypertension is these are still hybrid measures. We are still taking a random sample of charts, 100 per county if we can get them, to come up with these annual rates. And so, this is why our annual HEDIS® rates are still not based on the entire population, but that is something we are moving towards within the next few years. This is actually nationally mandated. These measures are converting to what is called ECDS and basically must include the entire population. So, there is some transition going on. We are being proactive: DataLink is part of that. The idea that a point-of-care test, even if it is not submitted with a CPT2 coding, can now be extracted from an Electronic Medical Record (EMR) and brought into our HEDIS® engine to actually do rate reporting. That's what I mean when I say that, opposed to retrospective data, having these current year updates that we can use in real time to really look at our progress is going to be much more sophisticated way of monitoring across the network.

Isaac Brown added that with the new counties, we are just seeing overall improvement in some of these areas. We have got a good QIP in place to some support them that they didn't have previously.

Pediatrician and Q/UAC voter Randy Thomas, MD, asked how much do we need to increase the Asian/Pacific Islander and Hispanic population to get to 4-Stars? Dr. Jalloh replied that is a data question that he could perhaps bring to the data team to see if they have sample size estimates. Kristin said this was a good point, and we know we will see big population changes over the next year: we will see an impact on our quality scores as well as challenges around access. We do have some headwinds, but that makes the strategic planning we are doing all the more important.

Dr. Moore added that the new federal Office of Management and Budget (OMB) requirements that have to be implemented by 2029 for basically changing the way that California addresses the Hispanic ethnicity group is going to dramatically decrease the individuals in that category and increase all the other categories: kind of scrambles all the math instantly and make any kind of comparisons difficult, he said. DHCS is moving very slowly to implement that.

Brian Montenegro. MD/Jennifer Wilson. MD to approve and accept the Grand Analysis. Motion unanimously carried.

VII. Adjournment to 7:30 – 9:00 a.m. Nov. 18, 2026

Dr. Netherda adjourned the meeting at 9 a.m.

Respectfully submitted by: Leslie Erickson, Program Coordinator II

Signature/Date of Approval:

Mark Netherda, MD
Medical Director for Quality and Committee Vice Chair

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Oct. 13, 2026 / 1:33 – 2:44 PM

Members Present:	Innes, Latrice, Compliance Manager, Grievance & Appeals
Ayala, Priscila, Director of Network Services	Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Services
Beard, Alyssa, RN, Manager of CC Regulatory Performance	Klakken, Vicky, Regional Director (NW-Eureka)
Bontrager, Mark, Senior Director of Behavioral Health, Health Services	Krznarich, Jackie, RN, Manager, Member Safety – Quality Inspections
Brincko, Aaron, Director of Provider Relations	Matthews, R. Douglas, "Doug," MD, Regional Medical Director (Chico)
Brown, Isaac, MHA/MBA, Senior Director, Q & PI	Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Emeritus Chair)
Campbell, Anna, MPH, Policy Analyst, Utilization Management	Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Crosby, Zhavontia, BSN, RN, PHN, Associate Director of Population Health	Newman, Rachel, RN, BSN, Associate Director, Credentialing
Devan, James, Director of Quality Improvement, QI	O'Connell, Lisa Brundage, MHA, Director, Enhanced Health Services
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Townsend, Colleen, MD, Regional Medical Director (SE-Fairfield)
Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI	Villasenor, Edna, Senior Director, Member Services and Grievance
Guevarra, Angela, RN, Director of Care Coordination	Ward, Lisa, MD, Regional Medical Director (SW-Santa Rosa)
Hightower, Tony, CPhT, Associate Director, UM Regulations	
Members Absent:	Hanusiak, Kenzie, Assoc. Dir., Regulatory Affairs & Compliance
Andrews, Leigha, Regional Director (SW)	Jalloh, Mohamed, Pharm.D, Dir. of Health Equity (Health Equity Officer)
Barresi, Katherine, RN, BSN, PHN, Chief Health Services Officer	Jensen, Annika, RN, Assoc. Dir. of Clinical Integration, Care Coordination
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations	Leung, Stan, Pharm.D, Director of Pharmacy Services
Bjork, Sonja, JD, Chief Executive Officer	Randhawa, Manleen, Senior Health Educator, Population Health
Davis, Wendi, Chief Operating Officer	Ruffin, DeLorean, DrPH, Director of Population Health
DeVido, Jeffrey, MD, Behavioral Health Clinical Director	Vaisenberg, Liat, Director of Health Analytics
Guests:	Morris, Matthew, MD, Regional Medical Director (Auburn)
Aarons, Rose, Quality Training Specialist & Dental Liaison, QI	Muncy, Kellie, Senior Manager of Configuration, Configuration
Akintan, Folo, MBBS/MD, MPH, MBA, Epidemiologist, Pop Health	Nguyen, Tom, Manager of Health Analytics, Finance
Beltran-Nampraseut, Athena, Program Manager II, QI (PCP QIP)	O'Leary, Hannah, MPH, CHES, Manager of Population Health
Bikila, Dejene, Manager of Data Science, Finance	Quichocho, Sue, Manager of Quality Measurement, QI
Chebolu, Radha, Sr. Health Data Analyst II, Finance	Rathnayake, Rasitha, Sr. Health Data Analyst I, Finance
Clark, Kristen, Manager of Quality & Training, Member Services	Rednic, Hanny, Program Manager I, Utilization Management
Durst, Jennifer, Senior Manager of Performance Improvement, QI (Santa Rosa)	Roach, Erika, Program Manager II, Network Services
Harris, Vander, Senior Health Data Analyst I, Finance	Rhorer, Jeanelle, Supervisor of Configuration, Configuration
Hendrix, Hillary, Executive Assistant, Behavioral Health	Roberts, Dorian, Associate Director, Provider Relations
Isola, Brandy, Manager of Performance Improvement, QI (Chico)	Salehi, Tiphanie, Senior Health Data Analyst II, Finance
Kim, Amanda, Improvement Advisor, QI (Redding)	Shamoiel, Shantal, County Child Welfare Liaison, Behavioral Health
Kubota, Marshall, Associate Medical Director	Stark, Rebecca, Regional Director (Chico)
Kung, Jen, Sr. Health Data Analyst II, Finance	Stites, Jaylyn, Program Manager II, Provider Relations (Redding)
Lee, Donna, Manager of Claims, Claims	Thomas, Penny, Senior Health Data Analyst I, Finance
Ling, Samuel, Sr. Health Data Analyst I, Finance	Tryan Tiffany, Manager of Performance Improvement, QI (Redding)
Leung, Paul, Sr. Health Data Analyst I, Finance	Watson, Deanna, Program Manager I, QI (ECM QIP)
Ling, Samuel, Sr. Health Data Analyst I, Finance	Williams, Tracy, Executive Assistant to the Chief Health Services Officer
Mednick, Christy, Sr. Health Data Analyst I, Finance	Yu, Fei, Sr. Data Scientist I, Finance

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

I. Call to Order
• Announcements
• Approval of Minutes
	Senior Director of Quality & Performance Improvement Isaac Brown, MHA/MBA, called the meeting to order at 1:32 p.m. from the Fairfield-West office.
	• Approval of the Sept. 8 IQI Minutes.
	• *Acceptance of the draft minutes of the*
	  o Aug. 27 Member Grievance Review Committee (MGRC)
	  o Sept. 24, June 18, and Feb. 5 Substance Use Internal Quality Improvement Committee (SUIQI)
	Isaac welcomed Zhavontia Crosby, RN, now in her third week as Partnership's Associate Director for Population Health. Zhavontia has worked in healthcare for more than 28 years, mostly in federally qualified health centers (QHCs) pushing forward quality initiatives.
		Motion to approve the IQI minutes as presented:
		Mark Netherda, MD
		Second: Lisa Ward, MD
		Motion passes unanimously
		Motion to accept the other minutes as presented:
		Mark Netherda, MD
		Second: Lisa O'Connell, MHA
		Motion passes unanimously

II. Old Business – None.		
III. New Business Consent Calendar (Committee Members as applicable)		
2026 Annual Oversight Audit: Carelon – Notice of Final Audit Results CY 2025 Q1/Q2 2026 Prior Authorization Metrics Report by Partnership County **Health Services Policies** Behavioral Health MCBP8015 – Coordination of Care for Child Welfare-Involved Members MPBP8007 – Screening and Treatment for Substance use Disorder MPBP8013 – Eating Disorder Management Policy Quality Improvement MCQP1021 – Initial Health Appointment – ***pulled for remark*** Utilization Management MCUG3032 – Orthotic and Prosthetic Appliances Guidelines MCUP2020 – Hospice Services MCUP3114 – Physical, Occupational and Speech Therapies MCUP3128 – Cardiac Rehabilitation MCIP3130 – Osteopathic Manipulation Treatment MPUP3116 – Positron Emission Tomography Scans (PET Scans) **Non-Health Services Policies** Member Services MP316 – Provider Request to **Reassign** Member & Assistance with Inappropriate Member Behavior – **NEW TITLE – *pulled*** **Leslie Erickson pulled MCQP1021 to note that Attachment A,** a sample provider welcome letter to a new member, is now translated into all threshold languages, including Punjabi. **Hanny Rednic pulled MP316 as its definition of "medical home" differed from that seen in other Partnership policies.** Senior Director of Member Services and Grievance Edna Villasenor noted that MP316's definition was pulled from Partnership's Managed Care Plan (MCP) contract with the Department of Health Care Services (DHCS). She read it into the record. IQI members discussed	Motion to **approve the slate without MCQP1021 and MP316:** Lisa Ward, MD Second: Kristine Gual *Motion passes unanimously* Next Steps: • Oct. 21 Quality/Utilization Advisory Committee (Q/UAC) • Nov. 4 Physician Advisory Committee (PAC) Motion to **approve MCQP1021 as presented:** Mark Netherda, MD Second: Kristine Gual *Motion passes unanimously* Motion to **approve MP316 as amended:** Mark Netherda, MD Second: Lisa Ward, MD *Motion passes unanimously*	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
whether it adequately captured when an individual primary care provider (PCP) or site might serve in such capacity. **IQI voted to approve the policy with an amended definition,** which was honed post-meeting via email from Santa Rosa Medical Director Lisa Ward, MD, and agreed to by several senior leaders. The first sentence below is drawn from the Contract: Medical Home: Medical home means a model of organization of Primary Care that delivers the core functions of primary health care, which is comprised of comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety. The Medical Home may refer to a provider organization or an individual primary care provider who is responsible for managing the Member's primary care needs and coordinating specialty services. **"Medical Home" is mentioned and/or defined in approximately 20 other Partnership policies. IQI's motion to approve as amended also included a proviso that staff may update their policy definition, where they exist, to match the new definition in MP316 without bringing that policy through IQI/Q/UAC/PAC.** In a separate concern, Senior Manager of Configuration Kellie Muncy asked how a policy could be on consent, rather than discussion, at committees if it involved a business or other systemic change, particularly in the adjudication of claims? She specifically called into question MCUP3114 – Physical, Occupational and Speech Therapies. Chief Medical Officer Robert Moore, MD, and Medical Director for Quality Mark Netherda, MD, both noted that the age and timing changes Kellie cited had been previously discussed and approved at committee. (Post meeting research revealed that the configuration changes were approved at PAC Sept. 10, 2025, but may not have been configured at that time.)		
IV.	**New Business – Discussion Policies**	
Hanny Rednic pulled MCUG3118 – Review Guidelines for Member Placement in Extended Care … for more work. UM intends to bring the policy to November Quality meetings.		
The department policy owner/designee must ensure the approved changes are appropriately followed up (check all that apply for each discussion policy):		
MPQG1005 – Adult Preventive Health Guidelines		
Policy Owner: Quality Improvement – *Presenter: Mark Netherda, MD, Medical Director for Quality*		
☐ 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	
This policy is updated to align with All Plan Letters (APLs) 26-014 (Cognitive Health) **and 26-015** (Immunization Requirements). **Section III.** – Partnership Advantage definition updated. **Section VI.A.8 is added**: For Members who are dually eligible for Medi-Cal and Medicare, Partnership will adhere to the IHA requirements in the PHM Policy Guide and MCP Contract. **Section VI.B.2 is modified:** Providers must ensure timely provision of immunizations to *adult* Members in accordance with *a recommendation from the CDC/ACIP (*Advisory Committee on Immunization Practices), *ACOG, AAP, or any modification or*		Motion to **approve with one amendment:** Robert Moore, MD, MPH, MBA Second: Kristine Gual *Motion passes unanimously* Next Steps:

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	supplement to that recommendation adopted by the California Department of Public Health (CDPH) regardless of the Member's age, sex, or medical condition, including pregnancy. Providers must document each *adult* Member's need for immunizations as part of all regular health visits. All provided immunizations must be documented in the California Immunization Registry (CAIR2). **Section VI.B.3 is modified:** Partnership, per APL 26-014, is no longer required to verify whether providers have completed DHCS Dementia Care Awareness cognitive health assessment training. Providers are no longer required to complete this training prior to billing for annual cognitive assessments. Providers will perform the annual cognitive health assessment as a part of an Evaluation and Management (E&M) visit *including, but not limited to, an office visit, consultation, or preventive medicine service. (Elements of the cognitive health assessment can be conducted by non-billing team members acting within their scope of practice and under the supervision of the billing Provider.)* Providers must have readily available documentation based on APL 26-014 guidelines in the Member's medical record. **Attachment A:** A line detailing Cognitive Health Assessment for members 65 years and older is added to the Behavioral Conditions section. Dr. Netherda went through the synopsis. Senior Manager of Configuration Kellie Muncy initiated a conversation about codes, stating that some Medicare G codes are now crossing over into Medi-Cal usage. Dr. Moore noted that the G0438 annual wellness code is not exclusive to cognitive testing and is not a denial for other codes: one code may be used for Medicare, another for Medi-Cal billing. **As Partnership no longer needs to verify whether providers are trained in administering cognitive testing, "certified" is struck from VI.B.3.a, now amended to read, in part, "~~Certified~~ Providers will perform the annual cognitive health assessment as a part of an Evaluation and Management (E&M) visit including, but not limited to, an office visit, …"**	Oct. 21 Q/UAC Nov. 4 PAC
MCUP3013 Durable Medical Equipment (DME) Authorization		
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director Utilization Management Regulations*		
☒ **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): We need to determine the process for how IPNs are approved and when they are published so that we do not see misalignment between policies and IPNs.***
☐ Configuration of HRP and/or Claims Editor System (CES)	☐ Configuration of Essette/Jiva	
Section I.F. - Policy MPUP3139 – Criteria and Guidelines for Utilization Management was added as a Related Policy. **Section III.B. -** The DHCS definition of DME was added **Section VI.A.1. –** This paragraph regarding the information required on a DME prescription was moved to the top of the policy. Note was also added to that a prescription can be written or the "electronic equivalent." **Section VI.A.2. –** The list of criteria we consider when authorizing DME was modified to include our policy MPUP3139 – Criteria and Guidelines for Utilization Management in lieu of "InterQual." Policy MPUP3139 provides a more thorough description of all criteria that Partnership would consider, including InterQual. **Section VI. F.2.b**. – This section regarding bathroom equipment was updated to say "When a TAR is required" because an IPN has been posted which now states that No TAR is required for several bathroom equipment items.		*There were no questions.* Motion to **approve as presented:** Lisa O'Connell Second: Brigid Gast, RN *Motion passes unanimously* Next Steps: Oct. 21 Q/UAC Nov. 4 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI. F.3.and VII.G. – This section regarding Compression Garments was removed and transferred to a different policy, MCUG3032 Orthotic and Prosthetic Appliances Guidelines, to be in alignment with where the criteria is shared in the DHCS Provider Manual. The Reference to the BREW form for Compression Garments at VII.G. was also removed and transferred to the other policy. **Attachment A:** The only change to this document was on page one to update policy reference to section VI.B. for Rental Only with a 10-month limit. **Attachment B:** Codes E0658 and E0659 were added to the list of Lymphedema pumps/compression devices, and a policy reference was updated to VI.E. for information on DME provided to disabled parents or guardians.	
MCUG3118 Prenatal & Perinatal Care		
Policy Owner: Utilization Management – *Colleen Townsend, MD, Regional Medical Director (Southeast)*		
☐ 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):* ***Provider Contracting to use updated Attachment A document as Contract Addendum***
☐ Configuration of HRP and/or Claims Editor System (CES)	☐ Configuration of Essette/Jiva	
This policy was updated to align with APL 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members. **Section I** – Policy numbers were updated as necessary. Policy MCQG1015 Pediatric Preventive Health Guidelines was removed from the Related Policies list and policy CLPM31 Obstetrical Services was added at I.K. **Section III.I** – Definition for Professional Organization was added to describe those recognized by DHCS for clinical guidance as per APL 26-005. **Section VI.B.** – Statement added to say, "No prior authorization is required for standard prenatal, maternal, and preventive services and care as defined by the most current clinical standards or guidelines of ACOG, AAFP, ACNM, NACPM and CPSP, as applicable." **Section VI.C.3.** – Paragraph updated to clarify requirements for different types of perinatal services programs. **Section VI.C.4.c.3)b)i.** – "Comprehensive Assessments" was added as a specific measure to be evaluated in quality monitoring of PHPS providers **Section VI.C.5.b.** – Statement added to say "Members may choose a midwifery provider outside of their capitated facility if that facility does not offer midwifery services for delivery." **Section VI.C.8. and 9.** – Regulatory requirement sources for perinatal services were updated to reference APL 26-005 and links to CPSP information were updated. Screening required by various agencies were separated into section VI.C.9 **Section VI.C.10.** - Statement added to say "Claims for PHPS services should be submitted using the codes defined by DHCS for CPSP services. These Z-codes should be used by all PHPS programs, both CDPH-recognized CPSP programs and CPSP-like programs." **Section VI.C.12.** – Reference was added for our policy MPNP9006 Doula Services Benefit. **Section VI.D.1.a.** - Statement added in the PHPS Standards of Perinatal Case Management section to say, "The entire assessment or portions of the assessment can be completed by the clinical provider or perinatal services provider. The results for assessments must be made available to clinical and perinatal services providers caring for the Member." **Section VI.D.4.** – Specified that every PHPS program "must" have a designated Clinical Director.		*There were no questions.* Motion to **approve as presented:** Lisa Ward, MD Second: Aaron Brincko *Motion passes unanimously* Next Steps: Oct. 21 Q/UAC Nov. 4 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.D.12.b.1) b) and VI.G.2.a.-e.– In the Nutrition Education Services section and the Diabetes Care in Pregnancy section, we updated the certification title for Certified Diabetes Care and Education Specialists (CDCES). **Section VI.D.12.c.1) a)i.** – Statement added to say "Patients who do not screen positive and who have risk factors for perinatal mood disorder should be provided with education on perinatal mood disorders, stress management and referred to local resources per USPSTF grade B recommendation." **Section VI.E.3.a.** – Specified that standardized assessment and reassessment tools, and the individualized care plan must be updated and revised as necessary <u>each trimester</u> and at the post-partum visit, <u>more frequently as needed</u>. **Section VI.E.7.a.** – Specified that Perinatal Services providers will maintain an updated list of staff working for them and their qualifications and "These will be provided to Partnership upon request and submitted with PHPS applications and updates." **Section VI.H.1.** - Statement added to say "PHPS programs should provide basic lactation support and education during and after pregnancy and should refer to local resources as needed to meet the Member's specific needs." **Section VI.H.3.** - Statement added to say "WIC programs in each county may provide lactation services for Members. PHPS/CPSP programs that do not have Lactation Education, Support or Consultation available should refer to local WIC programs and other community-based lactation services." **Section VI.I.2.** – Added reference to policy MCUP3124 Referral to Specialists (RAF) Policy **Section VI.I.2.a.** – Statement added to say "Members requiring a referral to a Medical or Obstetrics specialist should be referred to Partnership's Care Coordination Department for Complex Care Management." **Section VII. References** - Reference C. was updated to reflect APL 26-005. Hyperlinks were updated throughout as needed. Reference I was added for USPSTF Perinatal Depression Interventions and References J. – L. were added for recommended depression screenings cited in the policy. **Attachment A** – The PHPS Application and Update Form and Contracted Provider Addendum was updated to specify that all licensed program staff must be credentialed with Partnership or with a Partnership delegate, if applicable, "<u>prior to providing services to Partnership Members and in accordance with Partnership credentialing requirements</u>" by July 2026.	
MCUP3133 Wheelchair Mobility, Seating and Positional Components **Policy Owner: Utilization Management –** *Tony Hightower, CPhT, Associate Director Utilization Management Regulations*		
☒ **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	
This policy was updated due to align with new DHCS terminology and a new benefit code K0462. **Section III.B. and C.** – The previous definition for "Custom Rehabilitation Equipment" was updated to define a new term, "Complex Rehabilitation Technology (CRT)." Ad new definition for a "CRT Supplier" was also added. **Section III.K. and L.** – The acronym and definition for a Qualified Health Care Professional (QHCP) was updated. The definition of a Qualified Rehabilitation Technical Professional (QRTP) was also updated. **Section VI.** - Language was updated throughout to reflect "Complex Rehabilitation Technology" or CRT in lieu of "custom rehabilitation equipment."		Motion to **approve with one amendment:** Mark Netherda, MD Second: Kristine Gual *Motion passes unanimously* <u>Next Steps</u>: Oct. 21 Q/UAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.A.3. – Statement added to say, "Replacement wheelchairs will be considered based on Medi-Cal guidelines/ frequencies. A replacement that is requested and does not meet frequency limits will be considered based on a report of the need for replacement and documentation of the cost to repair (if appropriate) vs. replacement of the device. The request must document the medical need for continued use of the device." **Section VI.D.** - Language was added in the section on Seating and Positioning Component Coverage Criteria to say "Accessories or features that do not explicitly improve function, independence and safety to complete ADLS or that do not support a medical need are not covered." **Section VI.F. –** This section regarding Loaner Rental During Repair was updated to reflect new DHCS benefit coverage instead of Partnership's previous coverage as a BREW benefit. Code K0462 for rental of a power wheelchair during extended repair will now be covered with no TAR requirement for up to two one-month rental periods per year. Associate Medical Director Marshall Kubota asked for **clarity on VI.D:** *Seating and Positioning Component Coverage Criteria: SPC are covered when criteria 1. 2. and 3., at least one of 4. – 9., and 10. – 19. (if applicable) are met….*, questioning whether all or just one of 10-19 needed to be met? **Tony agreed to wordsmith this section based on a suggestion from Dr. Moore, and IQI agreed.** Kellie Muncy asked about the effective date. A DHCS bulletin announced the code K0462 would be effective Aug. 1, 2026. DHCS also updated a section of the Provider Manual in July, so IQI agreed to use Aug. 1 as the effective date.	Nov. 4 PAC **VI.D. is amended to begin: …** SPC are covered when criteria 1. 2. and 3. and at least one of criteria 4. – 9. are met. Criteria 10. – 19. will then be applied if relevant features are requested. …

V. Presentations

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

- The Electronic Clinical Data Set (ECDS) Datalink Scaling Project (DataLink) is moving along. To date, 246,714 distinct Members are currently represented in the DataLink data across Partnership's service area. Six of 24 counties have reached the MY2026 target of 33% of county membership within the data pulls. Seven additional counties are within five percentage points of the 33% target.
- Quality Measure Score Improvement (QSMI) workgroups have created measure-specific toolkits, which Process Improvement managers are now reviewing.
- The Equity & Practice Transformation (EPT) Project officially concludes for provider practices in November 2026; however, Partnership is still required to submit a MY2026 data deliverable in 2027 to determine payment eligibility for practices who met the 90th percentile in their Population of Focus HEDIS-like measures.
- Each year, Shasta County Public Health organizes a free community-wide influenza vaccination event. This year's drive-through clinic in scheduled for Saturday, Oct. 17, from 10 a.m. to 2 p.m. at Partnership, 351 Hartnell Ave., Redding. Questions should be directed to Chandler Ackerman at cackerman@partnershiphp.org.

There were no questions for Isaac.

CY 2025 Primary Care Provider Quality Incentive Program (PCP QIP) Evaluation – *Athena Beltran-Nampraseut, CPhT, Program Manager II, QI*

The program covered 18 clinical measures across chronic disease management, preventative screening, pediatric access, and monitoring-only categories across three practice types: Family Medicine, Internal Medicine, and Pediatrics. Also included were five non-clinical measures across hospital utilization, primary care utilization and patient experience, with full and partial points targets varying according to internal benchmarks. Participation in the 11 unit-of-service (UOS) measures was optional, and one – extended office hours – was incentivized outside of the QIP. Most of the CY 2025 core measures continued from CY 2024 with the addition of well-child visits in the first 15-30 months of life (Pediatrics only) and chlamydia screening (16-18 year-olds (Pediatrics only) in the clinical measures; the deletion of risk-adjusted readmissions in the non-clinical measures, and the addition of five monitoring measures: well-child visits in the first 15-30 month of life (Family Medicine), chlamydia screening (16-24 y-o in Family Medicine) chlamydia screening (18-24 y-o in Internal Medicine) and topical fluoride in children (Family Medicine and Pediatrics only). The 2024 UOS measures continued in 2025, although dental fluoride varnish was deleted and academic detailing was added. Other 2025 adjustments included reducing healthcare disparity as a new optional clinical measure. Partial points target thresholds were raised back to the pre-Covid 75th percentile.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Eleven of the carryover clinical measures showed relative performance improvement ranging from .83% to 12.17% above 2024 marks plan-wide, Athena said. Moreover, most met or performed above the Healthcare Effectiveness Data Information Set (HEDIS®) minimum performance level (MPL), most significantly in cervical cancer screening and colorectal cancer screening. Dr. Moore commented that we did a 100% "chart chase" in HEDIS, so why the difference in the two chlamydia measures? Athena replied that different denominators applied; also, we do not look at the sexual activity of the children involved.

Relative improvement (RI) points were available for most existing clinical measures where a provider site met the 75th percentile target AND achieved an RI score of 15% or higher. Lead screening in children and diabetes – HbA1c good control had the highest RI scores plan-wide pushing providers to full points. 2025 participation was higher than in 2024 in five of nine UOS measures, Athen noted when discussing payouts. The highest UOS payouts were $524,000 for advanced care planning; $358,850 for early administration of the first HPV dose; and $344,802.57 for the new (and optional) reducing healthcare disparity measure.

In all, 384 provider organizations earned $55.7M in incentive payments, with Sonoma POs the highest earners by county of the 64-PO Santa Rosa region total of $13,002,478.62, and Solano POs the highest earners by county of the 62-PO Fairfield region total of $11,928,573.64.

In summary, 2025 programmatic changes saw six measures added, two removed, and partial points thresholds increase from the 50th percentile to the 75th percentile. Nine clinical measures ended above the MPL; five hit >= 50th; three finished >= the 75th and one achieved the 90th percentile. Among the non-clinical measures, three met full points thresholds, including the new-for-2025 hospital follow-up within 7 days after discharge. One non-clinical measure met its partial points threshold.

For CY 2027, six clinical measures will transition to ECDS reporting, (i.e., DataLink) in alignment with DHCS expectations. Thresholds will increase for patient experience, and improvement plans will be required where these thresholds are not met. (This is both a 5-Star NCQA Health Plan accreditation goal and a DHCS "withhold measure.") Two non-clinical measures will be renamed to "potentially preventable admissions" and "low-acuity non-emergent ED visits" in alignment with DHCS nomenclature. Tobacco use screening is moving to "monitoring" in alignment with HEDIS® and the UOS ECDS measure will be removed as DataLink is added in alignment with DHCS reporting requirements.

Dr. Moore commented that he didn't see anything that would require changes in addition to those described. Dr. Kubota expressed surprise at the "half million" paid out for advance care planning. Dr. Moore noted that national data shows that individuals who have such a plan have fewer end-of-life care issues. Partnership, however, has not independently analyzed this, Dr. Moore added as he acknowledged that this incentive is "controversial." He suggested that medical directors Matthew Morris, MD, and Bettina Spiller, MD, next year could sample the quality of care provided during these ACP discussions. Athena asked if the Member Safety Inspections team could partner in this effort, and team Manager Jackie Krzanich, RN, said yes. Dr. Netherda wondered if the Health Equity team is doing something along these lines? Dr. Moore concluded that working backwards from death in the hospital is difficult but can be done. He suggested that the matter might be a topic for a future annual Hospital Symposium.

Motion to accept the 2025 PCP QIP Evaluation as presented: Kristine Gual/James Devan

MY 2025 National Committee on Quality Assurance (NCQA) Health Plan Rating (HPR) and **5-Star Strategic Plan for Quality Improvement 2026-2029**
– Kristine Gual, PMP, CPHQ, Director of Quality Measurement, QI

Kristine in July presented our HEDIS® outcomes for 2025 Managed Care Accountability Set (MCAS) measure set and today circled back to talk about our NCQA Health Plan Rating. The timing is a little out of sync, she said: we don't hear from NCQA with our final outcomes usually until late August or early September. Our final HPR is 3-Stars. We did use the Child Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Survey for the health plan rating in 2025, and our county ratings were nearly identical to 2024 (which was the first year that our 10 incoming counties joined the Plan) yet we saw a decrease from 3.5-Stars to 3-Stars. We are still working on regaining that lost ground. Everyone is encouraged to look at the white paper in today's packet under FYI for more information, including a county-level breakdown on all of the 44 measures that make up the HPR.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Moving on to the Five-Star Strategic Plan for Quality Improvement 2026-2029, Kristine said that the last time we updated our strategic plan for the Quality Improvement department was in 2019. Today, we are in a different world, so it was definitely time for an update. A white paper that goes along with this presentation is also in the today's packet under FYI.

Every three years, Partnership updates its org-wide strategic plan, which looks at things much beyond the scope of quality improvement. This is in process right now with our Executive team and Board. They will come up with a set of "pillars," which have goals associated with them. The pillars are not yet defined, but in our last strategic plan we had a pillar for quality of care and health equity. We anticipate that there will be a similar pillar, and this is where we can see this QI plan located. There are many other departments' strategic plans going on now, including Health Equity and Member Experience. We all work together, and the idea is that everybody aligns; we may have different focus areas, but we are all moving in the same direction.

A little bit about the urgency of accelerating our performance at this time: we saw it in our health plan ratings that national trends in quality performance are outpacing Partnership. We are improving but not at the trajectory that we need to keep up with national Medicaid benchmarks or with performance by other California managed care plans. There is an enormous financial risk associated with this performance as well as to our members' health, which is really our mission. Finally, we want to see consistency across our network. We have a very diverse network, and performance on the quality plan is sometimes dependent on where you are located, what community you are part of, and so this is why that is related to equity.

Kristine then went through the plan's development process, which began in May with outside consultants, focus groups and interviews. We were able to develop a very comprehensive SWOT (Strengths, Weaknesses, Opportunities and Threats) as summarized in the white paper. We needed a criteria to bump that against so that we could come up with a focus plan that was achievable in three years. The criteria included member health and experience, regulatory and financial impact, and organizational capacity. We want to make sure that anything we decide to put time and effort into is sustainable, fits into our timeline and that we are able to have a regional approach. We are in the midst of our communications now and are interested in provider feedback on this plan. It will go to our Board on Oct. 28. Then we will go right into implementation, setting up tactical goals with the impacted departments and the provider network.

Kristine then went over the high-level strategic "aggressive" goals for the next three years. We can achieve these goals or make significant progress towards achieving all of them, she said. Improving member experience is actually a goal for our entire organization. Some needed metrics are getting needed care and getting care quickly. We want to perform at the 67th percentile or higher.

Our second strategic goal is around reducing avoidable utilization in things like ambulatory sensitive admissions. Our goal is to reduce by 10% or more annually plan-wide and to retain our actually high level of performance on hospital readmissions. This is where lower is better. We are currently performing at the 90th percentile. We want to retain that and keep that high performance. The final three strategic goals are around areas of preventive care: improving pediatric preventive care defined by well-child visits and immunizations, improving chronic disease outcomes like diabetes and hypertension, and improving timely access to prenatal care. This is consistent with what we shared this summer on our HEDIS® outcomes. Kristine noted. Our goal across our DHCS rating regions is to perform at the 67th percentile or higher in each of those rating regions.

We have a special focus on our rural regions because we know this is where the need is greatest and on reducing health inequities. Composite key indicators that will show us we are moving in the right direction include our NCQA Star rating. We will start with moving from a 3-Star to a 3.5-Star and then onward up to 4 and then 5. Our second success measure is our Quality Factor Score on our MCAS measures. We don't yet have that information from DHCS to compare across California, but we will share when DHCS releases that information for 2025.

How will we focus? We have objectives and lead departments defined to move the needle on five strategic goals: access to care, provider experience, member experience, data analytics and organizational excellence and culture. In access to care, the idea is not only to strengthen our network capacity, it is also to expand alternative access models to meet the needs of the community, like telehealth and mobile units. Provider engagement is Quality's wheelhouse: building the capacity of the network towards high performance on the prior unprioritized quality measures. Our Member Experience department is focused on better understanding drivers and resolving some of the highest priority gaps in the member journey. Member engagement is focused on improving outcomes for high needs populations. for example, D-SNP, high-needs care coordination and CalAIM. Finally, we are able to provide retrospective analytics, but the idea is to include real time analytics that maximizes opportunities for closing

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
care gaps and improving member health. Lastly, in this time of economic uncertainty, we want to make sure our resources as well directed and that we receive a return on investment for every initiative we launch. Although the Board is expected to final this on Oct. 28, we are still interested in conversations, discussions, and questions about the plan and we welcome provider engagement. We will be talking with our lead departments on finalizing smart goals around these different focus areas and building tactical plans. We will report annually on our progress. Kristine said she is "thankful" for new Director of Member Experience Irem Conery and is eager to work with her to align QI and Member Experience efforts. Dr. Moore noted that Chief Executive Officer Sonja Bjork, JD, has reviewed this plan, and that her sole recommendation is that Behavioral Health be involved.		
MY 2025 / RY 2026 Health Equity Disparities Grand Analysis – *Mohamed Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*		
Dr. Jalloh was unable to attend the meeting. He will present at the Oct. 21 Q/UAC.		
VI. FYI/Adjournment		
Isaac Brown adjourned the meeting at 3:25 p.m. IQI next will meet Tuesday, Nov. 10, 2026.		
Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement *Approval Signature:* *Date:* Issac Brown, MHA/MBA Senior Director, Quality & Performance Improvement		

PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI DEPARTMENT UPDATE
NOVEMBER 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** • The 2026 CG-CAHPS survey results were sent out to our qualifying provider network on Friday, October 16, 2026. • PCP QIP continues to assist with final revisions to the contract amendments for participation in the 2027 PCP QIP
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 for Measure Period I has been completed. The incentive checks were prepared and distributed via mail on October 14, 2026.
PERINATAL QUALITY INCENTIVE PROGRAM (PQIP)	**Program Overview** The Perinatal QIP offers financial incentives to participating Comprehensive Perinatal Services Programs (CPSP) and select non-CPSP providers providing quality and timely prenatal and postpartum care to Partnership members Program Update **Program Update** • The Perinatal QIP 2025-26 incentive payment validation process is nearly complete with payment distribution to go out by 11/30/2026. We are inviting several new providers to join the program
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** • Due to a recent notification from DHCS regarding changes to the ECM benefit, a revised 2027 ECM QIP measurement set proposal will be presented to the Physicians Advisory Committee (PAC) on 11/4/2026. • Once approved, the 2027 ECM QIP program specifications and related documents will be finalized and published to the ECM QIP webpage by 11/30/2026.

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** • The HQIP Preliminary Scoring for the 2025-26 Measurement Year was completed in October. Final payment scoring and incentive payment distribution are on track to be completed by 11/30/2026. The 2027 HQIP measurement should be finalized by the end of October and posted to the website.
EXTENDED CARE FACILITY INCENTIVE PROGRAM (EXT QIP)	**Program Overview** The EXT QIP offers financial incentives to support and improve the quality of long-term care provided to our members, with measures in the following domains: Clinical, Functional Status, Resource Use, and Operations / Satisfaction. **Program Update** • Phone outreach for facilities with outstanding 2026 QAPI plans and attestation forms will take place this month. • The 2027 EXT QIP program specifications and related documents will be finalized and published to the EXT QIP webpage by 11/30/26.

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** • N/A
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** • 2027 eReports scoping has been completed and development is in process. Weekly development meetings with Web Team started on 10/20/2026.
ECDS PROJECT (DATALINK)	**Program Overview** The Electronic Clinical Data Set (ECDS) Datalink Scaling Project (DataLink) is designed to transition Partnership from a successful pilot program to an enterprise-scale clinical data strategy that supports NCQA's move toward ECDS reporting, improves quality performance reporting, reduces reliance on manual chart review, and creates a

	sustainable interoperable clinical data asset across Partnership's provider network. Through governance, provider onboarding, data validation, and expanded use of structured clinical data, the project aims to improve quality measure reporting, mitigate regulatory and financial risk, and establish Datalink as a scalable long-term solution for quality measurement and population health initiatives. Partnership has prioritized receiving clinical data for members in eligible populations for high-priority HEDIS measures that have transitioned or are in process of transitioning to ECDS measures: • Childhood Immunization Status: Combination (CIS-E) • Immunizations for Adolescents (IMA-E) • Chlamydia Screening (CHL) • Lead Screening for Children (LSC-E) • Cervical Cancer Screening (CCS-E) • Colorectal Cancer Screening (COL-E) • Breast Cancer Screeening (BCS-E) • Controlling High Blood Pressure (CBP) • Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) **Program Update** • **246,714 distinct members** are currently represented in the DataLink data across the service area. • **6 of 24 counties** have reached the 33% target. • **7 additional counties** are within 5 percentage points of the 33% target. • September and October activities focused on collaborative data validation and improvement, as well as execution of a new contract with DataLink. Accordingly, **no new data pulls were conducted during the month of October**. Provider onboarding and planning for scalable integration into quality measurement and operational workflows continue.

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**

	• QI submitted a response to HSAG on the Disparity PIP in Solano County on 10/22/2026 and will be awaiting HSAG response for final scoring.
	• On 10/07/2026 DHCS announced the 2027-2029 mandated PIP categories:
	  ○ Clinical Topic: Reducing the Percentage of Members Utilizing Emergency Department Care More than Primary Care
	  ○ Nonclinical Topic: Improve the Getting Care Quickly Adult CAHPS Measure Rate

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** *In 2027, the Improvement Academy will formally introduce a tiered training pathway designed to build capability from foundational concepts to advanced execution. Learners begin with the ABCs of QI, progress to Performance Improvement in Action, and complete the pathway with QI Project Training. Continuing education credits will be available across the series.* **Level 1: 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:** No new update. **Level 2: Performance Improvement in Action** **Program Overview** The Performance Improvement in Action virtual 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 Performance Improvement in Action pilot concludes on 11/17/26, and a formal evaluation will follow. **Level 3: 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:** • The Fall 2026 cohort experienced a modest initial decline after kickoff but has since stabilized, with attendance decreasing from 92 participants in Session 1 to approximately 55 participants by Session 4, indicating a sustained core engagement level of roughly 60% of initial attendees • The cohort will officially conclude on 11/10/26.
Plan wide Performance Improvement	
Santa Rosa and Fairfield Regions (DHCS Financial Rating Region: NorthBay)	• QI Improvement Coaches are working with clinics to start end of year pushes for the QIP programs, as well as looking at early data and preparing for initiatives in 2027. • QI will be working with Quest Diagnostics to pilot a FIT gap closure project to evaluate vendor supported colorectal cancer screening.
Redding and Eureka Regions (DHCS FINANCIAL RATING REGION: Rural Upper North))	• Shasta Regional Medical Center has expanded imaging and is offering mammography. The QI team has been working with clinics in Shasta County to spread awareness to utilize the additional capacity alongside continuing mobile mammography to address overall need. • Adventist Health Joint Leadership Meeting was held on October 22, 2026. • Shasta Community Health Center's Joint Leadership Meeting is scheduled for November 9, 2026. • Improvement coaches are working with their sites to prepare for end of year gap closures. • Several parent organizations in the Redding/Eureka Region are recipients of the CalRHT funding focused on expanding primary, maternity, and whole person care in rural California.
Chico and Auburn Regions (DHCS Financial Rating Region: Rural Upper Central)	• Regional quality meetings were held in Chico and Auburn on 10/14/2026 and 10/12/2026 respectively. MY 2025 HEDIS data was shared and improvement efforts were discussed. • QI is proposing a pilot in the Chico and Auburn regions leveraging a lab partner to do bulk FIT kit ordering for colorectal cancer screening.

	• QI Improvement Coaches are working with clinics to start end of year pushes for the QIP programs, as well as looking at early data and preparing for initiatives in 2027. • QI Improvement coaches are also working with eligible providers to submit their applications for special funding. The applications are due 10/30 and for more information, see the Expanded Counties Reinvestment in Quality (E-RIQ) section below.
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** • The EPT Program is in its final phase and remains on track toward program closeout. • All provider deliverables have been received and are currently undergoing final review and validation. Results from the review process will be used to determine final incentive payments and complete remaining program requirements. • While provider participation concluded in November 2026, MCPs have a number of reporting and administrative activities remaining in 2027 to support final program reconciliation and final payment processing.
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.

<table>
<tr><td></td><td>
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.

Program Updates:

Phase I: All 10 counties were awarded funds, 7 have received the first installment and 3 are working towards contract execution.
Phase II: The application window is now closed, and submitted applications are currently under review. Final funding decisions and award notifications will be announced on 11/13/26.

</td></tr>
<tr><td>Mobile Mammography Program</td><td>
Program Overview
The Mobile Mammography Program Aims to boost breast cancer screening (BCS-E) 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

<table>
<tr><th colspan="5">EVENTS BY REGION AND MONTH</th></tr>
<tr><th>Region</th><th>October</th><th>November</th><th>December</th><th>Q4 Total</th></tr>
<tr><td>Auburn</td><td>1</td><td>2</td><td>0</td><td>3</td></tr>
<tr><td>Chico</td><td>5</td><td>3</td><td>2</td><td>10</td></tr>
<tr><td>Eureka</td><td>8</td><td>3</td><td>0</td><td>11</td></tr>
<tr><td>Fairfield</td><td>1</td><td>3</td><td>0</td><td>4</td></tr>
<tr><td>Redding</td><td>1</td><td>4</td><td>1</td><td>6</td></tr>
<tr><td>Santa Rosa</td><td>1</td><td>0</td><td>0</td><td>1</td></tr>
<tr><td>Monthly Total</td><td>17</td><td>15</td><td>3</td><td>35</td></tr>
</table>

The Mobile Mammography team will begin scheduling 2027 Q1 events in November 2026.
</td></tr>
</table>

Partnering For Pediatric Lead Prevention Program (PPLP)	**Program Overview** Provides LeadCare II POC devices to qualified providers and enrolls them in a year-long program with coaching and education. Offers lead poisoning prevention education to all and collaborates with local agencies. **Program Updates** • No new updates at this time.
Shasta County Drive-thru Flu Clinic	**Project Overview** Each year, Shasta County Public Health organizes a free community-wide influenza vaccination event, made possible by grant funding. This annual event plays a dual purpose. First, it helps Shasta County PH practice and evaluate mass vaccination operations in preparation for a potential pandemic while also increasing community access to the flu vaccination. Partnership plays a key role in supporting this event by providing the venue, assisting with marketing and outreach activities, and identifying populations of focus to help improve HEDIS and QIP performance rates. **Project Update** • This year's annual Shasta County Drive-Thru Flu Clinic has been rescheduled from Saturday, October 17, 2026 to Saturday, November 7, 2026 from 10 a.m. to 2 p.m. at Public Health's building on 2650 Breslauer Way, Redding. If you have any questions regarding this event, please reach out to Chandler Ackerman at cackerman@partnershiphp.org.
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) were approved by the Board of Directors on 10/28/2026 and are now final.
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** • No new updates at this time.
D-SNP MEDICARE	**D-SNP** **Program Overview** The D-SNP Quality team is responsible for 1) Development and finalization of the Model of Care document, 2) Management of Partnership's CMS Medicare Star quality program, and 3) Developing D-SNP readiness for all Quality Improvement teams. The team has revised QI Department D-SNP Project plans to reflect the launch postponement with vendor-related projects TBD. All QI D-SNP related project plans can be found on the Partnership Advantage Share Point Project plan site. **Program Update** • The Medicare Quality team will begin a series of Provider Education activities to assess Provider and clinical teams' D-SNP Quality knowledge, prioritize areas of focus, and introduce new information about Medicare Stars. This month, the team and Dr. Lisa Ward met with CMOs and Quality team members from PCPs in the Santa Rosa region for a focus group session to understand Medicare Quality priorities. • The D-SNP Quality team will release a series of articles in the upcoming Provider Newsletters starting in Winter 2026 through Winter 2027 to introduce Medicare Quality topics to the provider network.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 09/26/2026 TO 10/27/2026	**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** • 34 referrals were received with 28 coming from Grievance and Appeals, 4 from Care Coordination and 2 from QI Member Safety

	• 28 cases were processed and closed • 95 cases are currently open • One case was discussed at Peer Review Committee (PRC) on 10/21/2026 and there are five cases awaiting PRC review. • On October 28, 2026, two nurses provided an overview of the Potential Quality Issue (PQI) process during the Provider Relations Department meeting.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR)	**Program Overview** Site Review and Medical Record Review performed for monitoring of providers. **Program Update** Reporting period – July 1 thru September 30, 2026 Primary and OB Reviews:

Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued
Auburn	8	6	2	4
Chico	5	5	2	2
Eureka	11	9	1	3
Fairfield	6	6	2	3
Redding	4	4	1	3
Santa Rosa	3	4	1	2

New sites opened this period →

5 new reviews

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	**Program Overview** HEDIS is used to evaluate clinical quality in a standardized way. This program shares performance measurement rates with the intent of improving the quality of care delivered to members. **Program Update** • No Update
HEDIS® Program Overall	**Program Updates** • No Update

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	**Program Overview** The State of California requires all Managed Care Plans (MCPS) to be Health Plan (HP) 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** • Partnership received a HPA Renewal Survey Initial Issues Report on 10/08/2026. The NCQA Program Management Team and the key stakeholders discussed the issues with the NCQA surveyors during a conference call on 10/14/2026. Partnership then submitted responses to NCQA on 10/19/2026. The majority of the issues required re-directing the surveyor to annotations and bookmarks within documents that were originally submitted. A few issues required collaboration with the Business Owners, including collection of additional clarifying documents, which were submitted to NCQA for further assessment. • The Initial Issues Report is based on non-file review requirements. Assessment and results of the file review requirements (including impact on 80% scoring threshold and Must-Pass) are not available until the scheduled virtual file review on November 2-3, 2026. A Closing Conference Call will take place on 11/03/2026, at which time NCQA will review both file review and non-file review issues (i.e. identified gaps) with Partnership. • Partnership will receive a preliminary report between 10-14 calendar days following the Closing Call and may choose to comment on any factual errors or omissions within 10 calendar days. NCQA will release a final report within 34 calendar days from the Closing Conference Call, i.e. 12/07/2026. • NCQA released the new 2027 HPA Standards and Guidelines on 09/29/2026. The Standards and Guidelines are available for review on the Y:Drive. This year, NCQA added new AI requirements and clarified existing standards and guidelines, including compliance expectations for standards that are listed as Not Applicable for Renewal Survey, which necessitate Business Owners' (BOs) review and assessment of gaps in compliance. A Summary of Changes between the 2026 and 2027 HPA Standards and Guidelines will be shared with BOs on 12/11/2026 to assist with their gap assessment. BOs will return their completed gap assessments with action plans on 1/08/2027, and the NCQA Program Management Team will work closely with BOs over the next several months to ensure changes to required evidence are completely timely.
NCQA Health Outcome Accreditation (HOA)	**Program Overview** The State of California requires all Managed Care Plans (MCPs) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years. Partnership's next HOA Renewal Survey is tentatively scheduled for 05/16/2028. **Program Update**

	• The NCQA Program Management Team distributed the 2027 HOA Workbooks to applicable BOs on 11/04/2026. The 2027 HOA Workbook contains the Work Plan, Evidence Submission Library, and, as applicable, the Report Schedule for each BO. BOs are asked to confirm the information prepopulated in the workbook, including review and confirmation of any applicable delegated function(s), and provide updates, as needed, along with their attestations. The completed HOA workbook is due to the NCQA Program Management Team by 12/04/2026. This activity is required as part of the FY 26-27 NCQA-related HOA Key Activities, Milestone 1.
NCQA Health Plan Accreditation (HPA) and Health Outcomes Accreditation (HOA)	• The November 2026 NCQA Business Owner (BO) Check-in Meetings began on 11/05/2026 and will continue through 12/03/2026. NCQA Program Management Team will share status updates regarding the HPA Renewal Survey File Review results, the 2027 HPA Standards and Guidelines, and the HOA Renewal Survey timeline with the respective BOs. BOs were asked to notify the NCQA Program Management Team of any scheduling conflicts.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

QUALITY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)

Consent Calendar

Nov. 18, 2026

Staff deems that items on the Consent Calendar need not be discussed before approval.

		Pages
	Revised Enhanced Care Management Quality Incentive Program (ECM QIP) 2027 Measure Set Proposal *revised post August PAC approval per recent DHCS changes – direct questions to Deanna Watson*	41 – 43
	UM Delegated Hospitals Summary – *direct questions to Tony Hightower*	45 – 46
	G&A PULSE Report, Issue 23, November 2026 – *direct questions to Latrice Innes*	47 – 57
	2026 Timely Access Survey – *formerly 3rd Next Available Survey – direct question to Vander Harris*	59 – 80
Health Services Policies	**Care Coordination**	
	MCCP2022 – Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services	81 – 88
	MPCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services	89 – 114
	Populations Health Management	
	MPNP9006 – Doula Services Benefit	115 – 124
	Utilization Management	
	MCUG3038 – Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled, or Subacute) Facilities	125 – 137
	MCUP3003 – Guidelines for Acute Rehabilitation Services – **NEW TITLE**	139 – 144
	MCUP3102 – Vision Care	145 – 147
	MCUP3106 – Waiver Programs	149 – 154
	MPUP3144 – Residential Substance Use Disorder Treatment Authorization	155 – 160
Non-HS Policies	**Transportation**	
	MPTP2501 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)	161 – 172
	MPTP2502 – Emergency Medical Transportation	173 – 175

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2027 ECM QIP Measure Set Proposal

(Revised proposal based on DHCS changes announced after August PAC approval)

January 1, 2027 – December 31, 2027 (quarterly incentive payout)

Key: New Measure | Change to Measure | Remove Measure

Approved 2027 Measures (Q1 2027 only)	Proposed 2027 Measures (Q2-Q4 2027)
Gateway Measure: Timely Reporting Providers are required to submit three monthly reports on or before their due date. Incentive: TBD 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.	**Change to measure: TBD** (Incentive pool rate will be equal to 25% of the monthly payment amount (excluding engagement payments).
Measure 1: Care Plan and Release of Information (ROI) Forms Uploaded into PointClickCare 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.	**Keep measure - 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.	**Remove measure**

2027 ECM QIP Measure Set Proposal

(Revised proposal based on DHCS changes announced after August PAC approval)

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.	**Remove measure**
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	**Keep measure - no changes**

.	[9] **New Measure: PCP Connectedness** Description: Providers are incentivized to assist ECM members with reconnecting to their Primary Care Provider (PCP). Data must show at least one (1) PCP encounter (in-person or virtual visit) within the 2027 measurement year (January 1, 2026 – December 31, 2027). Incentive pool allotment: 25% Numerator: One (1) or more billed PCP encounters per year Targets: • Full credit: TBD • No partial credit No reporting to Partnership is required. Partnership will obtain and view data for evidence of PCP encounter(s).
	New Measure: Avoiding ED/IP Visits Description: Providers are incentivized for no avoidable emergency department (ED) visits or inpatient (IP) hospital admissions during one or more months of the quarter. Incentive pool allotment: 25% Numerator: • No avoidable ED visit or hospital admission for three (3) months in a quarter Targets: • Full credit: % TBD • Partial credit: % TBD No reporting to Partnership required. Partnership will obtain and review data as evidence that no visits occurred.

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UM Delegated Hospitals Summary
November 2026

Partnership HealthPlan of California currently delegates UM responsibilities to four (4) hospital groups with locations in Lake, Marin, Mendocino, Napa, and Solano Counties.

- **Adventist Health** (Adventist Clearlake, Adventist St. Helena, Adventist Ukiah Valley, Adventist Mendocino Coast, Howard Memorial)
    - Adventist Health acknowledged and agreed to the updated 2026 Delegation Agreement, effective March 1st, 2026, and signed the agreement on September 4th, 2026.
    - Currently operating on the Essette platform, which allows for greater operational efficiency and level of oversight.
    - CY2025 annual audit completed April 9th, 2026. Adventist team had zero (0) identified deficiencies for program and file review audits.
    - As part of implementation of NCQA's new UM11 – Information Integrity standards, the AH team participated in training related to the updated requirements. In addition, a targeted review of UM11A compliance was conducted during the audit process, which resulted in zero (0) findings
    - Received refresher in the Adverse Benefit Decision letters for NCQA standards and TAR review timeliness.
    - Partnership UM continues to monitor Adventist denials on a weekly basis for compliance and sustainability.

- **NorthBay Medical Center/ VacaValley Hospital**
    - Northbay Medical Center acknowledged and agreed to the updated 2026 Delegation Agreement, effective May 1st, 2026, and signed the agreement on July 8th, 2026.
    - Not currently operating on the Essette platform for prior authorizations, with no immediate plans to migrate. This poses a risk for DHCS and NCQA compliance for UM reviews and denials.
    - CY2025 annual audit completed April 16th, 2026. NBMC had several preliminary program review deficiencies related to NCQA UM11A – Information Integrity. As a result, a preliminary corrective action plan (CAP) was initiated on April 17th, 2026, with a submission due date of May 18th, 2026. CAP was successfully completed on July 14th, 2026, Northbay submitted all required documentation to satisfy CAP requirements.
    - NCQA UM11A – Information Integrity standards were reviewed, and our team provided education and supporting documentation to assist with implementation of these new requirements into their existing workflows.
    - Received refresher in the Adverse Benefit Decision letters for NCQA standards and TAR review timeliness.
    - Partnership UM continues to monitor Northbay's denials on a weekly basis for compliance.

- **Queen of the Valley Medical Center (QVMC)**
  - Queen of the Valley Medical Center acknowledged and agreed to the updated 2026 Delegation Agreement, effective March 1st, 2026, and signed the agreement on May 20th, 2026.
  - Currently operating on the Essette platform, which allows for greater operational efficiency and level of oversight.
  - CY2025 annual audit completed April 1st, 2026. During this audit cycle, the QVMC team received one (1) preliminary program review deficiency related to one physician's Q2 IRR score. A corrective action plan (CAP) was issued on March 10th, 2026, and supporting evidence submitted by QVMC on March 17th, 2026 was reviewed and determined sufficient to close out the CAP at the preliminary stage. QVMC received zero (0) file review deficiencies. The audit materials submitted by the QVMC team were organized and demonstrated compliance with applicable NCQA and DHCS requirements.
  - As part of implementation of NCQA's new UM11 – Information Integrity standards, the QVMC team participated in training related to the updated requirements. In addition, a focused review of UM11A compliance was conducted during the audit process, which resulted in zero (0) findings.
  - Received refresher in the Adverse Benefit Decision letters for NCQA standards and TAR review timeliness.
  - Partnership UM continues to monitor Queen of the Valley denials on a weekly basis for compliance and sustainability.

- **Marin Health Medical Center (MHMC)**
  - Marin Health Medical Center acknowledged and agreed to the updated 2026 Delegation Agreement, effective March 1st, 2026, and signed the agreement on June 16th, 2026.
  - Currently operating on the Essette platform, which allows for greater operational efficiency and level of oversight.
  - CY2025 annual audit completed on April 9th, 2026. For this audit, the MHMC team had zero (0) preliminary deficiency program review findings and zero (0) deficiencies for file review. The MHMC team provided an organized package of their utilization management documents that demonstrated compliance with NCQA and DHCS requirements.
  - As part of implementation of NCQA's new UM11 – Information Integrity standards, the MHMC team participated in training related to the updated requirements. In addition, a targeted review of UM11A compliance was conducted during the audit process, which resulted in zero (0) findings.
  - Received refresher in the Adverse Benefit Decision letters for NCQA standards and TAR review timeliness.
  - Partnership UM continues to monitor Marin Health denials on a weekly basis for compliance and sustainability.

GRIEVANCE & APPEALS | Pulse Report

Our Mission

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



G&A PULSE REPORT

INSIDE THIS ISSUE

PG. 6
The number of transportation concerns increased this quarter

PG. 9
The number of discrimination concerns decreased this quarter

ISSUE 23 | NOVEMBER 2026

The purpose of this report is to provide objective updates to all stakeholders regarding trends in member experience as expressed through Appeals, Grievances, Exempt Grievances, and State Hearings received in the Grievance & Appeals Department (G&A). The report contains data from the third quarter of 2026.

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

Fluctuations in data can happen. Therefore, statistics included in this report are presented with a 95% confidence level. Membership totals are calculated using monthly snapshot data, averaged across the county by quarter. The scheduling and ride data for Transportation was sourced from the Transportation Dashboard. The Community Supports enrollment information was sourced from the CalAIM Dashboard.

3Q26 HIGHLIGHTS

OVERALL NUMBERS

In 3Q26, G&A investigated 3,615 cases. The chart below shows a breakdown of the cases investigated this quarter. Of the 2,652 cases subject to DHCS-mandated timeframes, 99.2% were closed on time, which is above our goal.

3Q26 TOTAL INVESTIGATED CASES		
	# of Cases	% Total
Grievance	2,282	63.1%
Exempt	922	25.5%
Appeal	370	10.2%
State Hearing	41	1.1%
Grand Total	**3,615**	**100.0%**

KEY POINTS & TRENDS

Lost State Hearings. We lost one (1) State Hearings in 3Q26. This case was for power seat elevation on a member's existing power wheelchair. The Administrative Law Judge (ALJ) determined the power seat elevation was denied in error, as it would allow the member to accomplish their activities of daily living (ADLs). The submitted documentation also confirmed the need for power seat elevation to assist with ADLs. The ALJ also determined that Partnership needed to assess if the member not only needed the power seat elevation, but also a new power wheelchair as the member's wheelchair was five (5) years old.

The Community Supports benefit continues to be a driver for G&A cases. There were 297 cases closed related to Community Supports in 3Q26, 8.2% of our overall volume for the quarter. This was a 22.2% increase from the 243 cases closed in 2Q26. These cases were primarily related to the Medically Tailored Meals service. Medically Tailored Meals accounted for 105 of the 297 Community Supports cases this quarter. This makes up 35.4% of the total Community Supports-related concerns. Of those 105 Medically Tailored Meals cases, there were 75 Appeals and 30 Grievances (Standard and Exempt). Based on data from the CalAIM Dashboard (last updated on September 17, 2026), the top used benefit in 3Q26 continues to be Housing Transition and Navigation Services, with 10,740 members using the benefit. We closed 90 cases related to this benefit in 3Q26. This is an 80% increase compared to the 50 cases related to this benefit in 2Q26. Additionally, the Community Supports team confirmed there will be additional policy clarifications that will continue to drive our case volume. Benefits like Transitional Rent and Housing Deposits only apply to members without current housing, many of the cases for these benefits are complaints about being denied for services.

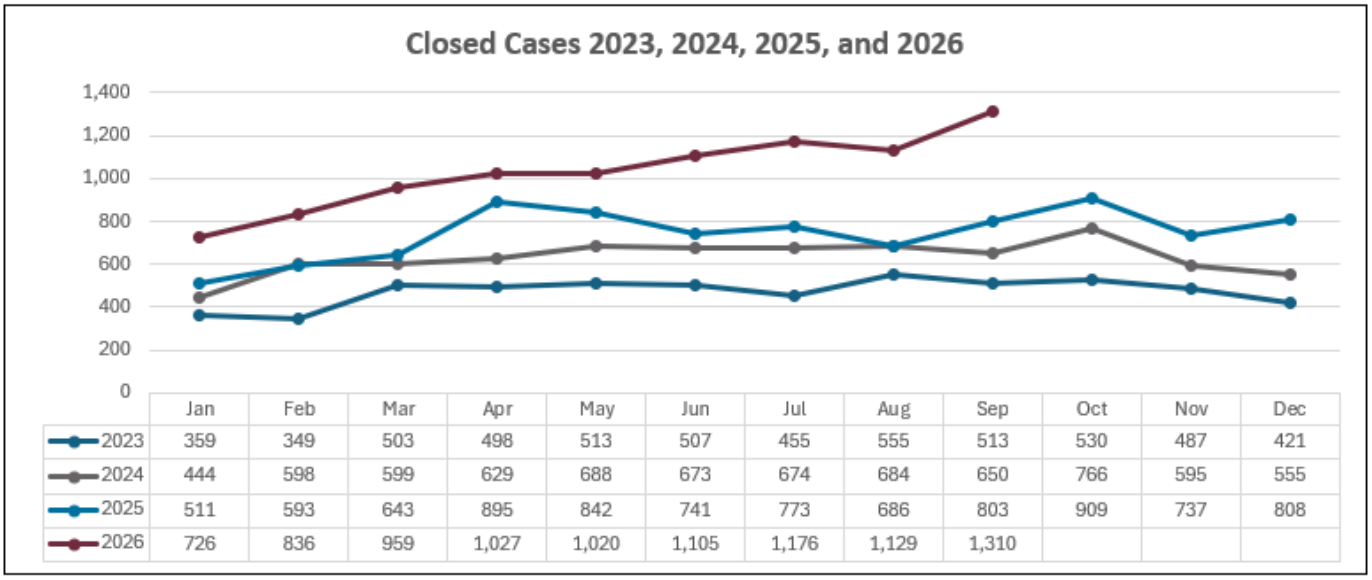
We have calculated the cases per 1,000 rates for each of the Community Supports benefits that contributed to our case volume in 3Q26, as well as the total overall below.

3Q26 Community Supports Cases by Benefit			
Benefit	# Cases	Members Enrolled	Cases per 1,000
Medically Tailored Meals	105	3,161	33.22
Housing Transition Navigation Services	90	10,740	8.38
Recuperative Care	31	1,913	16.20
Short-Term Post-Hospitalization Housing	24	1,196	20.07
Housing Deposits	17	349	48.71
Transitional Rent	11	16	687.50
Personal Care & Homemaker	7	1,370	5.11
Housing Tenancy and Sustaining Services	5	2,738	1.83
Sobering Centers	5	71	70.42
Day Habilitation Programs	1	1,205	0.83
Respite Services	1	837	1.19
Total	297	23,596	12.59

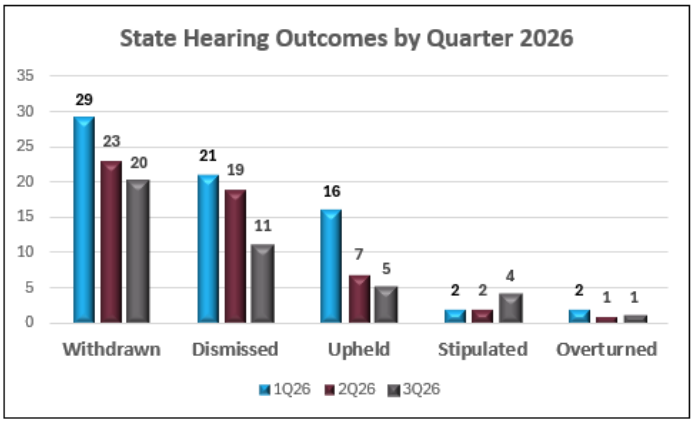
KEY STATISTICS

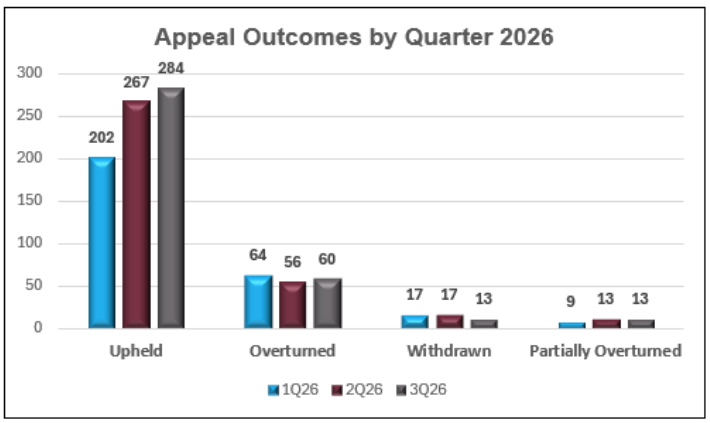
CHARTS OF KEY CASE TRENDS

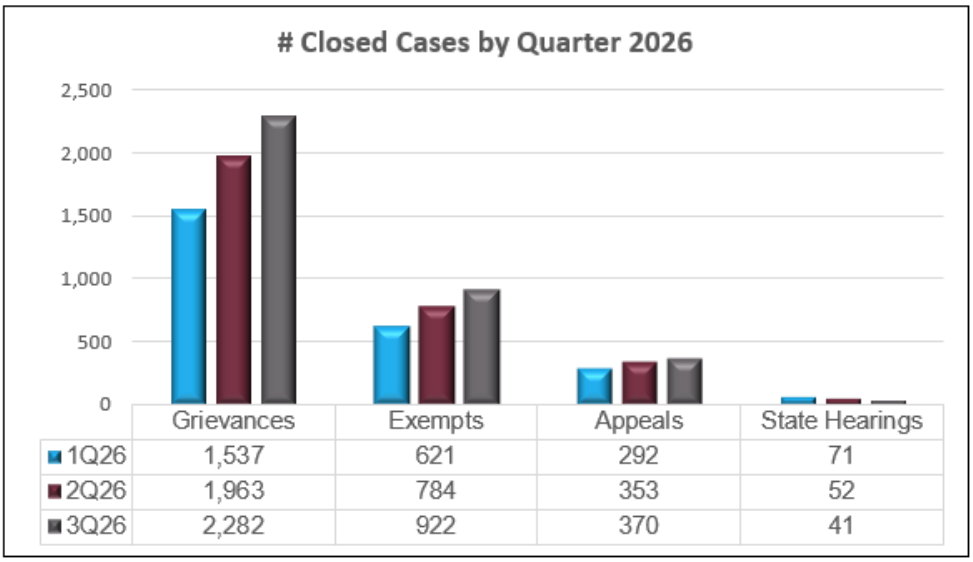
The following charts represent key data metrics used to track and trend Appeals, Grievances, and State Hearings over time.



	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
2023	359	349	503	498	513	507	455	555	513	530	487	421
2024	444	598	599	629	688	673	674	684	650	766	595	555
2025	511	593	643	895	842	741	773	686	803	909	737	808
2026	726	836	959	1,027	1,020	1,105	1,176	1,129	1,310			







	Grievances	Exempts	Appeals	State Hearings
1Q26	1,537	621	292	71
2Q26	1,963	784	353	52
3Q26	2,282	922	370	41

STATISTICS BY REGION

CHARTS OF CASE STATISTICS BY REGION

The following charts illustrate the distribution of closed cases across each region, providing a breakdown of the total number of cases closed, the average membership, and the number of cases closed per 1,000 members for 3Q26.

3Q26 CASES PER 1,000 PARTNERSHIP OVERALL		
# of Cases	Avg Membership	Cases p/1,000
3,615	871,215	4.15

3Q26 CASES BY COUNTY AUBURN REGION			
County	# of Cases	Avg Membership	Cases p/1,000
Nevada	144	27,549	5.23
Placer	278	59,836	4.65
Plumas	18	5,188	3.47
Sierra	2	781	2.56
Total	442	93,354	4.73

3Q26 CASES BY COUNTY FAIRFIELD REGION			
County	# of Cases	Avg Membership	Cases p/1,000
Solano	439	93,007	4.72
Napa	78	25,448	3.07
Yolo	236	50,734	4.65
Total	753	169,189	4.45

3Q26 CASES BY COUNTY EUREKA REGION			
County	# of Cases	Avg Membership	Cases p/1,000
Del Norte	77	11,598	6.64
Humboldt	293	53,219	5.51
Lake	123	32,015	3.84
Mendocino	92	38,006	2.42
Total	585	134,838	4.34

3Q26 CASES BY COUNTY SANTA ROSA REGION			
County	# of Cases	Avg Membership	Cases p/1,000
Sonoma	310	98,839	3.14
Marin	146	40,863	3.57
Total	456	139,702	3.26

3Q26 CASES BY COUNTY CHICO REGION			
County	# of Cases	Avg Membership	Cases p/1,000
Butte	372	82,813	4.49
Colusa	29	9,674	3.00
Glenn	29	38,355	0.76
Sutter	94	42,974	2.19
Yuba	93	35,577	2.61
Total	617	209,393	2.95

3Q26 CASES BY COUNTY REDDING REGION			
County	# of Cases	Avg Membership	Cases p/1,000
Lassen	53	7,975	6.65
Modoc	21	3,631	5.78
Shasta	411	63,380	6.48
Siskiyou	121	17,140	7.06
Tehama	130	27,853	4.67
Trinity	26	4,760	5.46
Total	762	124,739	6.11

DEMOGRAPHICS

CHARACTERISTICS OF FILING MEMBERS

The following charts represent key demographic data of members who filed an Appeal, Grievance, or State Hearing during 3Q26.

3Q26 CASES BY AGE		
Member Age	**% Cases**	**% Membership**
Age 0-10	5.0%	18.6%
Age 11-19	3.0%	17.0%
Age 20-44	26.0%	33.1%
Age 45-64	41.3%	19.6%
Age 65+	24.7%	11.7%
Grand Total	**100.0%**	**100.0%**

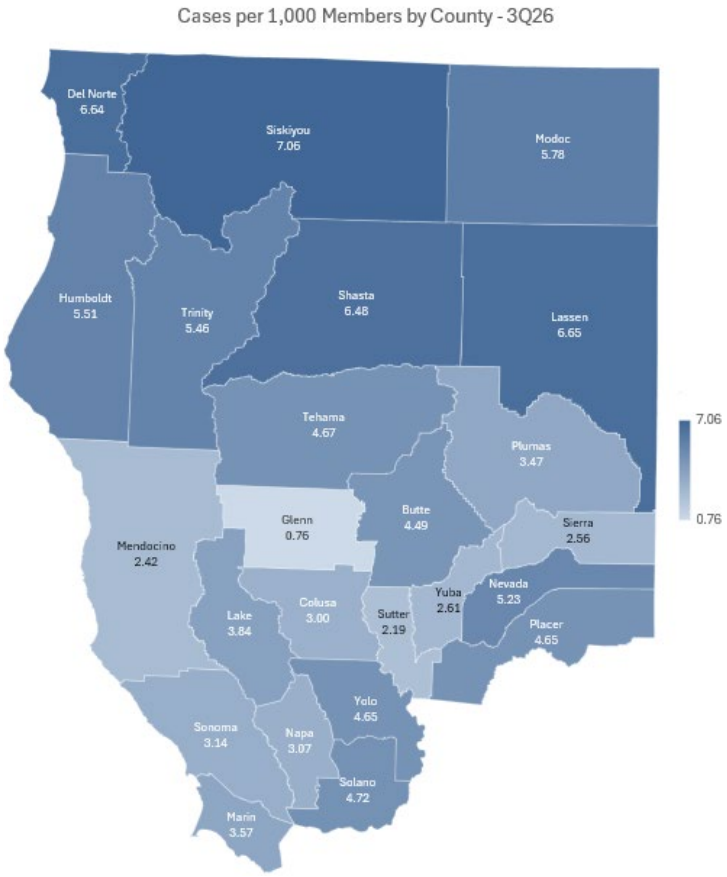
3Q26 CASES BY ETHNICITY		
Member Ethnicity	**% Cases**	**% Membership**
White	58.2%	38.5%
Hispanic	14.8%	33.8%
Other/No Response	14.0%	18.2%
Black (African American)	7.7%	3.6%
Asian	2.3%	4.0%
Native American	2.3%	1.8%
Hawaiian/Pacific Islander	0.7%	0.1%
Grand Total	**100.0%**	**100.0%**

3Q26 CASES BY LANGUAGE		
Member Language	**% Cases**	**% Membership**
English	93.8%	77.1%
Spanish	5.2%	19.4%
Other	0.5%	2.1%
Russian	0.2%	0.6%
Tagalog	0.2%	0.2%
Punjabi	0.1%	0.6%
Grand Total	**100.0%**	**100.0%**

3Q26 CASES BY GENDER		
Member Gender	**% Cases**	**% Membership**
Female	64.1%	52.3%
Male	35.9%	47.7%
Grand Total	**100.0%**	**100.0%**

"Krizol was incredibly kind when processing my grievance. She identified multiple additional concerns when processing my case and did not make me feel bad for filing a grievance. Your staff are well-trained and hard-working."

- Partnership Member



TRANSPORTATION

REPORTING PERIOD AND DEFINITION

This section covers quarterly statistics and trends in cases related to Transportation during 3Q26. Transportation statistics are calculated using the total number of completed trips per quarter. Note, each planned stop of a ride is counted as a trip.

3Q26 STATISTICS

Transportation cases in 3Q26 accounted for 1,893 cases of the total 3,615 cases closed. This represented 52.4% of all cases closed in 3Q26. This is an increase compared to the previous quarter in which 51.9% of the cases were related to transportation services. There were 1,794 Grievances (Exempt and Standard), 94 Appeals, and 5 State Hearings. There were 334,635 completed trips for the reporting period. While Transportation is a main contributor to our overall case volume, transportation issues only account for 1.1% of the completed trips in 3Q26.

TRENDING ISSUES

The top five (5) providers with reported concerns in 3Q26 were Lyft (215), North Bay Transit (77), Easy Day Ride (56), Budget Friendly (42) and Hey Taxi (36). Members had issues such as missed rides, drivers arriving late, driver behavior and vendor customer service. G&A is partnering with Transportation Services to calculate the percentage of rides with concerns for the top five (5) providers. This is captured in the table below.

3Q26 Transportation Trips with Concerns by Provider			
Provider	# Cases	Trips Completed	Trips with Concerns
Lyft	215	55,560	0.4%
North Bay Transit	77	18,510	0.4%
Easy Day Ride	56	10,542	0.5%
Budget Friendly	42	7,484	0.6%
Hey Taxi	36	16,081	0.2%

G&A identified multiple complaints against Transportation Services. The top three (3) complaints against the Transportation department for 3Q26 included Transportation Services' customer service, reimbursement timeframes for Gas Mileage, Lodging, and/or Meals, and scheduling issues. Complaints about Transportation Services' Customer Service included long wait times for the phone systems. Transportation Services has been working to resolve this issue. Additional information can be found in the Transportation Services Updates section.

TRANSPORTATION SERVICES UPDATES

Transportation Services continues to use G&A data to improve provider performance, operational processes, and member satisfaction by working directly with their providers. Transportation Services has experienced staffing difficulties, which is likely contributing to the increase in volume for 3Q26. They hired 18 new staff members in June 2026, and additional staff in August 2026 to meet the staffing needs resulting from increasing utilization of this benefit. Until the new staff are onboarded and trained, G&A will likely continue to see increased transportation related concerns.



W&R RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Wellness & Recovery (W&R) during 3Q26. It should be noted that W&R cases are measured based on the number of cases received per quarter, rather than the number of cases closed per quarter. This is due to DHCS' unique reporting of W&R cases.

3Q26 NUMBERS

There were five (5) W&R cases received in 3Q26, representing 0.1% of the total concerns reported this quarter.

TRENDING ISSUES

G&A received five (5) grievances and zero (0) appeals. Four (4) of the grievances received in 3Q26 were also resolved in the same quarter. One (1) case will be listed as closed in 4Q26.

In one (1) case, the member reported concerns that they were discriminated against due to their disability. Their disability requires them to use certain equipment to complete necessary testing. The involved facility required the member to use their own supplies. The member felt they should provide the needed supplies, as they are requiring the tests. Upon investigation, it was determined that the facility did have the supplies on hand. The staff member who had previously helped the member was unaware of where the supplies were stored. The member has since been provided with the needed supplies for testing. Discrimination was deemed as not likely to have occurred, as the staff member was not maliciously withholding the supplies, and the issue was resolved.

Two (2) of the five (5) complaints were regarding access to care issues. Two (2) cases were regarding interpersonal relationship issues. The other case was related to quality of care concerns.



DHCS REPORTING

DHCS requires quarterly reporting of W&R cases. The next two tables provide the specific number of W&R cases and which case category Partnership reported to DHCS. All the cases were closed within the 30-day DHCS regulatory timeframe.

3Q26 DHCS W&R Grievance Outcomes	
# of Grievances Resolved in Favor of Member	3
# of Grievances Resolved in Favor of Partnership	1

3Q26 DHCS Grievance Categories	
Access to Care	2
Interpersonal Relationship Issues	2
Quality of Care	1
Failure to Respect Enrollee's Rights	0
Other	0
Program Requirements	0

WCM RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Whole Child Model (WCM) during 3Q26.

3Q26 STATISTICS

A total of 40 WCM-related cases were closed in 3Q26, representing 1.1% of the 3,615 cases closed. These cases consist of 18 Appeals and 22 Grievances. There were no State Hearings reported in this quarter related to WCM.

TRENDING ISSUES

The most commonly reported issues were related to transportation, Durable Medical Equipment (DME), and private duty nursing. There were 13 Grievances, and five (5) Appeals related to transportation issues. This makes up 45.0% of the total cases related to WCM. Members reported concerns with missed rides and scheduling issues. Members also commonly appealed denials of lodging, meals, and gas mileage. There were two (2) upheld, two (2) overturned and one (1) partially overturned appeal for lodging and meals in this quarter. There were three (3) Grievances and six (6) Appeals related to DME.

There were three (3) Appeals related to private duty nursing. Two (2) of the three (3) Appeals were upheld. The appeal for home nursing that was overturned was due to the records received during the appeal. The member had the same health concerns as they did during a previous authorization period, but their nursing hours had been decreased. The documents received during the appeal showed that the member's condition had not improved, thus demonstrating a need for approving the same level of care that had been previously authorized.

DISCRIMINATION AGAINST CCS MEMBERS

G&A reviews all allegations of discrimination to determine if they fall under civil rights law. There were no discrimination cases reported for a WCM member during 3Q26.



ETHNICITY AND PREFERRED LANGUAGE

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

3Q26 WCM CASES BY ETHNICITY		
Member Ethnicity	**# of Cases**	**% of Cases**
White	17	42.5%
Hispanic	9	22.5%
No Response	7	17.5%
Black (African American)	3	7.5%
Other	2	5.0%
Alaskan Native or American Indian	1	2.5%
Other Asian	1	2.5%
Grand Total	**40**	**100.0%**

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

3Q26 WCM CASES BY LANGUAGE		
Member Language	**# of Cases**	**% of Cases**
English	37	92.5%
Spanish	3	7.5%
Grand Total	**40**	**100.0%**

DISCRIMINATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to discrimination during 3Q26. Because a member may report multiple discrimination allegations in a single Grievance, a case may fall into multiple categories. As a result, the number of concerns may exceed the total number of cases.

3Q26 DISCRIMINATION STATISTICS

G&A changed our process for internal classification of discrimination cases when they do not fall under a protected category. Our reporting has been updated to only include discrimination allegations that fall under a protected category. Discrimination allegations that do not fall under a protected category are still investigated, but as a Standard Grievance.

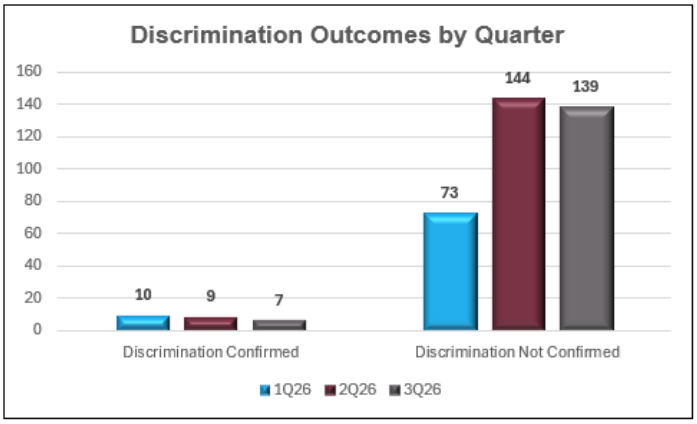
G&A investigated 108 cases containing 146 discrimination allegations in 3Q26. This represented 3.0% of all cases closed. Each of the 108 discrimination cases fell under a protected category.

After investigation, it was determined discrimination was likely to have occurred in six (6) cases with seven (7) concerns.

In two (2) of the cases, there were concerns related to a member's language or limited English skills. These members both alleged that provider's created barriers around interpretation services and refused to see the members due to the language barrier. These providers were both determined to have likely discriminated against the members involved. The cases were also both referred to the Quality Improvement department for further investigation.

3Q26 DISCRIMINATION TRENDS

Discrimination cases that fell under a protected category decreased from 113 in 2Q26 to 108 in 3Q26. This accounts for a 4.4% decrease in discrimination cases that fall under a protected category. The number of cases where discrimination was deemed likely has continued to decrease throughout the year, while the number of overall concerns has fluctuated.



3Q26 CASES BY CATEGORY

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

Discrimination Found Likely	
Civil Rights Category	# of Concerns
Race or Ethnicity	2
Disability	1
Gender	1
Gender Identity	1
Language Assistance Services	1
Limited English Skills	1
Total	7

QUALITY ASSURANCE

INTER-RATER RELIABILITY DEFINED

The quarterly Inter-Rater Reliability (IRR) audit provides physician oversight over clinical decisions made by Partnership's Grievance Registered Nurse team. A list of Grievances that were not previously reviewed by a Partnership Medical Director is forwarded to Partnership's Chief Medical Officer (CMO) or designated representative, of which a sample size is selected and evaluated. The Compliance Manager and Quality & Training Supervisor complete a subsequent comprehensive review to identify opportunities for operational improvements. Due to the timing of report generation, the data discussed reflects cases closed in 2Q26.

THE RESULTS

A sample size of 53 Grievances were evaluated for 2Q26.

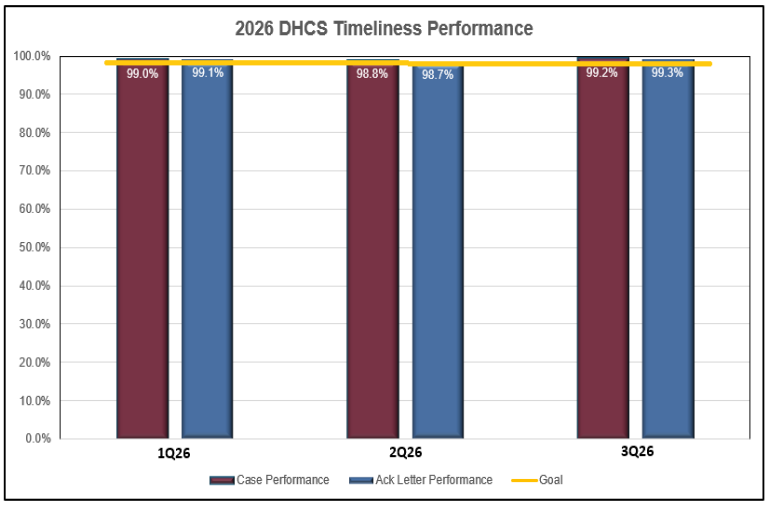
The G&A Nurse Specialists had no findings on this report.

Processing errors by G&A Case Analysts were identified during this reporting period. These issues included sending referrals outside of best practice timeframes. Referrals are expected to be sent within 5 calendar days of receipt of the case. The referrals on multiple cases were sent outside of that timeframe. Additionally, there were multiple instances of G&A Case Analysts not fully addressing the member's concerns, either in their case processing or in their resolution letters. There were also findings for incorrect documentation and reporting on their cases.



TIMELINESS

The target timeliness goal for closing cases and mailing acknowledgement letters is 98.3%. For 3Q26, 2,652 cases were subject to DHCS Turnaround Times (TAT). We achieved 99.2% timeliness for closing cases. The 21 cases were processed late because of delays in responses from providers, delays in sending and receiving translation requests, delays in receiving medical records and cases not being submitted by other departments timely. There were 19 late acknowledgment letters, achieving 99.3% timeliness. Delays included internal processing challenges and delays in case induction.



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

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2026 Timely Access Survey

(Previously 3rd Next Available)

Provider Relations & Health Analytics

Vander Harris

November 2026

Overview – Timely Access Survey

The survey is used to assess Partnership's compliance with the Accessibility standards annually

- The survey monitors appointment availability, telephone access and appointment wait time among primary care providers and high volume and high impact specialists

Moved from capturing 3rd next available in past surveys to now recording the next available appointment

- 3NA done to minimize the impact of short-term schedule fluctuations, cancellations, or one-off openings
- However, DHCS monitors next appointment availability, as this more closely reflects the experience a member would have when attempting to schedule

Survey Objectives:

- Assess compliance with Partnership access standards
- Review trends and identify opportunities to improve
- Assist providers to ensure standards are met

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

Methodology

The survey is administered by Partnership's Provider relations staff. One-time call to provider offices to request appointment information, providing a snapshot of access

Surveyed providers: Primary Care Providers (Family Practice, Internal Medicine and Pediatrics) and High-Volume/High-Impact Specialists

Telephonic survey: Telephonic survey by Provider Relations team during business hours in Q2-Q3 2026, asking specific appointment availability

Data Entry: Sugar Database with fields constructed to align with the survey questions which allows uniformity of data entry across interviewers

Data Validation and Analysis: Completed by Health Analytics using Tableau

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

Criteria/Targets

ALL REGIONS PRIMARY CARE PROVIDERS	Standard
Days to NA Adult Appt	<= 10 business days
Days to NA Pediatric Appt	<= 10 business days
Time to Next Available Newborn Appt	<= 48 Hours
Time to Next Available Urgent Appt	<= 48 Hours
HIGH-VOLUME SPECIALISTS	**Standard**
Days to NA Specialty appt	<=15 business days
Time to Next Available Urgent Appt	<= 48 Hours
PRENATAL CARE	**Standard**
Days to NA Prenatal Care (PCP & Specialists)	<= 10 days



PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Timely Access Surveyed Sites

Total of **1,028** sites survey across all regions and multiple specialties

Primary Care Access:

- Surveyed **366** providers

Specialty Providers:

- Surveyed **619** providers

Prenatal Providers:

- Surveyed **43** providers

Response Rate:

- **78%** of surveyed PCPs
- **55%** of surveyed Specialist



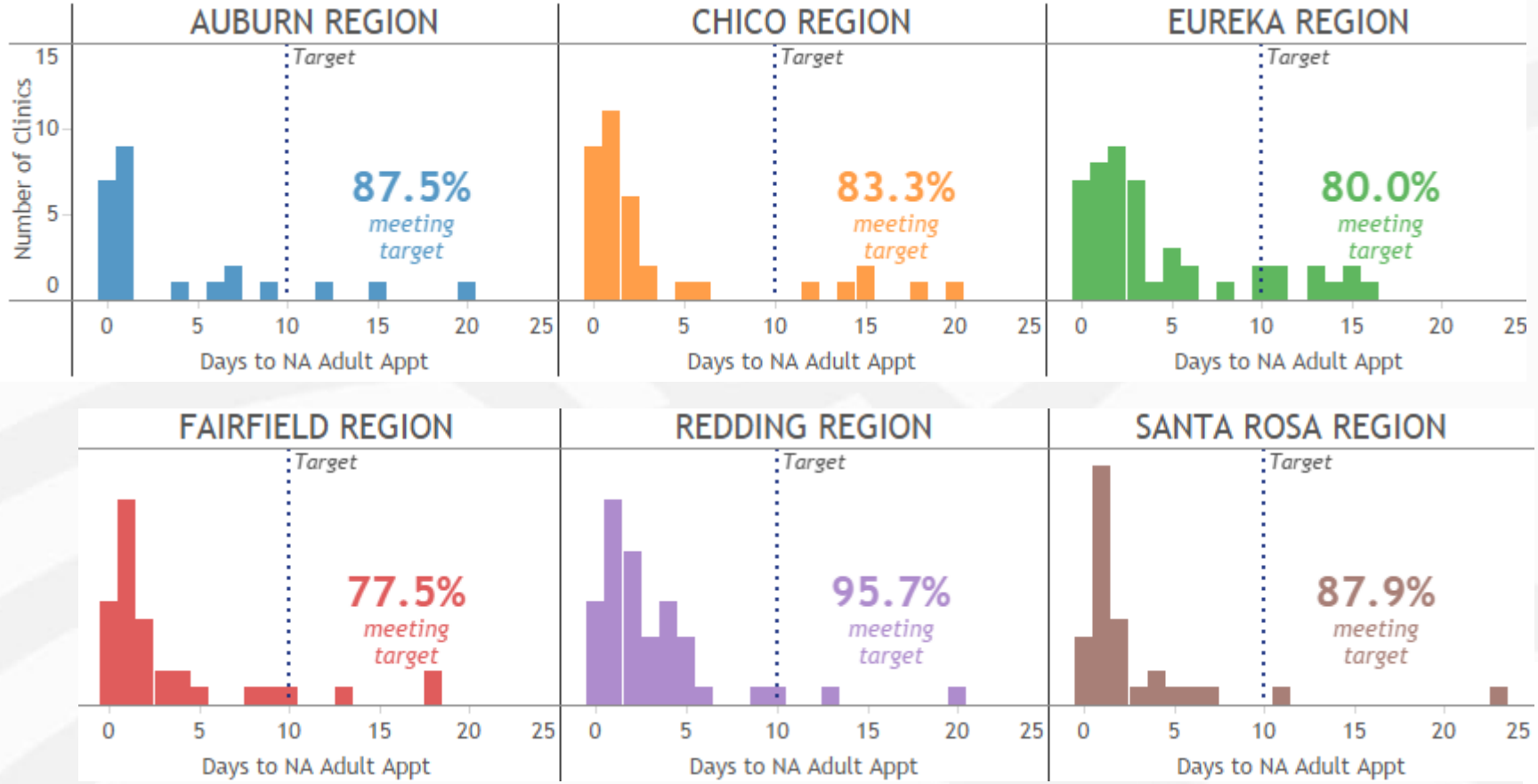


PCP Appointments

Adult PCP Appointments

Distribution of Clinics by Days to Next Available Appointment for Adults

Target for Adult Appointments:
<= 10 Business Days

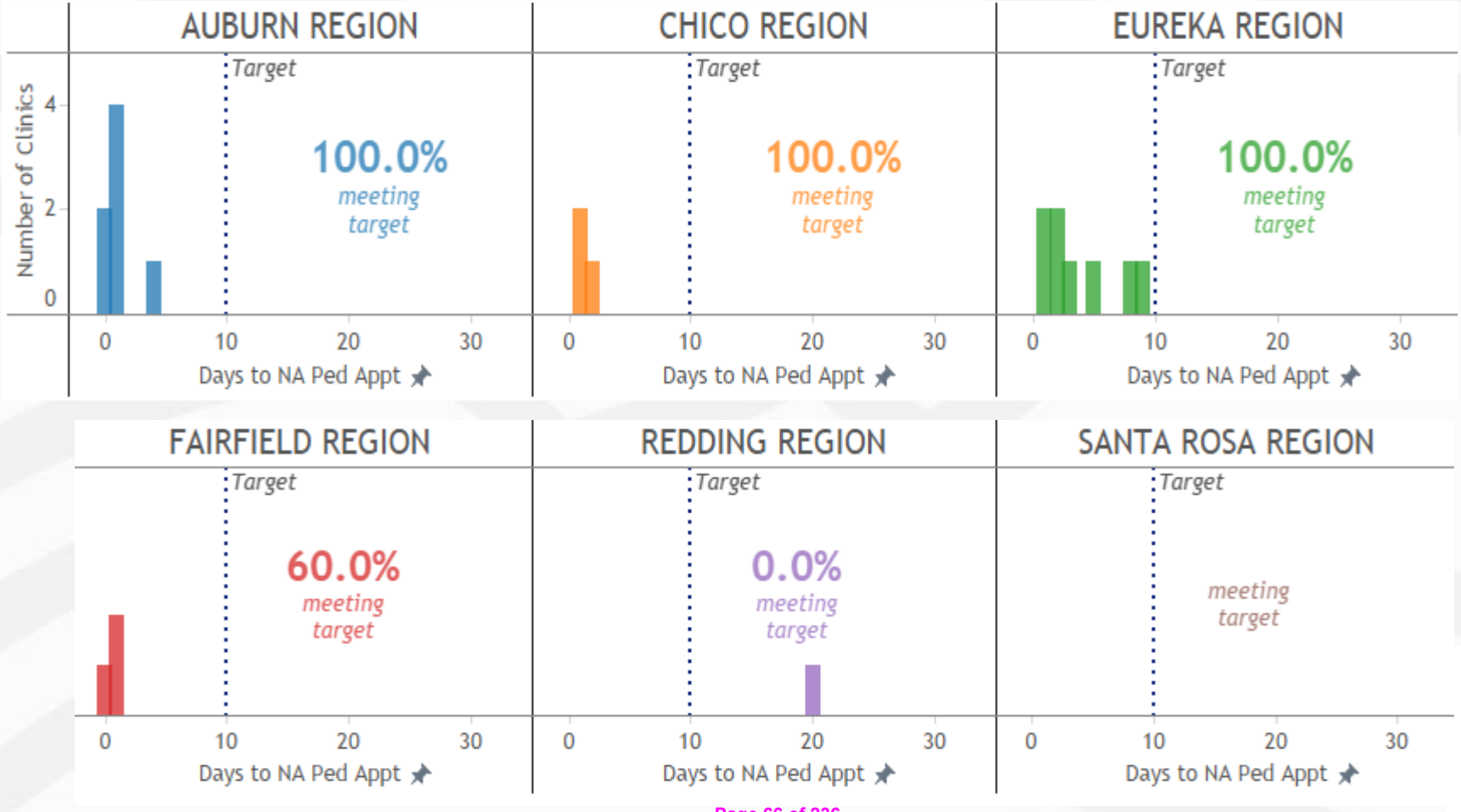


PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Pediatric PCP Appointments

Distribution of Clinics by Days to Next Available Pediatric Appt.

Target for Pediatric Appointments:
<= 10 Business Days

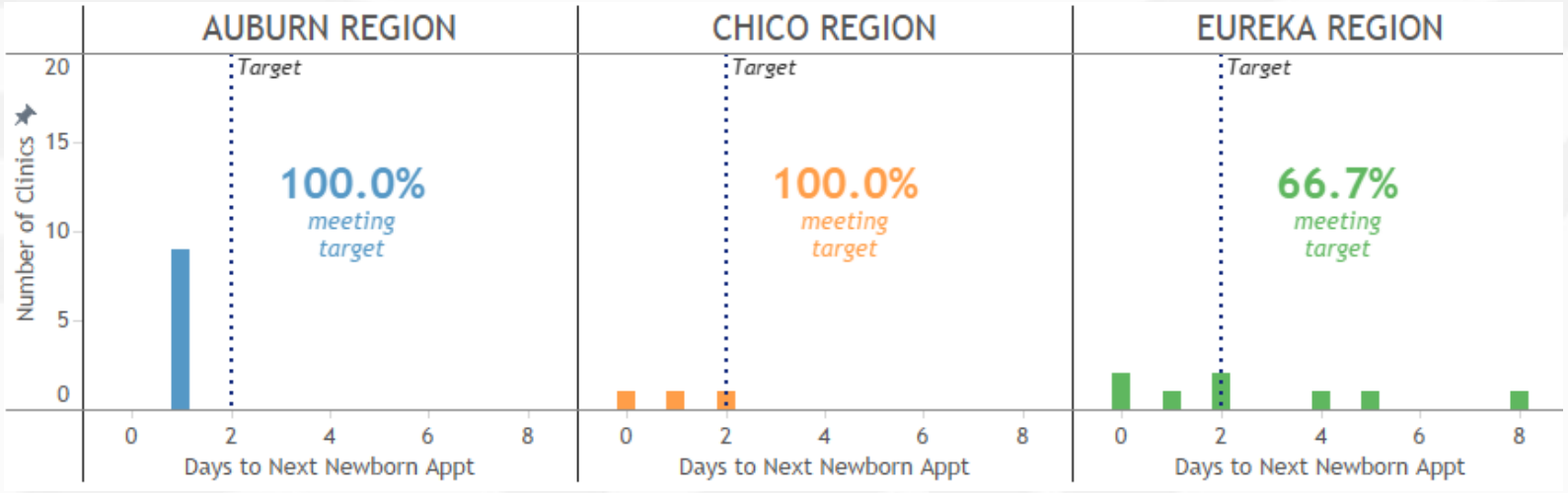


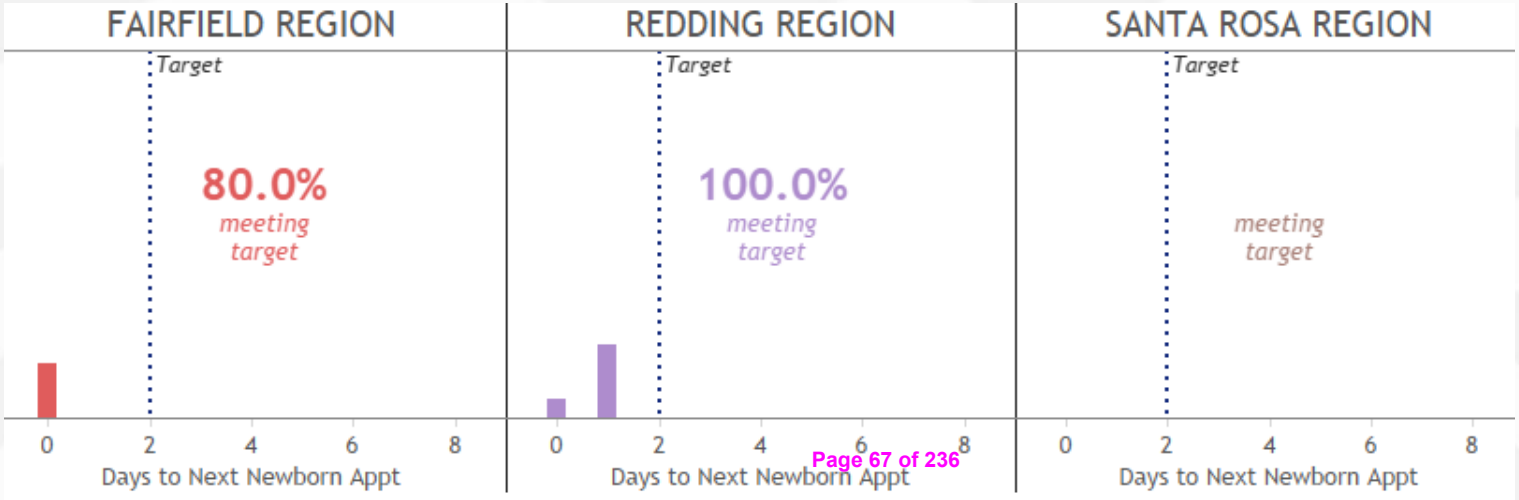
PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Newborn PCP Appointments

Distribution of Clinics by Days to Next Available Appointment for Newborns

Target for Newborn Appointments:
<= 2 Business Days



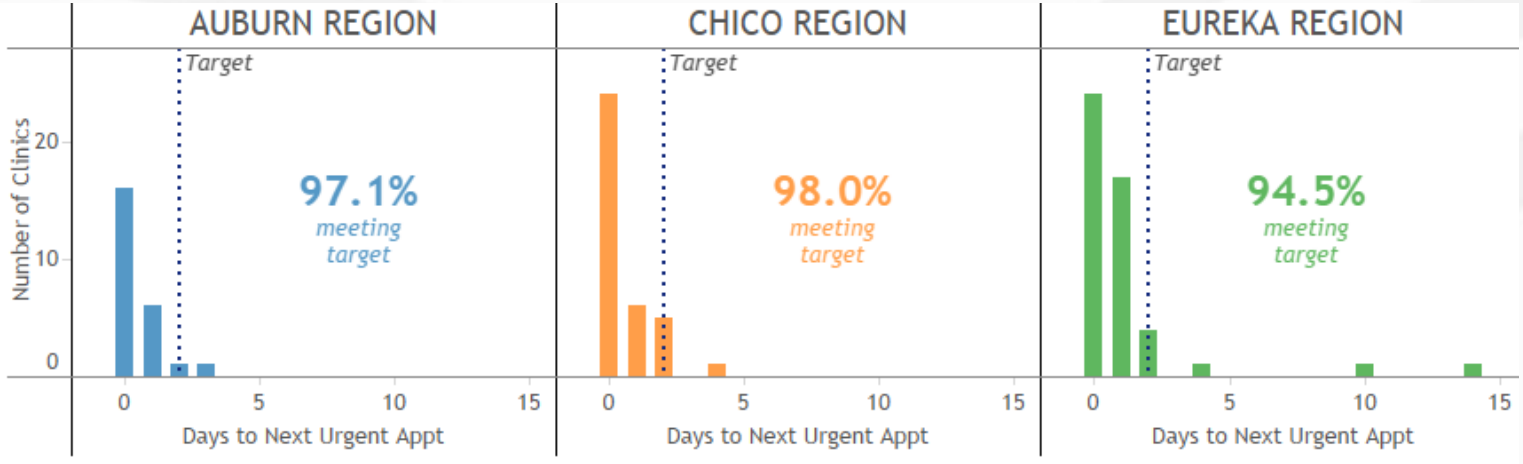


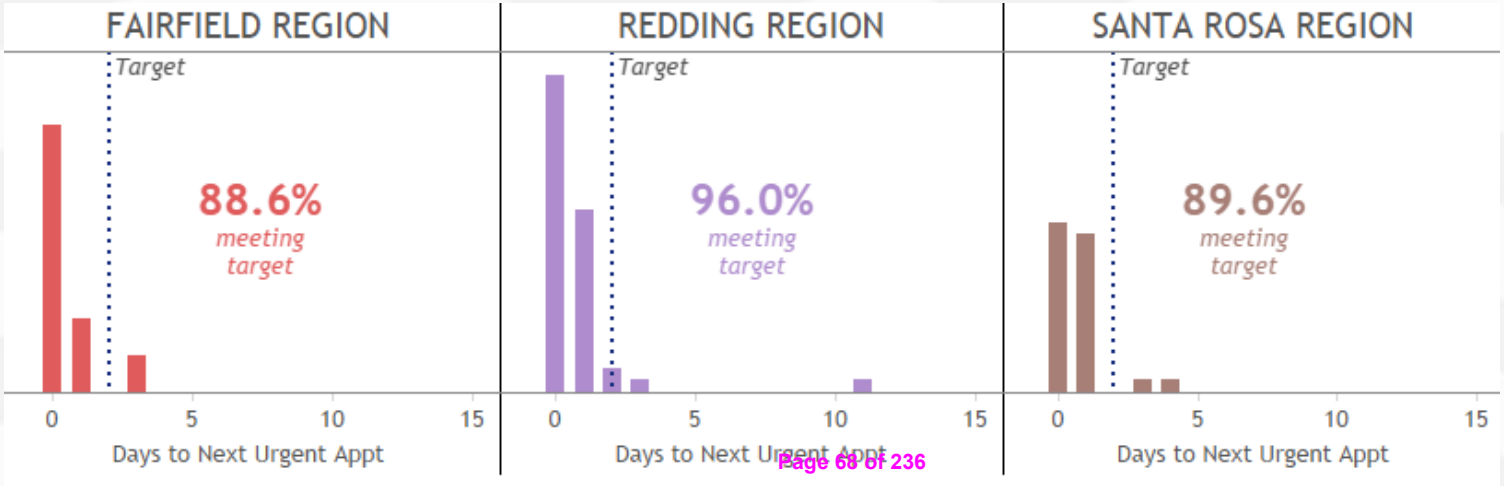
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Urgent PCP Appointments

Distribution of Clinics by Days to Next Available Urgent Appointment

Target for Urgent Appointments:
<= 2 Business Days

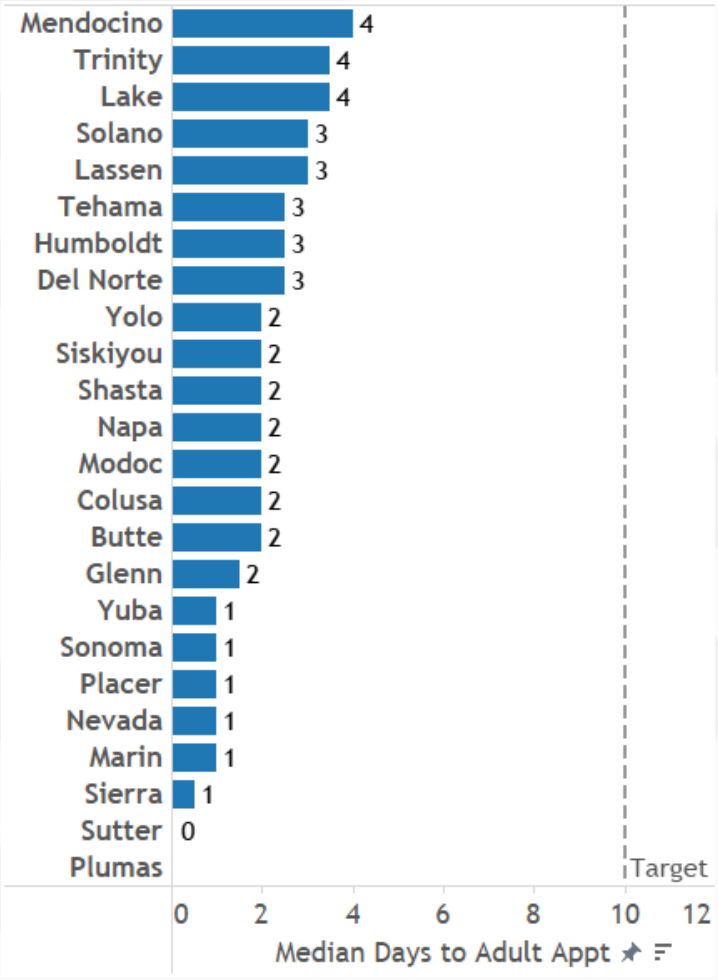




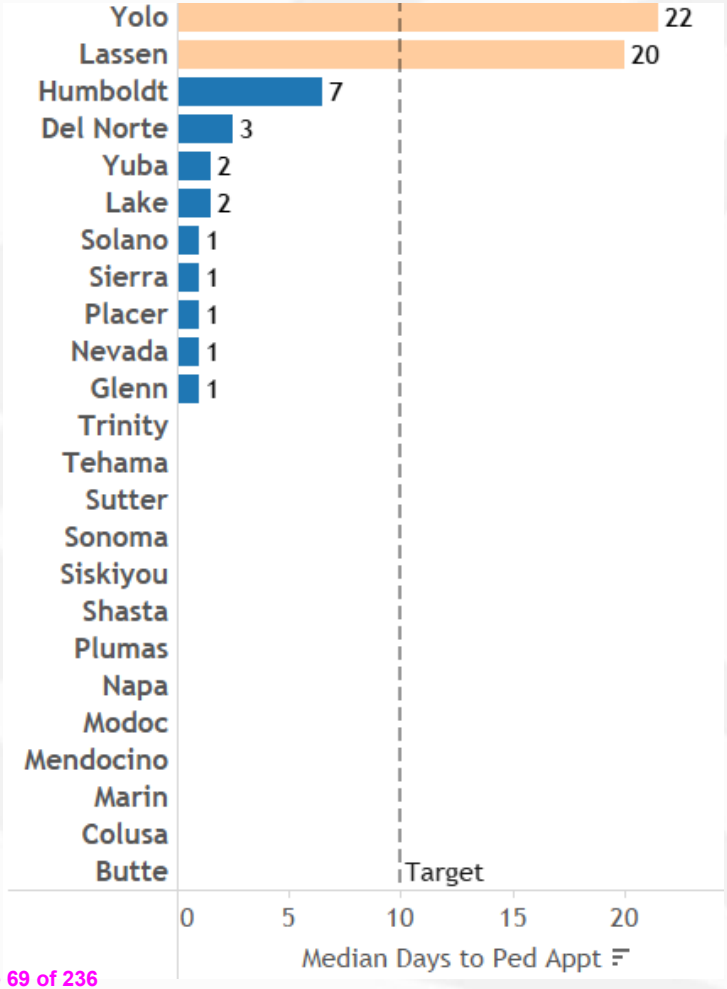
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Median Days to Appointments

Median Days to Adult Appts by County

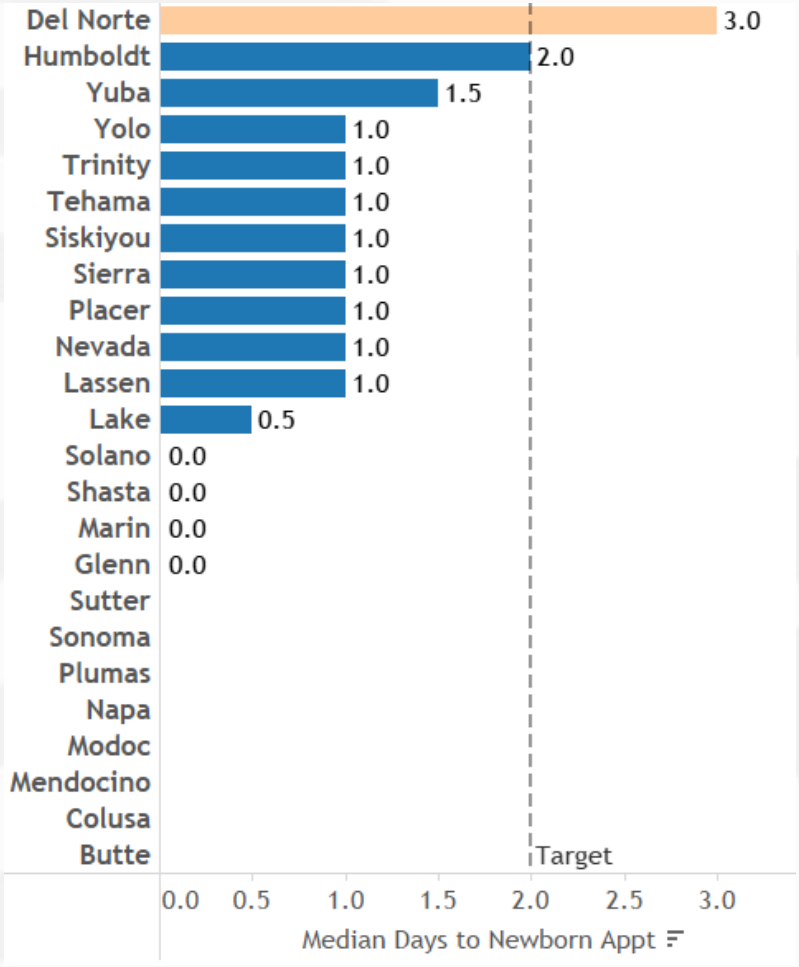


Median Days to Ped Appts by County

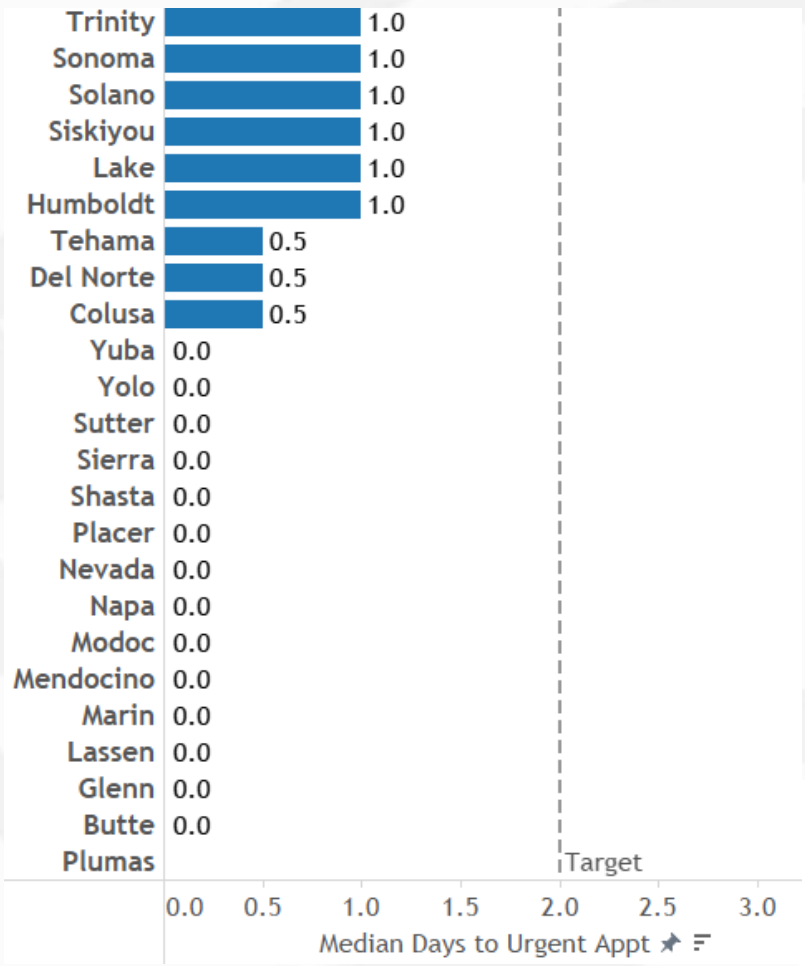


Median Days to Appointments

Median Days to Newborn Appts by County



Median Days to Urgent Appts by County



PCP Appointments Meeting Targets by County

% of Clinics Meeting PCP Standards by County

		Adult	Pediatric	Newborn	Urgent
AUBURN REGION	Placer	83%	100%	100%	95%
	Nevada	90%	100%	100%	100%
	Plumas				
	Sierra	100%	100%	100%	100%
CHICO REGION	Butte	69%			94%
	Sutter	100%			100%
	Yuba	100%	100%	100%	100%
	Glenn	83%	100%	100%	100%
	Colusa	75%			100%
EUREKA REGION	Humboldt	82%	100%	60%	100%
	Mendocino	79%			87%
	Lake	70%	100%	100%	91%
	Del Norte	100%	100%	50%	100%
FAIRFIELD REGION	Solano	64%	100%	100%	89%
	Yolo	82%	50%	75%	87%
	Napa	89%			90%
REDDING REGION	Shasta	100%		100%	100%
	Siskiyou	92%		100%	85%
	Tehama	100%		100%	100%
	Trinity	100%		100%	100%
	Modoc	100%			100%
	Lassen	75%	0%	100%	100%
SANTA ROSA REGION	Sonoma	90%			91%
	Marin	85%		100%	88%

Summary

- Overall ~85% of clinics met the **Adult** appt target
- **Pediatric** appt response has suffered so large variation
- All counties have high share of counties meeting **Urgent** target

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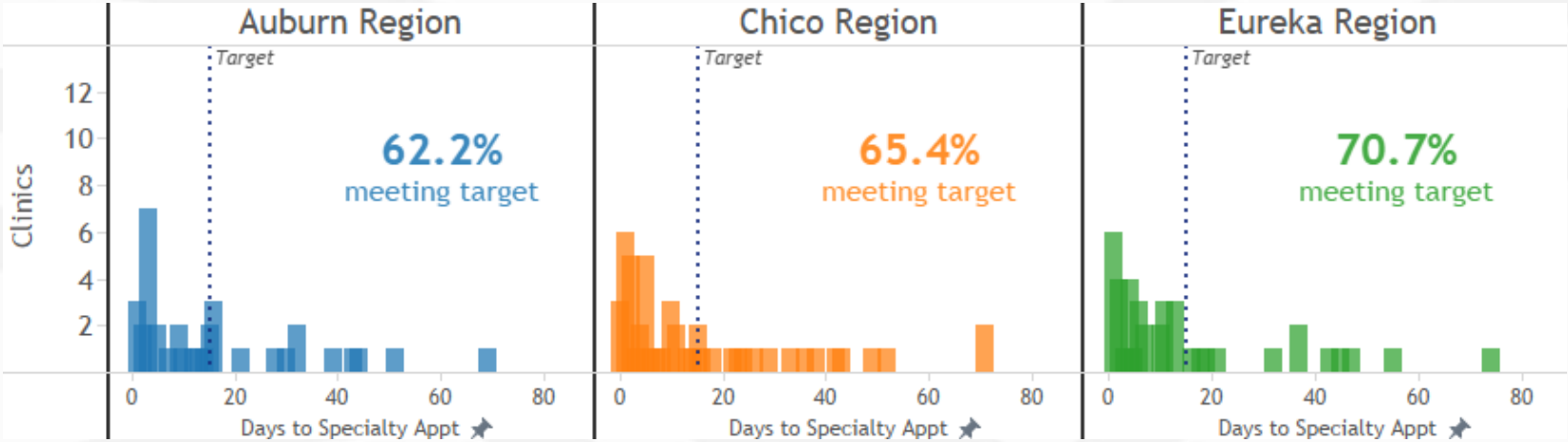


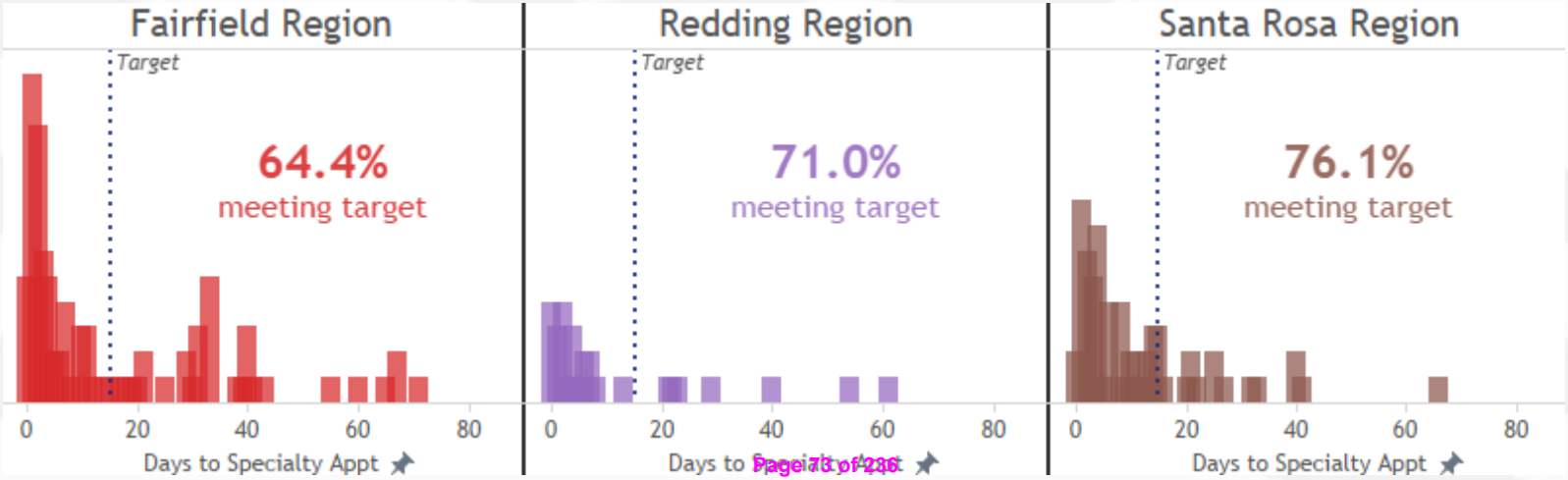
Specialty Appointments

Specialty Appointments

Distribution of Specialty Clinics by Next Non-Urgent Specialty Appt.

Target for Specialty Appointments:
<= 15 Business Days

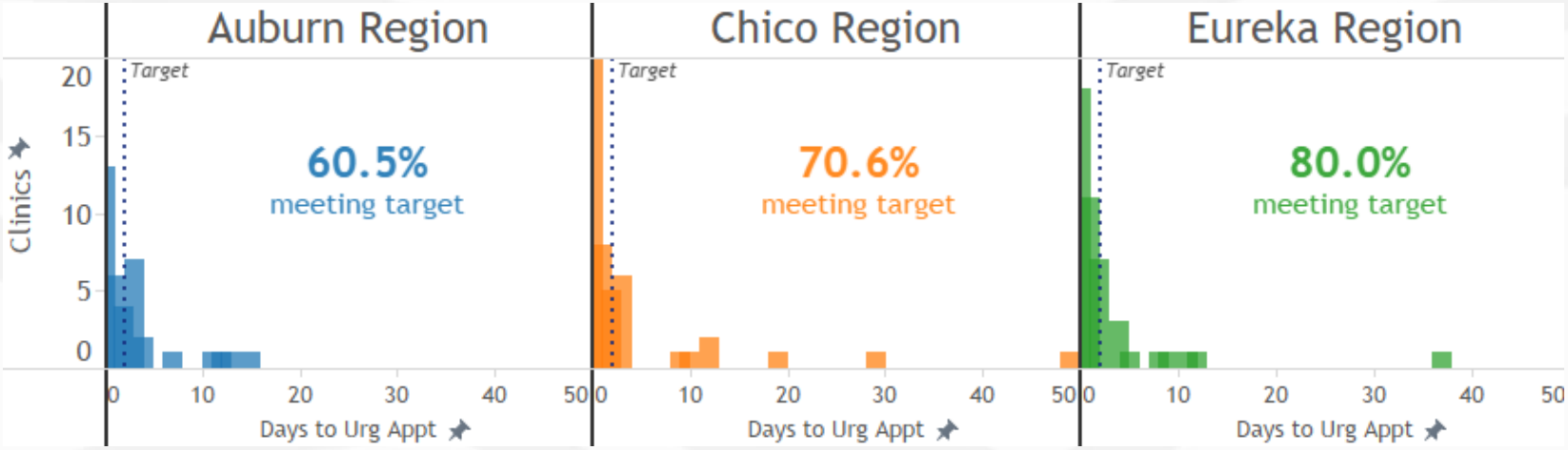


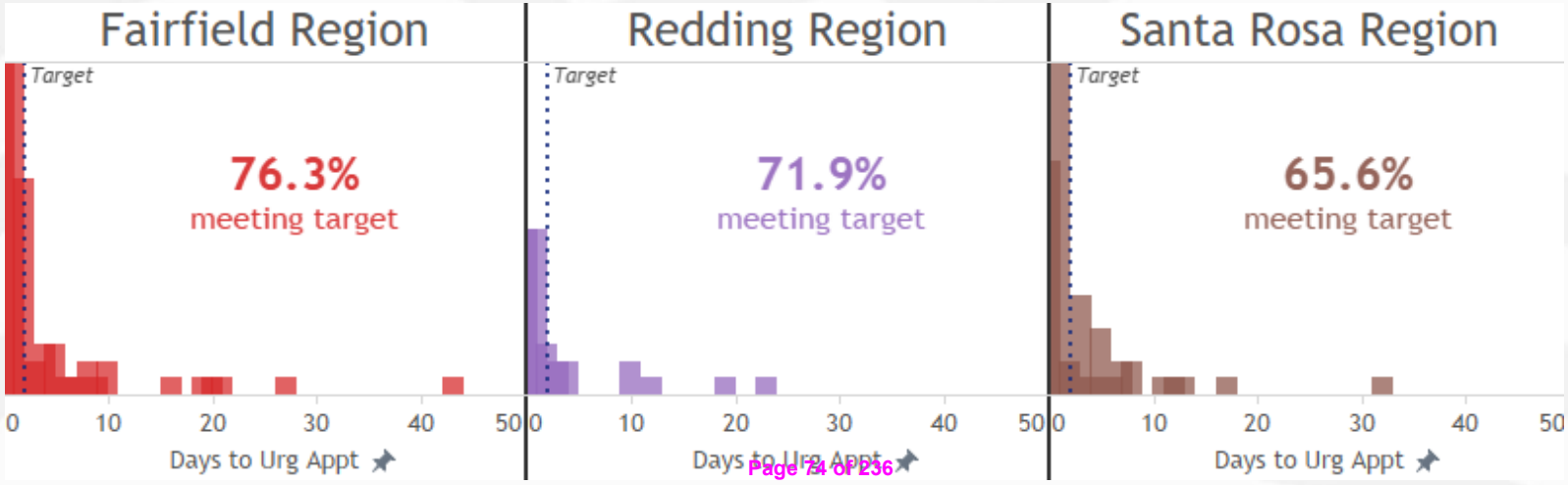


Specialty Appointments

Distribution of Specialty Clinics by Next Available Urgent Specialty Appt.

Target for Urgent Specialty Appts:
<= 2 Business Days





Share of Clinics Meeting Targets by Specialty

% of Clinics Meeting Standards by Specialty, 2026

	Auburn Region	Chico Region	Eureka Region	Fairfield Region	Redding Region	Santa Rosa Region	Grand Total
Cardiology	50%	71%	33%	55%	100%	85%	66%
DERMATOLOGY	50%	0%	33%	44%	33%	75%	45%
ENDOCRINOLOGY				50%		100%	80%
GASTROENTEROLOGY	100%	0%	100%	100%	100%	20%	66%
GENERAL SURGERY	100%	100%	60%	100%	100%	100%	92%
NEPHROLOGY		100%	100%	80%	0%	100%	81%
NEUROLOGY	0%	0%*	100%*	40%	0%	50%	33%
OB/GYN	100%	33%	100%	100%	100%	100%	86%
ONCOLOGY/HEMAT..	100%	100%		50%	100%	100%	90%
OPHTHALMOLOGY	50%	71%	50%	62%	42%	80%	60%
ORTHOPAEDIC SURGERY	50%	75%	100%	75%	75%	81%	77%
Otolaryngology (ENT)	0%	100%	100%	50%	100%	50%	62%
PAIN MANAGEMENT		0%	100%	33%	100%	75%	53%
Physical Medicine/Rehab		33%	0%*	100%*	100%	0%	42%
Podiatry Orthopedic	83%	100%	75%	100%	100%	87%	90%
Pulmonology	100%	100%	100%	42%		66%	64%
UROLOGY	0%	33%	0%	40%		66%	35%

Summary

- Specialties with highest % of clinics meeting standards: ***Oncology, General Surgery, Podiatry***
- Specialties with lowest % of clinics meeting standards: ***Urology, Neurology***
- **Eureka And Redding Region** has greatest # of specialties meeting standards.
- **Auburn and Fairfield Region** has lowest # of specialties meeting standards.

* single provider

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Clinics not Meeting Targets for Specialty Appointments

Auburn & Chico Region Specialty Providers

Specialty Group	Provider Name	
Cardiology	Adventist Health Physicians Network-481 Plumas Blvd Ste 201	49
	Sutter Medical Group Placer-2 Medical Plaza Dr Ste 250 Cardio	30
	Sutter Medical Group Placer-2 Medical Plaza Ste 130 Cardio/Vasc S..	39
DERMATOLOGY	Sutter Medical Group Placer-3 Medical Plaza Dr Ste 230 Derm	51
	Sutter North Medical Group-Dermatology	71
ENDOCRINOLOGY	Jahangir Mahmoudi, MD Inc.	42
GASTROENTEROLO..	Oroville Gastroenterology	36
OB/GYN	Sutter North Medical Group-969 Plumas St Ste 103	38
	Sutter North Medical Group-969 Plumas St Ste 116	52
OPHTHALMOLOGY	Sierra View Medical Eye, Inc	32
	Stabel Eye Clinic	26
Otolaryngology (ENT)	Sacramento Ear Nose & Throat-Roseville 2 Medical Plaza	43
	Sacramento Ear Nose & Throat-Roseville 5 Medical Plaza	44
	Sutter Medical Group Placer-3 Medical Plaza Dr Ste 220 Otolaryngo..	69
PAIN MANAGEMENT	Sutter North Medical Group-Pain Management	29
Physical Medicine/Rehab	Interventional Pain Solutions-Chico	33
Podiatry Orthopedic	Sutter Medical Group Placer-3 Medical Plaza Dr Ste 110 Podiatry	32

Fairfield & Santa Rosa Region Specialty Prov.

Specialty Group	Provider Name	
Cardiology	MarinHealth Medical Network Cardio-3250 Beard Rd	29
	Providence Medical Group, Napa-3443 Villa Ln Ste 102	33
	Sutter Medical Group of the Redwoods-Cardio 34 Mark West	27
	Sutter Medical Group Solano-2720 Low Ct Cardiology	38
DERMATOLOGY	MarinHealth Medical Network Dermatology-5000 Civic Center Dr	66
	Pacific Skin Institute-Vacaville	43
	Solano Dermatology Associates-St Helena	29
	Solano Dermatology Associates-Vacaville	41
	Solano Dermatology Associates-Vallejo	33
ENDOCRINOLOGY	Woodland Clinic-632 W Gibson Endocrinology	39
GASTROENTERO..	Providence Medical Group, Sonoma-500 Doyle Park Dr Ste 205	32
NEUROLOGY	NorthBay Healthcare Group-1010 Nut Tree Rd Ste 100 Neuro/PT	33
	NorthBay Healthcare Group-Neurology/PT	33
	Providence Medical Group, Napa-1100 Trancas Ste 205	65
ONCOLOGY/HE..	Adventist Health St. Helena - Martin O'Neil Cancer Center	40
OPHTHALMOLO..	Eye Care Center of Napa Valley-Napa	33
	North Bay Eye Associates Inc.-Santa Rosa	40

Eureka & Redding Region Specialty Providers

Specialty Group	Provider Name	
Cardiology	Adventist Health Physicians Network-475 N Forbes St Cardio	32
	Providence Medical Group, Humboldt-2332 23rd St	74
DERMATOLOGY	CK Derm-Eureka	55
	CK Derm-Redding	23
	North Pacific Dermatology-Fortuna	37
	Shasta Community Health Center	22
GENERAL SURGERY	Adventist Health Howard Memorial-3 Marcela Dr	19
	Cobb, Luther Fuson, MD	37
NEUROLOGY	Catalyst Neuromedical Center	54
OPHTHALMOLO..	Humboldt Medical Eye Associates	18
	Larkspur Optometry	29
	Riverside EyeCare Professionals	61
	Shasta Eye Medical Group -3190 Churn Creek Rd	40
	Ukiah Valley Spec HB-248 B Hospital Drive-Opth	47
ORTHOPAEDIC SURGERY	Guthrie, Todd Bruce, MD	21
Physical Medicine/Rehab	Providence Medical Group, Humboldt-2675 Harris St Physical Med & Rehab	21
Podiatry	Humboldt Foot and Ankle PC	

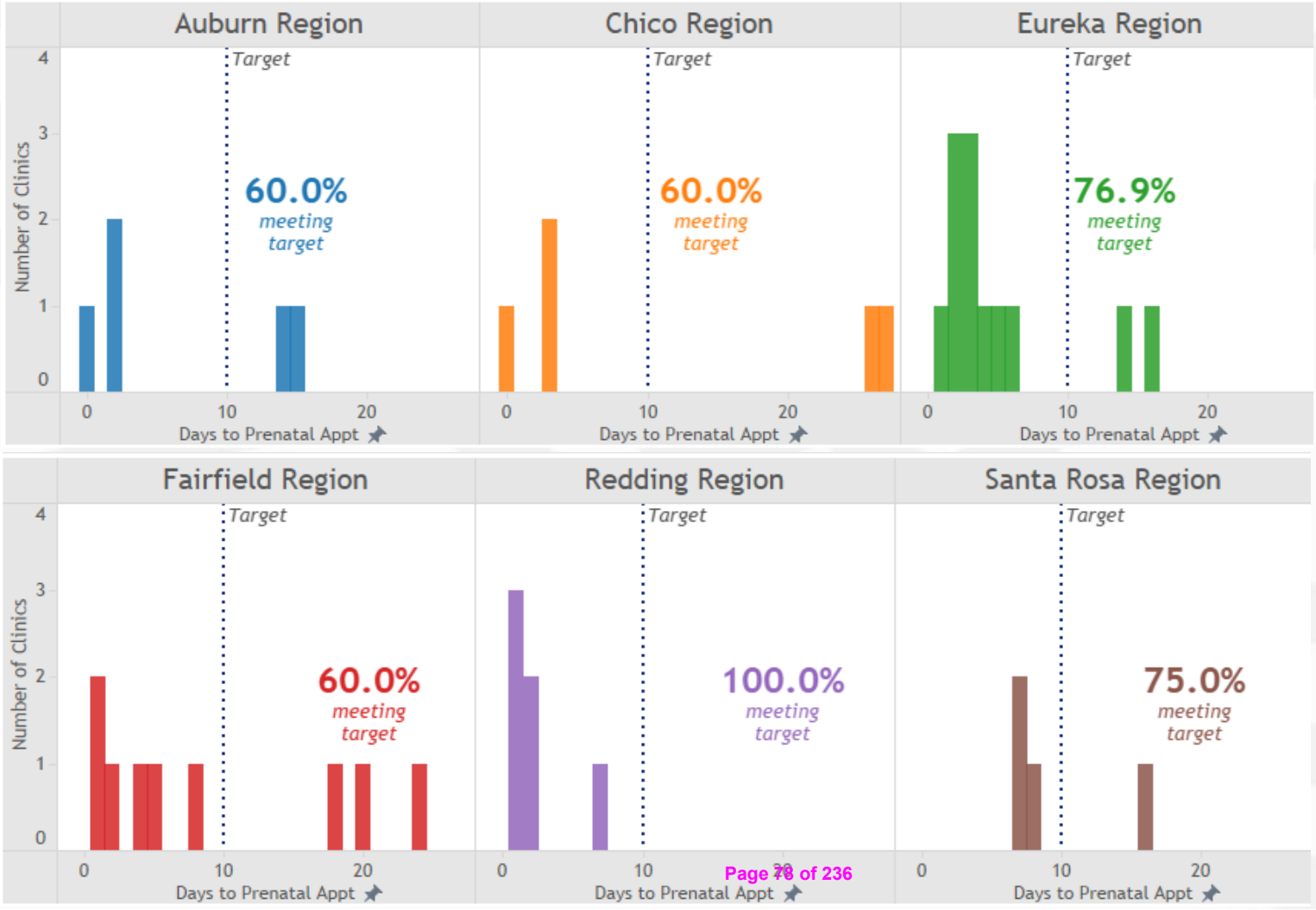
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Prenatal Appointments

Prenatal Appointments Meeting Targets

Distribution of Clinics by Days to Next Prenatal Appt.

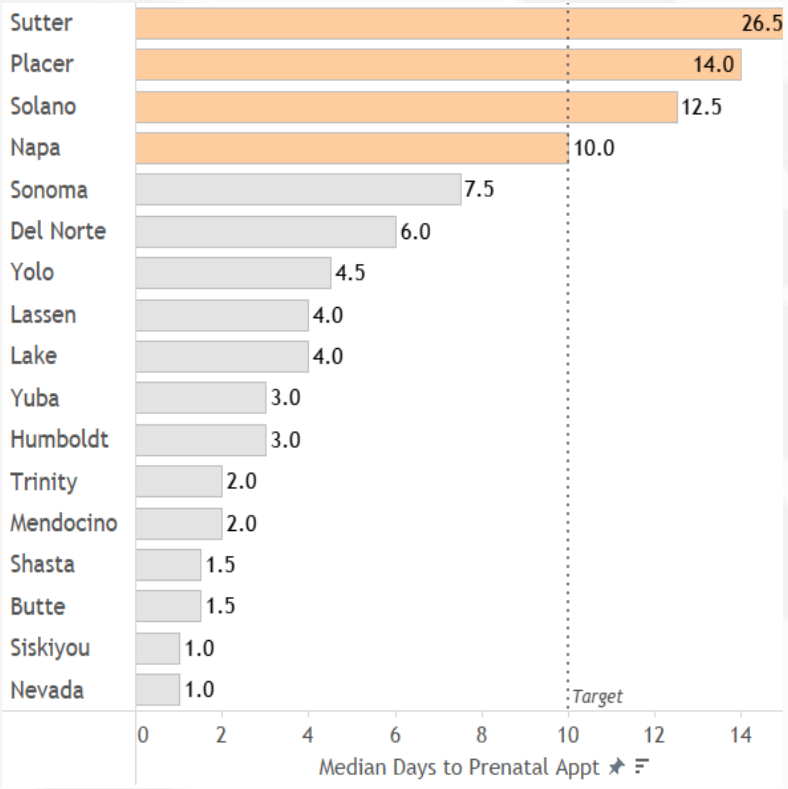


Target NA Appointment Prenatal Care
PCP <= 10 days
Specialist <= 10 days

Prenatal Appointments Meeting Targets

The median wait for counties varied greatly and individual sites may have exceeded target greatly

Days to Prenatal Appts by County



Clinics that Missed Prenatal Target

Region	County	Location	
Auburn Region	Placer	Chapa-De Indian Health-Auburn	15
		Sutter Medical Group Placer-11795 Education St Ste 2..	14
Chico Region	Sutter	Sutter North Medical Group-969 Plumas St Ste 103	26
		Sutter North Medical Group-969 Plumas St Ste 116	27
Eureka Region	Humboldt	UIHS-Potawot Health Village	16
		UIHS-Weitchpec Health Clinic	14
	Lake	Adventist Health Clearlake-15230 Lakeshore Dr	65
Fairfield Region	Napa	Providence Medical Group, Napa-1100 Trancas Ste 209	18
	Solano	NorthBay Health Women's Health-Fairfield	20
		Sutter Medical Group Solano-770 Mason St -OB/GYN	44
	Yolo	Winters Healthcare Foundation, Inc.-Winters	24
Santa Rosa Region	Sonoma	Providence Medical Group, Sonoma-1550A Profession..	16

Target
NA Appointment
Prenatal Care
PCP <= 10 days
Specialist <= 10 days

Thank You!

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCCP2022 (previously MCUP3065; UP100365)				**Lead Department: Health Services** Business Unit: Care Coordination	
Policy/Procedure Title: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 03/16/2005 (MCUP3065)			**Next Review Date:** ~~01/14/2027~~01/13/2028 **Last Review Date:** ~~01/14/2026~~01/13/2027		
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:** ~~01/14/2026~~01/13/2027	

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCCP2024 – Whole Child Model for California Children's Services (CCS)
C. MCUP3126 – Behavioral Health Treatment~~herapy~~ (BHT) for Members Under the Age of 21
~~D.~~ MPTP2501 – Transportation Policy~~Guidelines~~ for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
~~E.~~D.
~~F.~~E. MCQG1015 – Pediatric Preventive Health Guidelines
~~G.~~F. MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities
~~H.~~G. MPUP3048 – Dental Services (including Dental Anesthesia)
~~I.~~H. MPUG3019 – Hearing Aid Guidelines
~~J.~~I. MCCP2031 – Private Duty Nursing Under EPSDT
~~K.~~J. MPBP8003 – Mental Health Services
~~L.~~K. MPND9002 – Cultural & Linguistic Program Description
~~M.~~L. MCCP2035 – Local Health Department (LHD) Coordination
~~N.~~M. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
~~O.~~N. MCUP3102 – Vision Care
~~P.~~O. MCUP3020 – Hospice Services ~~Guidelines~~
~~Q.~~P. MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Provider Relations
~~D.~~E. Care Coordination

III. DEFINITIONS:

A. Ameliorate: To make more tolerable or to make better
B. 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.
C. DHCS: Department of Health Care Services
D. EPSDT: Early and Periodic Screening, Diagnostic, and Treatment (*see also Medi-Cal for Kids and Teens*

below)

E. FFS: Fee-for-Service
F. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled
G. Hospice Care: Services provided to a terminally ill patient with a prognosis of life of 6 months or less, if the disease follows its normal course. For children, curative services may be provided concurrently with hospice services.
H. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative
I. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing
J. LEA: Local Education Agency
K. Maintenance Services: Services that sustain or support rather than cure or improve health problems
L. Medi-Cal for Kids and Teens: DHCS refers to EPSDT as "Medi-Cal for Kids and Teens" in outreach and education materials. DHCS has developed child-focused and teen-focused brochures that provide an overview of EPSDT, including Covered Services, how to access those services, and the importance of Preventive Care and also a "Medi-Cal for Kids & Teens: Your Medi-Cal Rights" letter that illustrates what to do if Medi-Cal care is denied, delayed, reduced, or stopped, including who to contact, how to file grievances and appeals, and how to access other enrollee assistance resources.
M. Medical Necessity for EPSDT Services: For individuals under 21 years of age, a service is medically necessary if the service meets the standards set for in Section 1396d(r)(5) of Title 42 of the United States Code and is necessary to correct or ameliorate defects and physical and mental illnesses and conditions that are discovered by screening services.
N. NCHCC: Northern California Hearing Coordination Center
O. Newborn Hearing Screening Program (NHSP): DHCS has implemented this statewide comprehensive program that helps identify hearing loss in infants and guide families to the appropriate services needed to develop communication skills.
P. Palliative Care: Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care can be provided as part of Hospice Care at the end of life, or as a set of supportive services for individuals with life-threatening conditions who have a life expectancy that is longer than 6 months.
Q. TCM: Targeted Case Management
R. 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 Partnership HealthPlan of California's (Partnership's) responsibility to cover medically necessary services not covered under the Medi-Cal Program for individuals under the age of 21 under the Early and Periodic Screening Diagnostic, and Treatment (EPSDT) supplemental services benefit, also referred to as "Medi-Cal for Kids and Teens."

VI. POLICY / PROCEDURE:

A. Partnership covers and ensures the provision of screenings and preventive and medically necessary diagnostic and treatment services for Members under the age of 21 in accordance with the EPDST program benefit.
B. Partnership provides information regarding EPSDT services for Members which can be found in the Partnership Medi-Cal Member Handbook and in the "Medi-Cal for Kids and Teens" letter and education materials provided by DHCS and available on their website: https://www.dhcs.ca.gov/services/Medi-Cal-

For-Kids-and-Teens/Pages/Resources.aspx . In addition, Partnership annually provides information to all Members, their families ~~amilies~~ and~~and~~/or caregivers about available EPSDT services through Partnership's website at http://www.partnershiphp.org/ and also through Member Newsletters which are mailed twice a year (summer and winter) and can also be accessed from this Partnership webpage: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Member-Newsletter.aspx .

1. Partnership provides Member information in accordance with all language and accessibility standards as described in Partnership policy *MPND9002 Cultural & Linguistic Program Description*.

C. Section 1905(r) of the Social Security Act (SSA) defines the EPSDT benefit to include a comprehensive array of preventative, diagnostic, and treatment services for low-income individuals under the age of 21. Title 42 of the United States Code (USC), Section 1396d(r), defines EPSDT services to include the following:

1. Early and Periodic Screening, Diagnostic and Treatment services: These are services that are provided at intervals, which meet reasonable standards of medical and dental practice, as determined by the State after consultation with recognized medical and dental organizations involved in child health care, and at such other intervals indicated as medically necessary to determine the existence of physical or mental illnesses or conditions. Screening services, at a minimum must include a comprehensive health and developmental history (including assessment of both physical and mental health development); a comprehensive unclothed exam; appropriate immunizations (according to Title 42 of USC Section 1396s(c)(2)(B)(i) for pediatric vaccines for age and health history); laboratory tests (including blood lead level assessment appropriate for age and risk factors); and health education (including anticipatory guidance).
2. Vision services provided at intervals, which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Vision services must include, at a minimum, diagnosis and treatment for defects in vision, including eyeglasses.
   a. For more information, see Partnership policy *MCUP3102 Vision Care.*
3. Dental services provided at intervals, which meet reasonable standards of dental practice, as determined by the State after consultation with recognized dental organizations involved in child health care, and other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Dental services must include, at a minimum, treatment of relief of pain and infections, restoration of teeth, and maintenance of dental health. Dental services are carved out to the State, with the exception of medically necessary dental anesthesia.
   ~~b.~~a. For more information, see Partnership policy *MPUP3048 Dental Services (including Dental Anesthesia).*
4. Hearing services provided at intervals, which meet reasonable standards of medical practice, as determined by the State after consultation with recognized medical organizations involved in child health care, and at other intervals indicated as medically necessary to determine the existence of a suspected illness or condition. Hearing services must include, at a minimum, diagnosis and treatment for defects in hearing, including hearing aids.
   ~~c.~~a. For more information, see Partnership policy *MPUG3019 Hearing Aid Guidelines.*
5. Other necessary health care, diagnostic services, treatment and other measures as described in 42 USC 1396d(a), to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services or items are listed in the state plan or are covered for adults.

~~2.~~6. Partnership ensures that Members have timely access to all medically necessary EPSDT services and that appropriate diagnostic and treatment services are initiated as soon as possible, but no later than 60 calendar days following either a preventative screening or other visit that identifies a need for

follow-up.

D. The EPSDT benefit in California is established in the Medi-Cal Schedule of Benefits set forth in Welfare and Institutions Code (WIC) Section 14132(v), which states that "Early and periodic screening, diagnosis and treatment for any individual under the age of 21 years of age is covered, consistent with the requirements of Subchapter XIX (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code."

E. For Members under the age of 21, Partnership will provide the EPSDT benefit in accordance with the AAP/Bright Futures periodicity schedule.
   1. For more information, see Partnership policy *MCQG1015 —Pediatric Preventive Health Guidelines.*

~~E.~~F. For Members under the age of 21, Partnership will provide and cover all medically necessary EPSDT service that meets the standards set forth in Title 42 of the USC Section 1396d(r)(5), unless otherwise carved out of Partnership's contract, regardless of whether such services are covered under California's Medicaid State Plan for adults, when the services are determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions.

~~F.~~G. An EPSDT service need not cure a condition in order to be covered. Services that maintain or improve the child's current health condition are also covered under EPSDT because they 'ameliorate' a condition. Services are covered when they prevent a condition from worsening or prevent development of additional health problems.

~~G.~~H. Additional services must be provided if determined to be medically necessary for an individual child (as per III.L above). Medical necessity determinations for services requested under EPSDT are individualized. Flat or hard limits based on a monetary cap or budgetary constraints are not consistent with EPSDT requirements and are not permitted. Requests are reviewed on a case-by-case basis and take into account the particular needs of the Member:
   1. Children with mild to moderate mental health issues or conditions are the responsibility of Partnership and services for them are available through Carelon Behavioral Health's provider network as Partnership's subcontractor. Referrals for services should be made to Partnership's behavioral health access team~~line~~.
   2. The supplies, items or equipment to be provided are medical in nature.
   3. The services are not requested solely for the convenience of the Member, family, physician or other provider of service(s).
   4. The services are not unsafe for the individual, and are not experimental.
   5. The services are neither primarily cosmetic in nature nor primarily for the purpose of improving the Member's appearance. The correction of severe or disabling disfigurement shall not be considered to be primarily cosmetic nor primarily for the purpose of improving the Member's appearance.
   6. Where alternative medically accepted modes of treatment are available, the services are the most cost-effective.

~~H.~~I. EPSDT services must meet all of the following criteria:
   1. Must be generally accepted by the professional medical community as effective and proven treatments for the conditions for which they are proposed to be used. Such acceptance shall be demonstrated by scientific evidence consisting of well-designed and well-conducted investigations published in peer-review journals and have opinions and evaluations published by national medical and dental organizations, consensus panels, and other technology evaluation bodies. Such evidence shall demonstrate that the services can screen, diagnose, correct or ameliorate the conditions for which they are prescribed.
   2. Are within the authorized scope of practice of the provider, and are an appropriate mode of treatment for the health condition of the Member.
   3. The predicted beneficial outcome of the services outweighs the potential harmful effects.
   4. Available scientific evidence demonstrates that the services improve the overall health outcomes as much as, or more than, established alternatives.

5. The total cost of providing services and all other medically necessary Medi-Cal services to the beneficiary is not greater than the costs incurred in providing medically necessary equivalent services at the appropriate institutional level of care as outlined by State and Federal law.

I.J. Upon adequate evidence that a Member has a California Children's Services (CCS) eligible condition, Partnership will refer the Member to the local county CCS office for determination of CCS program eligibility. If the local CCS program does not approve eligibility, Partnership remains responsible for the provision of all medically necessary covered services for the Member. For more information, see Partnership policy *MCCP2024 Whole Child Model for California Children's Services (CCS).*

K. Partnership is responsible for providing medically necessary Behavioral Health Treatment (BHT) under EPSDT.

1. For more information, see Partnership policy *MCUP3126 Behavioral Health Treatmenttherapy (BHT) for Members Under the Age of 21.*

J.L. Partnership has the primary responsibility to provide medically necessary EPSDT services, including services which exceed the amount provided by Local Education Agency (LEA) programs, Regional Centers (RCs), CCS, or local governmental health programs, and will not rely on these or other entities as the primary provider. Where another entity, such as an LEA, RC, or local governmental health program has overlapping responsibility for providing services to a Member under the age of 21, Partnership will:

1. Assess what level of EPSDT medically necessary services the Member requires
2. Determine what level of service (if any) is being provided by the other entities, and
3. Coordinate the provision of services with the other entities to ensure that Partnership and the other entities are not providing duplicative services, and that the Member is receiving all medically necessary services in a timely manner.

K.M. Targeted Case Management (TCM)

The EPSDT benefit includes case management and care coordination for all medically necessary EPSDT services. Partnership ensures the coverage of TCM services designed to assist the Member in gaining access to necessary medical, social and educational and other services. When the need for TCM services is identified, Partnership shall:

1. Determine whether a Member requires Case Management (CM) or Targeted Case Management (TCM) services under EPSDT.
2. For Members who are eligible for CM or TCM services, Partnership will either provide services or refer and collaborate with the appropriate agency, RC or local government health program where applicable.
3. If a Member is currently receiving TCM services, Partnership will coordinate the Member's health care needs and EPSDT services with the TCM provider.
4. If Partnership determines that an eligible Member is not accepted for TCM services, Partnership will ensure that the Member has access to services comparable to EPSDT TCM services.

L.N. Transportation

1. Under the EPSDT benefit, for Members under the age of 21, Partnership:
   a. May provide medical Non-Emergency Medical Transportation (NEMT) and Nnon-Mmedical Transportation (NMT) transportation, meals and/or lodging to and from any medically necessary covered EPSDT appointment as outlined by in Title 42 CFRCode of Federal Regulations (CFR) Section §440.17 (a)(3).
   b. Shall provide appointment scheduling assistance to and from medical appointments for the medically necessary EPSDT services covered by Partnership.
2. For more information, see Partnership policy *MPTP2501 Transportation PolicyGuidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT).*

M.O. Dental Services

1. Most dental services are carved-out of Partnership's contract with DHCS. Under EPSDT, for

Member under the age of 21 Partnership will:

a. Cover and ensure that dental screenings/oral health assessments for all Members are included as part of the initial health appointment.
b. Ensure providers perform a dental screening/oral health assessment as part of every periodic assessment
c. Encourage providers to make annual dental referrals no later than 12 months of age or when referral is indicated.
d. Cover and ensure that fluoride varnish and oral fluoride supplementation assessment and provision is consistent with AAP/Bright Futures periodicity schedule and anticipatory guidance.
e. Cover and ensure the provision of covered medical services related to dental services that are not provided by dentists or dental anesthetists.
f. Ensure that providers refer Members to appropriate Medi-Cal dental providers.

2. For more information, see Partnership policy *MPUP3048 Dental Services (including Dental Anesthesia).*

~~N.~~P. Hospice Services

1. Children receiving hospice care services for a terminal illness and life expectancy of six months or less may receive additional services than are available for adults.
2. Children are eligible for hospice care under the same criteria as adults (a physician certifies the Member as having a life expectancy of six months or less), although children under 21 years of age also may elect to receive concurrent curative treatment of the hospice-related diagnosis and concurrent palliative care.
3. For more information, see Partnership policy *MCUP3020 Hospice Service*s ~~Guidelines~~ and *MCUP3140 Palliative Care: Pediatric Program for Members Under the Age of 21.*

~~O.~~Q. Excluded Services

For Members under the age of 21, Partnership is required to cover all medically necessary EPSDT services except those services that are specifically carved out of Partnership's contract with DHCS. Carved-out services vary and can include, but are not limited to, dental services, specialty mental health services, non-medical services provided by the Regional Center(s), etc. In addition, Partnership does not reimburse families or caregivers for care.

~~P.~~R. For services to be considered under the EPSDT benefit, a Treatment Authorization Request (TAR) must be accompanied by the following information:

1. The principal diagnosis and significant associated diagnoses
2. Prognosis
3. Date of onset of the illness or condition; and etiology if known
4. Clinical significance or functional impairment caused by the illness or condition
5. Specific types of services to be rendered by each discipline, and anticipated time for achievement of the goals
6. The extent to which health care services have been previously provided to address the illness or condition, and results demonstrated by prior care
7. Any other documentation available that may assist Partnership in making determinations related to medical necessity.

~~Q.~~S. Newborn Hearing Screening Program (NHSP)

1. Partnership is responsible for case management services related to EPSDT and collaborates with the PCP and/or Specialist to ensure follow-up for missed EPSDT-related appointments, which includes follow-up with the families of babies that miss their hearing screening or diagnostic appointments. Partnership's Care Coordination department will receive referrals from the Northern California Hearing Coordination Center (NCHCC) to assist in case management services for access to care concerns and following up on missed hearing screening or diagnostic appointments.
2. Partnership providers can refer Members who have missed or failed EPSDT-related appointments

through the external referral form on the Partnership's website. Our Care Coordination staff may also reach out to the Member once the referral is received to assist with care coordination services and identify barriers.

~~R.~~T. Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled-Habilitative (ICF/DD-H) homes, and Intermediate Care Facilities for the Developmentally Disabled-Nursing (ICF/DD-N)

1. For more information, refer to Partnership policy *MPCP2006 Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities* and *MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities.*

VII. REFERENCES:

A. Title 42 United States Code (USC) Sections 1396, 1396d(a) and (r), 1396s(c)(2)(B)(i)
B. Title 22 California Code of Regulation (CCR) Section51340(e)
C. Title 9, California Code of Regulation (CCR), Section 1810.247, 1820.205, 1830.210
D. Welfare and Institutions Code (WIC) Section 14132(v)
E. Mental Health Parity and Addiction Equity Act
F. Social Security Act Section 1905 (a) and (r)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-005: Requirements for Coverage of Early and Periodic Screening, Diagnostic, and Treatment Services for Medi-Cal Members Under the Age of 21 (03/16/2023)
H. DHCS webpage with resources for "Medi-Cal for Kids and Teens": https://www.dhcs.ca.gov/services/Medi-Cal-For-Kids-and-Teens/Pages/Resources.aspx
I. DHCS APL 26-012~~23-023~~ Intermediate Care Facilities for Individuals with Developmental Disabilities ~~–~~ Long-Term Care Benefit ~~Standardization and Transition of Members to Managed Care~~Under Managed Care (06/10/2026 Supersedes APL 24-011~~*Revised* 11/28/2023~~)
J. DHCS APL 25-008 Hospice Services and Medi-Cal Managed Care (05/05/2025)
K. DHCS APL 26-015 Immunization Requirements (07/14/2026 Supersedes 24-008)
L. EPSDT Benefit Overview (Medi-Cal Provider Manual)
~~J.~~M. Immunizations (Medi-Cal Provider Manual)

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

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

X. REVISION DATES:

MCCP2022 - (as of 02/15/17)
08/16/17; *06/13/18; 02/13/19; 11/13/19; 02/12/20; 09/09/20; 09/08/21; 10/12/22; 10/11/23; 02/14/24; 06/12/24; 09/11/24; 02/12/25; 01/14/26; 1/13/27

*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:
MCUP3065 (03/16/2005 to 02/15/2017)
10/18/06; 07/15/09; 01/18/12; 02/18/15; 02/17/16 to 02/15/2017

Policy/Procedure Number: MCCP2022 (previously MCUP3065, UP100365)			**Lead Department: Health Services** Business Unit: Care Coordination
Policy/Procedure Title: Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/16/2005 (MCUP3065)			**Next Review Date: 01/134/20287** **Last Review Date: 01/134/20276**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPCP2019 (previously MCCP2019, MCUP3117)			**Lead Department: Health Services** Business Unit: Care Coordination	
Policy/Procedure Title: Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services			☒ **External Policy** ☐ **Internal Policy**	
Original Date: Approved by DHCS 04/11/2013, First Committee Review 08/20/2014 (MCUP3117)		**Next Review Date:** ~~01/14/2027~~01/13/2028 **Last Review Date:** ~~01/14/2026~~01/13/2027		
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:** ~~01/14/2026~~01/13/2027	

I. RELATED POLICIES:

A. MCUP3012 – Discharge Planning (Non-capitated Members)
B. MPUP3039 – Direct Members
C. MPCP2007 – Complex Case Management
D. MPCP2023 – New Member Needs Assessment
E. MCCP2024 – Whole Child Model for California Children's Services (CCS)
F. MPCD2013 – Care Coordination Program Description
G. MCAP7002 – CalAIM Enhanced Care Management (ECM)
H. MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
I. MPCP2014 – Continuity of Care

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
~~C.~~D. Care Coordination

III. DEFINITIONS:

A. 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.
B. 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.
C. Health Care Guide (HCG): A non-clinical Care Coordination staff m~~M~~ember who provides support and guidance to Members, families, providers, community agencies and the interdisciplinary care team to assist in coordination of benefits in a timely and cost-effective manner while connecting Members to available internal and external resources.
D. Health Risk Assessment (HRA): An assessment form mailed to newly enrolled adult Members (ages 21 and over) with corresponding Seniors and Persons with Disabilities (SPD) aid codes who may be at risk for adverse health outcomes without support from an Individualized Care Plan (ICP).
E. Individualized Care Plan (ICP): A Member-focused care plan designed to optimize the Member's health, function, and well-being.

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

G. Nurse Case Manager (NCM): A registered nurse in Care Coordination who works with the multidisciplinary team in order to facilitate coordination of the comprehensive medical, behavioral, and psychosocial needs of the Member while promoting quality and cost-effective outcomes.

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

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

J. Social Worker (SW): A social worker in Care Coordination who provides Members and/or their families with the supports needed to cope with chronic, acute and/or terminal illnesses, often complicated by other social/environmental or historical factors.

IV. ATTACHMENTS:

A. Health Risk Assessment (HRA)
B. Pediatric HRA
C. HRA Stratification Matrix
D. PHRA Stratification Matrix

V. PURPOSE:

~~This policy describes the process Partnership Health Plan of California (Partnership) will follow to assess new enrollees who are designated as Seniors and Persons with Disabilities (SPD) and/or California Children's Services (CCS) upon enrollment and at least annually thereafter. The purpose of the assessment is to identify those SPD/CCS Members at high risk for adverse health outcomes and to initiate appropriate individualized care plans to reduce that risk and optimize health.~~This policy describes the process Partnership Health Plan of California (Partnership) will follow to assess new Members/Enrollees who are designated as Seniors and Persons with Disabilities (SPD) and/or California Children's Services (CCS) upon enrollment and at least annually thereafter. The purpose of the assessment is to identify those SPD/CCS

Members/Enrollees at high risk for adverse health outcomes and to initiate appropriate individualized care plans to reduce that risk and optimize health.

VI. POLICY / PROCEDURE:

A. Member/Enrollee Risk Stratification
Partnership considers all newly enrolled SPD/CCS Members/Enrollees as higher risk and therefore they are comprehensively assessed via the Health Risk Assessment (HRA) or Pediatric Health Risk Assessment (PHRA) form to determine their current health risk.

B. HRA/PHRA Process
1. All newly enrolled Members/Enrollees designated with an SPD aid code and/or CCS identifier are sent the HRA (Attachment A) or PHRA (Attachment B) via mail within 10 calendar days of enrollment into the plan.
2. The HRA/PHRA forms are reviewed by the Chief Medical Officer, the Health Educator, and by the Consumer or Family Advisory Committee prior to implementation by the health plan, as are any and all revisions to the HRA/PHRA.
3. All newly enrolled SPD/CCS Members/Enrollees are contacted telephonically within 45 days of enrollment in order to encourage the Member/Enrollee to return the HRA/PHRA.
4. All questions on the HRA/PHRA forms are sent to each SPD/CCS beneficiary according to age upon enrollment. In no instance are any questions in the HRA/PHRA forms sent to a subset of the SPD/CCS population.
5. For those HRA/PHRAs completed, the Member's/Enrollee's responses will be captured and evaluated as follows:
   a. Adult Member/Enrollee responses will be captured and evaluated utilizing the HRA Stratification Matrix (Attachment C) for adult Members/Enrollees. Adult Members/Enrollees will be placed in low- or high-risk categories:
      1) Low-Risk – Member/Enrollee will benefit from basic case management; or
      2) High-Risk – Member/Enrollee requires complex case management through an individualized care plan (ICP) to prevent adverse health outcomes.
   b. Pediatric Members who complete a PHRA are classified as high-risk in accordance with policy *MCCP2024 Whole Child Model for California Children's Services (CCS).* Other Members may also be identified as high-risk based on additional criteria outlined in the policy.

C. Care Coordination
1. Low-Risk Members/Enrollees
   a. Adult Members/Enrollees who are stratified as low-risk based on their responses to the HRA will be contacted by a Health Care Guide (HCG) within 30 calendar days of the returned HRA.
   b. The role of the HCG is to identify barriers to care and safety and to carry out non-clinical interventions to eliminate those barriers. Examples include, but are not limited to:
      1) Work with the primary care provider and/or specialist's offices to coordinate appointments
      2) Contact durable medical equipment (DME) vendors to facilitate timely delivery of appropriate medical equipment
      3) Work with community-based organizations to assist Members/Enrollees with access to psychosocial services
      4) Arrange transportation as appropriate
      5) Resolve any claims issues
      6) Provide support and encouragement to the Member and caregiver
      7) Evaluate the Member/Enrollees for need for additional case management services available through the health plan.
      8) Facilitate referrals for Long Term Support Services (LTSS) needs identified

c. The HCG, ~~Nurse Case Manager (~~NCM~~)~~, and ~~Social Worker (~~SW~~)~~ work together. Any clinical issues will be the responsibility of a licensed clinician.

2. High-Risk Members/Enrollees
   a. Adult Members/Enrollees stratified as high-risk, as well as all pediatric Members/Enrollees who complete a PHRA, will be contacted by a NCM or SW within 14 days of the returned HRA/PHRA, and the Member/Enrollee will be offered enrollment into Complex Case Management (CCM) (see policy *MPCP2007 Complex Case Management*.) The Nurse Case Manager (NCM)/Social Worker (SW) collaborates with the Member/~~an~~ Enrollee's~~Member's~~ interdisciplinary care team -and is responsible for the development of the individualized care plan (ICP) for a Member/Enrollee stratified as high-risk. ~~They~~ For Partnership Advantage Enrollees, the care team includes the Interdisciplinary Care Team (ICT). The NCM/SW is ~~are~~ also responsible for providing education and clinical support, facilitating appropriate communication among the interdisciplinary care team participants, and working closely with outside agencies and available community resources.
   b. The NCM/SW will discuss the HRA/PHRA results with the Member and develop an ICP with interventions tailored to the particular needs of the Member. The care plan will include, but is not limited to, needs such as:
      1) The Member's/Enrollee's identified medical care needs
      2) Access to primary and/or specialty care
      3) DME and/or medications
      4) Assessment of Member's/Enrollee's current use of community resources as well as provision of referrals to appropriate resources and/or services outside of the Plan's benefits (i.e. mental health and behavioral health services, personal care, housing, meal delivery programs, energy assistance programs and services for individuals with intellectual and developmental disabilities)
      5) Identification of the Member's/Enrollee's caregiver(s) and need for their involvement in the care plan
      6) Identification of an action plan to assist the Member/Enrollee's with other activities or services needed to optimize their health status, including:
         a) Process/Plan for coordination of care across all settings, including those outside the provider network
         b) Process/Plan for referrals to resolve any physical or cognitive barriers to access care
         c) Process/Plan for helping to facilitate communication among the Member's/Enrollee's health care providers
         d) Process/Plan for identifying a Member's/Enrollee's need for other activities/services that would optimize their health status (e.g. self-management skills, health education classes, etc.)
         e) For the Member/Enrollee in a facility, a plan to ensure discharge planning and coordination is implemented
         f) Designated date of follow-up and reassessment as often as necessary, but not less than annually
         g) Referrals to LTSS services where applicable
   c. For adult and pediatric Members/Enrollees stratified as high-risk, Partnership shall offer the CalAIM Enhanced Care Management (ECM) benefit for eligible Members/Enrollees. The ECM benefit is unique and distinct from the care management services or programs offered by Partnership.
      ~~7)~~1) For more information, see Partnership policies *MCAP7002 CalAIM Enhanced Care Management (ECM)* and *MCAP7001 CalAIM Service Authorization Process for Enhanced*

Care Management (ECM) and/or Community Supports (CS).

D. Assessment and Reassessment
   1. Populations required to receive an assessment as referenced in the Department of Health Care Services (DHCS) *All Plan Letter (APL) 22-024 "Population Health Management Policy Guide" (11/28/2022)* and the latest version of the *DHCS CalAIM: Population Health Management (PHM) Policy Guide* include:
      a. Those with long-term services and supports (LTSS) needs (as required by federal and state law and waiver)
      b. Those entering CCM, refer to policy *MPCP2007 Complex Case Management.*
      c. Those entering ECM, refer to policy *MCAP7002 CalAIM Enhanced Care Management (ECM)*
      d. Children with Special Health Care Needs (CSHCN)
      e. Pregnant Individuals
      f. Seniors and persons with disabilities who meet the definition of "high-risk" as established in existing APL requirements, namely:
         1) Members/Enrollees who have been authorized to receive:
            a) IHSS greater than, or equal to, 195 hours per month;
            b) Community-Based Adult Services (CBAS), and/or
            c) Multipurpose Senior Services Program (MSSP) Services
         2) Members/Enrollees who:
            a) Have been on oxygen within the past 90 days;
            b) Are residing in an acute hospital setting;
            c) Have been hospitalized within the last 90 days or have had three or more hospitalizations within the past year;
            d) Have had three or more emergency room visits in the past year in combination with other evidence of high utilization of services (e.g., multiple prescriptions consistent with the diagnosis of chronic diseases);
            e) Have a behavioral health diagnosis or developmental disability in addition to one or more chronic medical diagnoses or a social circumstance of concern (e.g., homelessness);
            f) Have end-stage renal disease, acquired immunodeficiency syndrome (AIDS), and/or a recent organ transplant;
            g) Have cancer and are currently being treated;
            h) Are pregnant;
            i) Have been prescribed antipsychotic medication within the past 90 days;
            j) Have been prescribed 15 or more prescriptions in the past 90 days;
            k) Have a self-report of a deteriorating condition; and
            l) Have other conditions as determined by the Partnership, based on local resources.
   2. Each month, Partnership leverages age-based algorithms to capture emerging risk in the entire population including, but not limited to SPD or CCS Members/Enrollees, to promote timely reassessment for Members/Enrollees whose risk level demonstrates need for intervention.
      a. The Monthly Utilization Report analyzes claims data and other predictive modeling factors for Members/Enrollees based upon age – adults (ages 21 and over) and pediatrics (under age 21).
      b. Any Member/Enrollee who shows as high-risk on one of these reports will be contacted by Partnership Care Coordination staff for telephonic reassessment, unless the Member/Enrollee is currently enrolled in care coordination. Members/Enrollees recently closed to care coordination will be reassessed if their case was closed more than 30 calendar days prior to new risk identification for pediatric Members/Enrollees, and 90 days prior to new risk identification for adult Members/Enrollees.

c. In addition, if the Monthly Utilization Report reveals a potential CCS condition in a pediatric Member/Enrollee, that case will be referred to the CCS County program for CCS eligibility determination according to policy *MCCP2024 Whole Child Model for California Children's Services (CCS).*

E. Extended Continuity of Care (COC)
1. Newly enrolled SPD/CCS Members/Enrollees who request continued access to a provider who is not part of Partnership's network will be permitted to remain with that provider for up to 12 months as long as certain criteria are met. Partnership will begin processing requests for extended COC and will follow the COC process as described in policy *MPCP2014 Continuity of Care.*

F. Diversity Equity and Inclusion Training
1. Partnership provides Partnership-developed sensitivity, diversity, cultural competency and cultural humility, and health equity trainings to Partnership staff; providers and provider staff, and delegated entities and delegate's staff.
2. Partnership also provides training to each aforementioned party who serves seniors and individuals living with disabilities. This training is done via webinar.
3. Documentation of trainings is maintained and is available upon request.

VII. REFERENCES:

A. Welfare and Institutions Code Section 14182
B. DHCS All Plan Letter 22-024: Population Health Management Program Guide (11/28/2022)
C. DHCS CalAIM: Population Health Management (PHM) Policy Guide (July 2026~~5~~)
D. DHCS All Plan Letter 24-015: California Children's Services Whole Child Model Program (12/02/2024)
E. DHCS All Plan Letter 23-025: Diversity, Equity, and Inclusion Training Program Requirements (09/14/2023)
F. DHCS ~~Medi-Cal Managed Care Plans Mandatory or Voluntary Enrollment by Medi-Cal Aid Codes 2022-2023~~Medi-Cal Managed Care Plans Mandatory or Voluntary Enrollment by Medi-Cal Aid Codes 2025 Forward
G. CalAIM Dual Eligible Special Needs Plan Policy Guide- Contract Year 2026 (February~~June~~ 2026~~5~~)
H. Risk Stratification, Segmentation, and Tiering Transparency Document (August 2026~~July 2025~~)

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 (effective 02/15/17)
10/18/17; *11/14/18; 11/13/19; 09/09/20, 09/08/21; 10/12/22; 11/08/23; 10/09/24; 02/12/25; **MPCP** 01/14/26; 01/13/27

Partnership Advantage (Program effective January 1, 2028)
01/14/26; 01/13/27

*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: MPCP2019 (previously MCCP2019, MCUP3117)			**Lead Department: Health Services** Business Unit: Care Coordination
Policy/Procedure Title: Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: Approved by DHCS 04/11/2013, First Committee Review 08/20/2014 (MCUP3117)			**Next Review Date: 01/134/20287** **Last Review Date: 01/134/20276**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

PREVIOUSLY APPLIED TO:
MCUP3117 (04/11/2013 to 02/15/2017)
05/20/15; 04/20/16 to 02/15/17

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

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

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

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

Partnership HealthPlan of California
Health Risk Assessment Form
~~Seniors and Persons with Disabilities (SPD)~~

This form will help Partnership HealthPlan of California learn about your health and wellness needs and find ways we can help you. Please take a few minutes to fill out this form and send it back as soon as possible.

If you think you need to see a doctor before Partnership calls you, you should go to the doctor or hospital at that time.

If you have questions, please call Partnership at **(800) 809-1350**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call **(800) 735-2929**.

Please return your completed form in the green envelope.
Partnership HealthPlan of California
4665 Business Center Drive
Fairfield, CA 94534

Filling out this form is voluntary.
We will not deny your care because of how you respond.

Name of Partnership Member: _____

Date of Birth: _____ **Medi-Cal ID Number:** _____

1. What is your preferred language?
   ☐ English ☐ Spanish ☐ Russian ☐ Mandarin ☐ Tagalog ☐ Other

2. What was your gender at birth?
   ☐ Male ☐ Female ☐ Other

3. What do you like to be called?
   ☐ He/Him/His ☐ She/Her/Hers ☐ They/Them/Their ☐ Other

4. Do you have trouble communicating due to hearing, vision, or speech problems?
   ☐Yes ☐No
   If yes, do you need special materials/equipment? ☐Yes ☐No

5. Do you have a regular doctor? ☐Yes ☐No

6. Do you see a specialist (a doctor who specializes in health problems, like heart, kidney, cancer or other health problems)?
   ☐Yes ☐No

7. Do you feel your doctor(s) understand your medical needs?
   ☐Yes ☐No

8. Do you need to see a doctor in the next 60 days? ☐Yes ☐No
   If yes, do you have the appointment scheduled? ☐Yes ☐No

9. Do you get services or care from a regional center that cares for people with developmental disabilities? ☐Yes ☐No

10. Are you pregnant? ☐Yes ☐No

11. Have you been to the emergency room 2 or more times in the last 12 months? ☐Yes ☐No

12. Have you been admitted to the hospital in the last 12 months? ☐Yes ☐No

13. Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, or ostomy bags? ☐Yes ☐No
    If yes, do you need help getting more supplies? ☐Yes ☐No

14. Do you smoke or use tobacco products? ☐Yes ☐No
    If yes, would you like help quitting? ☐Yes ☐No

15. Do you use home oxygen? ☐Yes ☐No

16. How many prescription medicines do you take each day?
    ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 or more

17. Have you ever been told you have any of these health problems? (check yes or no for each of the problems below)
    California Children's Services (CCS) condition ☐Yes ☐No
    Asthma/Lung problems ☐Yes ☐No
    Heart problems ☐Yes ☐No
    Diabetes ☐Yes ☐No
    HIV or AIDS ☐Yes ☐No
    Kidney Disease ☐Yes ☐No
    Seizures ☐Yes ☐No
    Cancer ☐Yes ☐No
    Medical Therapy Program or Unit (MTP/MTU) condition ☐Yes ☐No

If yes to any, do you see a doctor or specialist for any of these problems?
☐Yes ☐No

If yes to any, have you ever had any surgeries for these problems?
☐Yes ☐No

Do you need help finding a doctor to help you with these problems?
☐Yes ☐No

18. Have you ever been told you have a mental or behavioral health problem such as depression, bipolar disorder, or schizophrenia? ☐Yes ☐No
If yes, do you need help finding a doctor to help you with a mental or behavioral health problem? ☐Yes ☐No

19. Would like more information about how to improve your health or stay healthy?
☐Yes ☐No

20. Do you need help with any of these actions? (**Yes** or **No** to each individual action, choose **N/A** if this is something you have never done)

Taking a bath or shower	☐Yes	☐No	☐N/A
Going up stairs	☐Yes	☐No	☐N/A
Eating	☐Yes	☐No	☐N/A
Getting dressed	☐Yes	☐No	☐N/A
Brushing teeth, brushing hair, shaving	☐Yes	☐No	☐N/A
Making meals or cooking	☐Yes	☐No	☐N/A
Getting out of a bed or a chair	☐Yes	☐No	☐N/A
Shopping and getting food	☐Yes	☐No	☐N/A
Using the toilet	☐Yes	☐No	☐N/A
Making it to the toilet on time/without an "accident"	☐Yes	☐No	☐N/A
Walking	☐Yes	☐No	☐N/A
Washing dishes or clothes	☐Yes	☐No	☐N/A
Writing checks or keeping track of money	☐Yes	☐No	☐N/A
Getting a ride to the doctor or to see your friends	☐Yes	☐No	☐N/A
Doing house or yard work	☐Yes	☐No	☐N/A
Going out to visit family or friends	☐Yes	☐No	☐N/A
Using the phone	☐Yes	☐No	☐N/A
Keeping track of appointments	☐Yes	☐No	☐N/A

If yes, are you getting all the help you need with these actions?
☐Yes ☐No ☐N/A

21. Can you live safely and move easily around your home?

☐Yes ☐No ☐N/A

*If **no***, does the place where you live have:
(Yes, No, or N/A to each individual item)

Good lighting	☐Yes	☐No	☐N/A
Good heating	☐Yes	☐No	☐N/A
Good cooling	☐Yes	☐No	☐N/A
Rails for any stairs or ramps	☐Yes	☐No	☐N/A
Hot water	☐Yes	☐No	☐N/A
Indoor toilet	☐Yes	☐No	☐N/A
A door to the outside that locks	☐Yes	☐No	☐N/A
Stairs to get into your home or stairs inside your home	☐Yes	☐No	☐N/A
Elevator	☐Yes	☐No	☐N/A
Space to use a wheelchair	☐Yes	☐No	☐N/A
Clear ways to exit your home	☐Yes	☐No	☐N/A

22. I would like to ask you about how you think you are managing your health conditions

Do you need help taking your medications?	☐Yes	☐No	☐N/A
Do you need help filling out health forms?	☐Yes	☐No	☐N/A
Do you need help answering questions during a doctor's visit?	☐Yes	☐No	☐N/A

23. Which of the following answers best describes how you feel with your medical needs? (check all that apply)

- ☐ I sometimes forget what I am supposed to do for my health
- ☐ I can't afford all of things I need to take care of myself
- ☐ It's hard to read or understand directions at times
- ☐ I'm confused about what I really need to do for my health
- ☐ I don't think it is necessary to do what my doctor says all of the time
- ☐ I don't understand my medical needs
- ☐ I feel confident that I know how to take care of what I need

24. Do you have family members or others willing and able to help you when you need it?

☐Yes ☐No ☐N/A

25. Do you ever think your caregiver has a hard time giving you all the help you need?
☐Yes ☐No ☐N/A

26. Are you afraid of anyone or is anyone hurting you?
☐Yes ☐No ☐N/A

27. Is anyone using your money without your ok? ☐Yes ☐No ☐N/A

28. Have you had any changes in thinking, remembering, or making decisions?
☐Yes ☐No ☐N/A

29. Have you fallen in the last month? ☐Yes ☐No ☐N/A
Are you afraid of falling? ☐Yes ☐No ☐N/A

30. Do you sometimes run out of money to pay for food, rent, bills, and medicine?
☐Yes ☐No ☐N/A

31. Over the past month (30 days), how many days have you felt lonely?
☐None – I never feel lonely
☐Less than 5 days
☐More than half the days (more than 15)
☐Most days – I always feel lonely

32. In general, would you say that your health is
☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

Signature of person filling out the form: _____

Date: _____

If not signed by member, what is your relationship to the member:
Parent/ Guardian/ Other Representative

Thank you for your time filling out this form.

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Partnership HealthPlan of California
Pediatric Health Risk Assessment Form

Please take a few minutes to complete this form to help us learn about your child's health and wellness needs. We want to use these answers to help you get the right care as soon as possible.

If you think you need to see a doctor before Partnership calls you, you should go to the doctor or hospital at that time.

If you have questions, please call Partnership at **(800) 809-1350** Monday – Friday, 8 a.m. – 5 p.m. TTY users can call **(800) 735-2929**.

Please return this completed form in the green envelope

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

Filling out this form is voluntary. We will not deny your care because of how you respond.

Name of Partnership CCS Member: _____

Date of Birth: _____ **Medi-Cal ID Number:** _____

1. Who is answering the questions on this survey?
   ☐ Mother ☐ Father ☐ Grandparent ☐ Foster Parent ☐ Self
   ☐ Other Family Member: _____ ☐ Other: _____

2. What is your preferred language?
   ☐ English ☐ Spanish ☐ Tagalog ☐ Russian ☐Other: _____

3. Does your child have difficulty with any of the following? (Choose **N/A** if you would not expect other children of this age to be able to do this on his/her own)

Taking care of him/herself, such as:			
Feeding him/herself (feeding)	☐Yes	☐No	☐N/A
Taking a bath or shower (bathing)	☐Yes	☐No	☐N/A
Getting dressed (dressing)	☐Yes	☐No	☐N/A
Going to the toilet (toileting)	☐Yes	☐No	☐N/A
Making it to the toilet on time/without an "accident" (continence)	☐Yes	☐No	☐N/A
Being active, like:			
Walking (mobility)	☐Yes	☐No	☐N/A
Getting out of a bed or a chair (transferring)	☐Yes	☐No	☐N/A
Going up or down stairs	☐Yes	☐No	☐N/A
Showing independence by:			
Going out to visit family or friends	☐Yes	☐No	☐N/A
Going to school or work	☐Yes	☐No	☐N/A
Making doctor or dentist appointments	☐Yes	☐No	☐N/A
Using the phone, tablet, or computer	☐Yes	☐No	☐N/A
Other _____	☐Yes	☐No	☐N/A

4. Does your child get services or care from a Regional Center that provides care for people with developmental disabilities? ☐Yes ☐No ☐Not sure
   What is the name of the center where you go?_____

5. Does your child receive any of the following services? (Check all that apply)
   - ☐ Speech Therapy
     Where is this received? ☐Home ☐School ☐Medical Therapy Program (MTP) or Medical Therapy Unit (MTU)
     ☐Other _____
   - ☐ Physical Therapy
     Where is this received? ☐Home ☐School ☐MTP/MTU
     ☐Other _____
   - ☐ Occupational Therapy
     Where is this received? ☐Home ☐School ☐MTP/MTU
     ☐Other _____
   - ☐ Respiratory Therapy
     Where is this received? ☐Home ☐School
     ☐Other _____
   - ☐ Nursing Services
     Where is this received? ☐Home ☐School Hours/days per week? _____
     ☐Other _____
   - ☐ Mental or Behavioral Therapy
     Where is this received? ☐Home ☐School
     ☐Other _____
   - ☐ Individualized Education Plan (IEP) or 504 Plan or other learning support?
     Which one(s)? ☐IEP ☐504
     ☐School Name_____
   - ☐ Other supportive services (Respite Care, Palliative Care, etc.)
     Please explain _____
     Where is this received? ☐Home ☐School
     ☐Other_____

6. In general, would you say that your child's health is
   ☐Excellent ☐Very Good ☐Good ☐Fair ☐Poor

7. Does your child have any allergies?
   - ☐ Food(s) (please specify) _____
   Environmental (seasonal, dust, pollution, etc.)
   (please specify) _____
   - ☐ Medication(s) (please specify) _____
   - ☐ No Known Allergies

8. Does your child use durable medical equipment (DME) or supplies that were ordered for your child's specific needs?

☐ Yes (check all that apply)

- ☐ Glasses
- ☐ Hearing Aids
- ☐ Cochlear Implant
- ☐ Wheelchair
- ☐ Brace
- ☐ Orthotics
- ☐ Walker
- ☐ Car Seat
- ☐ Bed
- ☐ Ventilator/breathing machine
- ☐ Oxygen
- ☐ Percussion Vest
- ☐ Insulin Pump/Continuous Glucose Monitor
- ☐ Intravenous pump/Infusion device
- ☐ Feeding pump/Gastrostomy Tube (GT)/Jejunostomy Tube (JT)/ Gastrojejunostomy Tube (GJT)
- ☐ Other (please specify) _____

Who ordered it? _____

Date of last order _____

Who was the vendor? _____

Vendor Phone:_____

9. What is your child's current:

Height _____ Weight _____

10. Has your child ever had surgery?

☐ Yes ☐ No ☐ Don't Know

Please list each surgery	**Date or Year**

Please list each surgery	Date or Year
☐ **More than can fit here**	

11. Has your child been to the emergency room (ER) in the last 6 months?
    ☐ Yes ☐ No ☐ Don't know
    i. How many times?_____
    ii. When?_____

12. Has your child been in the hospital overnight in the last 6 months?
    ☐ Yes ☐ No ☐ Don't know
    i. How many times?_____
    ii. When?_____

13. What medications does your child take? Please include prescriptions, over-the-counter medications, vitamins, herbal supplements and other remedies. **Start with the medications your child is taking now, and then add medications your child has taken in the past**.

Medication/Vitamin/Supplement Name	Current	Past
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Medication/Vitamin/Supplement Name	Current	Past
	☐	☐
	☐	☐
☐ More than can fit here	☐	☐

14. Have you ever been told by a medical professional you that your child has any of the following problems? For each problem, check whether it is a problem now or was a problem in the past.

	Current	Past
Asthma	☐	☐
Cystic Fibrosis	☐	☐
Ventilator Dependent	☐	☐
Other Lung Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Congenital Heart Disease	☐	☐
Heart Murmur	☐	☐
Other Heart Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Para/Quadriplegia	☐	☐
Seizures/Epilepsy	☐	☐
Cerebral Palsy	☐	☐
Other Neurological Conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Muscular Dystrophy	☐	☐
Broken bone(s)	☐	☐
Scoliosis	☐	☐
Other bone or muscle disorders	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Ostomy/G Tube /Colostomy/Urostomy	☐	☐
Crohn's Disease/Ulcerative Colitis	☐	☐
Celiac Disease	☐	☐
Other gastrointestinal (GI)/stomach/digestion conditions	☐	☐
What is/are the conditions(s)?	☐	☐
_____		
Sickle Cell Anemia	☐	☐
Hemophilia	☐	☐
Other Blood Conditions	☐	☐
What is/are the conditions(s)?	☐	☐

	Current	Past
Diabetes	☐	☐
Immune Disorder	☐	☐
What is/are the conditions(s)?	☐	☐
Kidney Disease	☐	☐
Is your child on dialysis?	☐	☐
Liver Condition	☐	☐
Genetic Conditions, i.e. Down Syndrome	☐	☐
What is/are the conditions(s)?	☐	☐
Growth / Developmental Delays	☐	☐
Birth Defects	☐	☐
What is/are the conditions(s)?	☐	☐
Underweight / Failure to Thrive	☐	☐
Hearing Problems	☐	☐
Vision Problems	☐	☐
Speech Problems	☐	☐
Migraines / Headaches	☐	☐
Poisoning	☐	☐
Other	☐	☐
What is/are the conditions(s)?	☐	☐
	☐	☐

15. Does your child need a specialist to provide care for any of these conditions?
    - ☐ Yes
        - ☐ Which condition(s) _____
    - ☐ No – my child already has provider(s) for all his/her needs
        - ☐ Name/Specialty _____
        - ☐ Name/Specialty _____
        - ☐ Name/Specialty _____
    - ☐ No – my child does not need a specialist for his/her condition
16. Who are your child's medical providers?
    - ◊ Primary Care Provider (PCP) in your community
        - ☐ Do not have one
    - ☐ Provider Name: _____
    - ☐ Provider Phone: _____
    - ☐ Last Appointment: Date:_____
    - ☐ Next Appointment: Date:_____

◊ Specialty Care Center
- ☐ N/A
- ☐ Facility Name: _____
- ☐ Facility Phone: _____
- ☐ Last Appointment: Date:_____
- ☐ Next Appointment: Date:_____

◊ Regular Dental Care
- ☐ Do not have one
- ☐ Provider Name: _____
- ☐ Provider Phone: _____
- ☐ Last Appointment: Date:_____

◊ Regular Vision Care
- ☐ Do not have one
- ☐ Provider Name: _____
- ☐ Provider Phone: _____
- ☐ Last Appointment: Date:_____

◊ Ongoing care from Mental or Behavioral Health Specialist
- ☐ N/A
- ☐ Provider Name: _____
- ☐ Provider Phone: _____
- ☐ Condition(s) being treated for:

_____

☐ My child does not get regular care from any provider

◊ Do you need help choosing a provider for your child?
☐ Yes ☐ No ☐ Don't know

17. Have your child's medical conditions caused him/her to miss activities, work, or school in the past year? If yes, please describe:

_____
_____
_____

18. What is the best time of day (Monday to Friday, 7:30 a.m. to 5:30 p.m.) to call you to discuss your child's needs in more detail?

_____

Signature of Person
Filling Out the Form: _____ Date:_____

Thank you for your time filling out this form.
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Adult Health Risk Assessment (HRA) Stratification Matrix

All questions in the HRA are asked to each new member with a Seniors and Persons with Disabilities (SPD) aid code and/or California Children's Services (CCS) identifier. All SPD/CCS beneficiaries are treated as high risk initially, per policy MPCP2019. The responses noted below are used to determine if an SPD/CCS member should be referred to a Social Worker (MSW); or Nurse Case Manager (NCM) for development of an individualized care plan (ICP). If there is any uncertainty, then the referral should be sent to a NCM. If the member identifies all "no" answers, please send a "Welcome Letter".

(Question #)	Response	High Risk (MSW)	High Risk (CM)
(1) What is your preferred language?	English		
	Spanish		
	Russian		
	Mandarin		
	Tagalog		
	Other		
(2) What was your gender at birth?	Male		
	Female		
	Other		
(3) What do you prefer to be called	he/him/his	(if different)	
	she/her/hers	(if different)	
	they/them/theirs	(if different)	
	other		
(4) Do you ever have trouble communicating due to hearing, vision, or speech problems?	Yes		
	No		
If yes, do you need special materials/equipment?	Yes		X
	No		
(5) Do you have a regular doctor?	No		
	Yes		
(6) Do you see a Specialist (a doctor that specializes in certain health conditions, like a cardiologist, nephrologist, oncologist, or other doctor)?	No	X	X
	Yes		
(7) Do you feel your doctor(s) understand(s) your overall medical needs?	No		
	Yes		

(Question #)	Response	High Risk (MSW)	High Risk (CM)
(8) Do you need to see a doctor within the next 60 days?	No		
If yes, do you already have an appointment scheduled?	Yes		X
	Yes		
	No		X
(9) Do you get services or care from a Regional Center?	No		
	Yes	X	
(10) If you are **female**, are you pregnant?	No		
	Yes		X
(11) Have you been to the emergency room two (2) or more times in the last twelve (12) months?	No		
	Yes		X
(12) Have you been admitted to the hospital in the last twelve (12) months?	No		
	Yes		X
(13) Are you using medical equipment or supplies such as a hospital bed, wheelchair, walker, or ostomy bags?	No		
	Yes		
If yes, do you need help obtaining more supplies?	No		
	Yes		X
(14) Do you smoke or use tobacco products?	No		
	Yes		
If yes, would you like help quitting?	No		
	Yes	X	
(15) Do you use home oxygen?	No		
	Yes		X
(16) How many prescription medications do you take each day?	> 8		X
(17) Have you ever been diagnosed with any of the following health conditions? (check yes or no for each of the conditions below)			
California Children's Services (CCS) condition	Yes		X
	No		
Asthma/Lung Problems	Yes		
	No		
Heart Problems	Yes		
	No		
Diabetes	Yes		
	No		
HIV or AIDs	Yes		
	No		
Kidney Disease	Yes		
	No		

(Question #)	Response	High Risk (MSW)	High Risk (CM)
Seizures	Yes		
	No		
Cancer	Yes		
	No		
Medical Therapy Program or Unit (MTP/MTU)	Yes		X
	No		
If yes to any, do you see a doctor or specialist or any of the condition(s) above?	No		
	Yes		
If yes to any, have you ever had any surgeries for these conditions?	Yes		X
	No		
Do you need help finding a doctor to help you with any of the condition(s) above?	Yes		X
	No		
(18) Have you ever been told you have a mental or behavioral health condition such as depression, bipolar disorder, or schizophrenia?	No		
	Yes	X	X
Do you need help finding a doctor to help you with a mental or behavioral health condition?	No		
	Yes	X	X
(19) Would like more information about how to improve your health or stay healthy?	No		
	Yes		X
(20) Do you need help with any of these Actions? (list follows)	No		
	Yes		
If yes, are you getting all the help you need?	No	X	
	Yes		
(21) Can you live safely and move easily around your home? (list follows)	No to any	X	X
	Yes		
(22) I would like to ask you about how you think you are managing your health conditions	No	X	
	Yes to any	X	
Do you need help taking your medications	No		
	Yes		X
Do you need help filling out health forms?	No		
	Yes	X	
Do you need help answering questions during a doctor's visit?	No		
	Yes		X
(23) Which of the following answers best describes how you feel with your medical needs? (check all that apply)	No		
I sometimes forget what I am supposed to do for my health			
I can't afford all of the things I need to take care of myself	Yes		X
It's hard to read or understand directions at times	Yes	X	
I'm confused about what I really need to do for my health	Yes		X
I don't think it is necessary to do what my doctor says all of the time	Yes		X
I don't understand my medical needs	Yes		X
I feel confident that I know how to take care of what I need	Yes		X

(Question #)	Response	High Risk (MSW)	High Risk (CM)
(24) Do you have family members or others willing and able to help you when you need it?	Yes		X
	No		
(26) Do you ever think your caregiver has a hard time giving you all the help you need?	No	X	
	Yes	X	
(26) Are you afraid of anyone or is anyone hurting you?	No		
	Yes	X	
(27) Is anyone using your money without your okay?	No		
	Yes	X	
(28) Have you had any changes in thinking, remembering, or making decisions?	No		
	Yes	X	X
(29) Have you fallen in the last month?	No		
	Yes		X
Are you afraid of falling?	No		
	Yes	X	X
(30) Do you sometimes run out of money to pay for food, rent, bills, and medicine?	No		
	Yes	X	
(31) Over the past month (30 days), how many days have you felt lonely?	No		
None – I never feel lonely			
Less than 5 days			
More than half the days (more than 15)			
Most days – I always feel lonely		X	
(32) In general, would you say that your health is?		X	
	Excellent		
	Very Good		
	Good		X
	Fair		X
	Poor		X

Pediatric Health Risk Assessment (PHRA) Stratification Matrix

All questions in the HRA are asked to each new member with a Seniors and Persons with Disabilities (SPD) aid code and/or California Children's Services (CCS) identifier. All SPD/CCS beneficiaries are treated as high risk initially, per policy MPCP2019. The responses noted below are used to determine if an SPD/CCS member should be referred to a Social Worker (MSW); or Nurse Case Manager (NCM) for development of an individualized care plan (ICP). If there is any uncertainty, then the referral should be sent to a NCM. If the member identifies all "no" answers, please send a "Welcome Letter".

(Question #)	Response	High Risk (MSW)	High Risk (NCM)
(1) Who is answering the questions on this survey?	Self		
	Other		
(2) What is your preferred language?	English		
	Spanish		
	Russian		
	Mandarin		
	Tagalog		
	Other		
(3) Does your child have difficulty with any of the following? (Choose N/A if you would not expect other children at this age to be able to this this on their own)	Yes		
	No		
If yes to any of the above, does your child get all the help they need?	Yes		
	No		X
(4) Does your child get services from a Regional Center that provides care for people with developmental disabilities?	Yes	X	
	No		
	Not Sure	X	
(5) Does your child receive any of the following services?			
Speech Therapy	Yes		X
Physical Therapy	Yes		X
Occupational Therapy	Yes		X
Respiratory Therapy	Yes		X
Nursing Services	Yes		X
Mental or Behavioral Therapy	Yes	X	
Individualized Education Plan (IEP) or 504 Plan or other learning support	Yes		X
Other supportive services			X

(Question #)	Response	High Risk (MSW)	High Risk (NCM)
(6) In general, would you say that your child's health is	Excellent		
	Very Good		
	Good		X
	Fair		X
	Poor		X
(7) Does your child have any allergies? (list follows)	Yes		X
	No		
(8) Does your child use medical equipment (DME) or supplies that were ordered for your child's specific needs? (list follows)	Yes		X
	No		
(9) What is your child's current height/weight?			
(10) Has your child ever had surgery?	Yes		X
	No		
	Don't Know	X	
(11) Have you been to the emergency room (ER) in the last 6 months?	Yes		X
	No		
	Don't know	X	
(12) Has your child been in the hospital overnight in the past 6 months?	Yes		X
	No		
	Don't know	X	
(13) What medications does your child take? Please include prescriptions, over-the-counter medications, vitamins, herbal supplements and other remedies. Start with the medications your child is taking now, and then add medications your child has taken in the past.	Medications Listed		X
	No Medications Listed		
(14) Have you ever been told by a medical professional you that your child has any of the following problems? For each problem, check whether it is a problem now or was a problem in the past. (check yes for any conditions marked)	Yes		X
	No		
(15) Does your child need a specialist to provide care for any of these conditions?	Yes		X
	No – has a provider		
	No – Specialist Not Needed		
(16) Who are your child's medical providers?			
Primary Care Provider			
Specialty Care Center			

(Question #)	Response	High Risk (MSW)	High Risk (NCM)
Regular Dental Care			
Regular Vision Care			
Ongoing care from Mental or Behavioral Health Specialist			
My child does not get regular care from any provider – do you need help choosing a provider for your child?	Yes		X
	No		
	Don't Know		X
(17) Have your child's medical conditions caused him/her to miss activities, work, or school in the past year?	Yes	X	
	No		

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPNP9006 (previously MCNP9006)</td><td colspan="2">Lead Department: Health Services
Business Unit: Population Health</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Doula Services Benefit</td><td colspan="2">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 01/10/2024
Effective Date: 01/01/2023</td><td colspan="3">Next Review Date: ~~01/14/2027~~01/13/2028
Last Review Date: ~~01/14/2026~~01/13/2027</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~01/14/2026~~01/13/2027</td></tr>
</table>

I. RELATED POLICIES:

A. MPND9001 – Population Health Management Strategy & Program Description
B. MPND9002 – Cultural and Linguistic Program Description
C. MCUG3118 – Prenatal & Perinatal Care
D. MCUP3041 – Treatment Authorization Request (TAR) Review Process
E. MCUP3113 – Telehealth Services
F. MPCR15 – Doula Credentialing and Re-Credentialing Criteria
G. MPNET100 – Access Standards and Monitoring
H. MPPR200 – Partnership Provider Contracts
I. MPPRO1102 – Contracted Provider Education
J. MCAP7002 – CalAIM Enhanced Care Management (ECM)
K. MCAP7001 – CalAIM Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. The Comprehensive Perinatal Services Program (CPSP): Has divided authority between the California Department of Health Care 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 ~~Also see~~ the Partnership HealthPlan Perinatal Services (PHPS) definition ~~below~~.~~]~~)*
B. Community-Based Organization (CBO): A public or private non-profit organization dedicated to the overall health, well-being, and functions of their community.
C. Doulas are trained birth workers credentialed by Partnership to provide health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support before, during, and after miscarriage, stillbirth, and abortion. Doulas are not licensed and they do not require clinical supervision.

Policy/Procedure Number: MPNP9006 (previously MCNP9006)			Lead Department: Health Services Business Unit: Population Health
Policy/Procedure Title: Doula Services Benefit			☒ **External Policy** ☐ **Internal Policy**
Original Date: 01/10/2024 Effective Date: 01/01/2023			**Next Review Date: 01/14/202701/13/2028** **Last Review Date: 01/14/202601/13/2027**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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

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

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

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

IV. ATTACHMENTS:

A. Medi-Cal Doula Services Recommendation Form
B. Doula Crosswalk Coding Information

V. PURPOSE:

To define the doula services Medi-Cal benefit (effective January 1, 2023) including services offered and pathways to certification.

VI. POLICY / PROCEDURE:

A. Partnership HealthPlan of California (Partnership) recognizes the doula services benefit as a means to provide person-centered, culturally competent care that supports the racial, ethnic, linguistic, and cultural diversity of our members while adhering to evidence-based best practices.
   1. Doula services are aimed at preventing perinatal complications and improving health outcomes for birthing parents and infants.
   2. Doulas are trained birth workers who offer various types of support, including health navigation; lactation support; development of a birth plan; and linkages to community-based resources.
   3. Doula services may be provided virtually (telehealth) or in-person with locations in any setting including, but not limited to homes, office visits, hospitals, or alternative birth centers.

B. Doula qualifications, requirements and recommended training are detailed in Partnership's policy MPCR15 Doula Credentialing and Re-Credentialing Criteria.
   1. Doulas must attest that they will support and encourage care for the pregnant member and the newborn in alignment with the American College of Obstetricians and Gynecologists (ACOG) evidence-based guidelines, including recommended provider visits, and will encourage members to discuss clinical questions, including ~~and~~ vaccinations, with their licensed health care provider. ~~for the pregnant member and the newborn.~~

C. Informing providers about the Doula Benefit
   1. Partnership publicizes our current understanding of the regulatory framework for doulas with our provider network and CBOs in community meetings, provider meetings, and in Provider Newsletters as applicable.
   2. Partnership's Provider Relations department educates providers on doula services through the Medical Director's Newsletter, quarterly Provider Newsletters, bulletins, and other mechanisms of education to ensure providers know how to leverage this benefit on behalf of their members.

D. Informing members about the Doula Benefit
   1. Partnership's Health Education team crafts culturally and linguistically appropriate communication to explain doula services to our members.
      a. Members are informed of the Doula Services benefit in the Partnership Member Handbook, known as the Evidence of Coverage (EOC), which is distributed annually to Partnership members by Member Services and is also available on the Partnership website at PartnershipHP.org in the Members section. Partnership Advantage enrollees (as defined in III.E.), are eligible for doula services under their Medi-Cal benefit as described in this policy.
      b. Partnership's Health Education team and Communications department collaborate to ensure there are written notices in the Member Newsletter and that the Partnership webpage is updated with these new services. Members qualifying for doula services are given information about how doulas can provide support during pregnancy, postpartum, and after childbirth, during miscarriage, stillbirth, and abortion.

E. Eligibility for Doula Services
   1. Partnership Medi-Cal members and Partnership Advantage enrollees who are currently pregnant or have been pregnant in the last 365 days are considered eligible and are recommended to receive the doula services benefit.
      a. A licensed provider (a physician or other licensed practitioner of healing arts acting within their scope of practice under state law) may provide a recommendation for a Partnership Member to have doula services. This may be noted in the member's medical record and/or a written recommendation forwarded to the doula.
         1) The recommending provider does not need to be enrolled in Medi-Cal, Medicare or be a Partnership network provider.
         2) DHCS has created an optional Medi-Cal Doula Services Recommendation form that recommending providers may choose to use (see Attachment A).
      b. Doulas must verify that the member's Medi-Cal (or Partnership Advantage as applicable) eligibility for the month of services is valid by contacting Partnership to verify eligibility.
      c. Doula services can only be provided during pregnancy; labor and delivery, including stillbirth; miscarriage; abortion; and within one year of the end of a member's pregnancy.
      d. Doulas must document in the records, the name/practice information of a collaborating provider involved in the care of the member. If no collaborating provider has been established, the doula shall document efforts to assist the member in connecting with appropriate prenatal and postpartum care.
         1) A collaborating provider is a licensed practitioner of the healing arts who is involved in the member's care acting within their scope of practice (LCSW, MD, DO, NP, PA).
   2. The DHCS standing recommendation for doula services implemented on November 1, 2023 authorizes the following:
      a. One initial visit.
      b. Up to eight (8) additional visits (may be provided in any combination of prenatal and postpartum visits).
      c. Support during labor and delivery (including labor and delivery resulting in a stillbirth),

abortion, or miscarriage.

d. Up to two extended three-hour postpartum visits after the end of a pregnancy (these two visits would not require the member to meet additional criteria or receive a separate recommendation)
   1) The extended postpartum visits are billed in 15-minute increments, up to three hours, up to two visits per pregnancy per individual, provided on separate days.

e. All visits are limited to one per day per member, and only one doula may bill for a visit provided to the same member on the same day (excluding labor and delivery).
   1) On the day of labor/delivery, stillbirth, abortion, or miscarriage support:
      a) One doula may bill for labor and delivery, stillbirth, abortion or miscarriage support, and
      b) One prenatal *or* one postpartum visit may be provided, also. This visit may be billed by a different doula.

3. A Treatment Authorization Request (TAR) is required for additional visits (beyond eight) during the postpartum period [see policy MCUP3041 Treatment Authorization Request (TAR) Review Process].
   a. A recommendation from a physician or other LPHA acting within their scope of practice under state law is required.
   b. The request for additional visits will be evaluated for medical necessity; the LPHA can note the medical need for the member or include chart notes that specify the need for additional visits.
   c. The additional recommendation may authorize up to nine (9) additional postpartum visits.

~~3.~~4. Members retain all applicable grievance and appeal rights regarding authorization decisions in accordance with Partnership policies and regulatory requirements.

F. Documentation Requirements
1. Doulas must document each visit with:
   a. National Provider Identifier (NPI)
   b. Date, time, and duration of services provided to the member
   c. Service(s) provided
   d. Length of time spent with member that day
   e. Initial visit records must include documentation of a collaborating or recommending perinatal provider (medical, behavioral health, or licensed CPSP provider)
2. Documentation should be integrated into the member's medical record from the recommending provider, and available for encounter data reporting. Doulas will share documentation with the member's perinatal providers.
3. Documentation must be accessible to Partnership and DHCS upon request and maintained in accordance with Partnership record retention requirements.

~~3.~~4. For telehealth services, doulas shall document the modality used, member consent when required, and the location of the doula and member consistent with applicable DHCS telehealth requirements.

G. Standards for Doula Services
1. Partnership will not establish unreasonable or arbitrary barriers for accessing doula services.
2. Partnership complies with all reporting and oversight requirements including monitoring for fraud, waste, and abuse of doula services through committees that review for over and under-utilization of services. Monitoring activities may include claims review, encounter validation, documentation auditing, provider education, corrective action plans, and referral to RAC when warranted.
3. Partnership utilizes doula services to help address basic population health management, improve engagement, quality and health equity, and to improve efficiencies.
4. Partnership encourages providers to integrate doulas into basic population health management for obstetric care activities. This may include:
   a. Referrals for pregnant members requiring preventive care

   b. Referrals for children requiring well-baby care
   c. Referrals for members with Limited English Proficiency (LEP) or members who are not familiar with Medi-Cal benefits
5. Partnership will monitor the network to ensure an appropriate network of doulas and coordinate for out-of-network (OON) access to doula services when medically necessary or if an in-network doula provider is not available within applicable access standards.
6. Partnership will track quality and utilization measures for doula services as recommended by DHCS.

H. Doula Services Provided
1. Refer to sections VI.E.2. for a description of doula services authorized under the DHCS standing recommendation and section VI.E.3. for services that require prior authorization.
2. For pregnancy-related services that are available through Medi-Cal, doulas should work with the member's provider or with Partnership to refer the member to a network provider who is able to render the service. These Medi-Cal services include but are not limited to:
   a. Behavioral health services
   b. Belly binding after cesarean section by clinical personnel
   c. Clinical case coordination
   d. Health care services related to pregnancy, birth, and the postpartum period
   e. Childbirth education group classes
   f. Comprehensive health education including orientation, assessment, and planning (CPSP services)
   g. Hypnotherapy (non-specialty mental health services)
   h. Lactation consulting, group classes, and supplies
   i. Nutrition services (assessment, counseling, and development of care plan)
   j. Transportation
   k. Medically appropriate Community Supports services
3. Doulas may provide assistive or supportive services (e.g. folding laundry) in the home of the member during a prenatal or postpartum visit, while providing emotional support and offering advice on infant care.
   a. The assistive and supportive services must be incidental to the doula services being provided during that face-to-face visit
   b. The member cannot be billed for assistive or supportive services

I. Non-Covered Services:
1. Doula services do not include diagnosis of medical conditions, provision of medical advice, or any type of clinical assessment, exam, or procedure.
2. Doulas are not prohibited from teaching classes that are available at no cost to Members to whom they are providing doula services.
3. The following services for pregnant or postpartum beneficiaries are not covered under current DHCS Medi-Cal guidance or as doula services, and may be updated as state requirements change:
   a. Belly binding (traditional/ceremonial)
   b. Birthing ceremonies (i.e., sealing, closing the bones, etc.)
   c. Group classes on baby wearing
   d. Massage (maternal or infant)
   e. Photography
   f. Placenta encapsulation
   g. Shopping
   h. Vaginal steams
   i. Yoga

J. Training and Education:

1. Partnership will provide all necessary initial and ongoing trainings and resources for individuals providing doula services as specified in Partnership policy MPPRO1102 Contract Provider Education.

K. Billing, Claims, and Payments
1. Partnership makes payments in compliance with the clean claims requirements and timeframes outlined in its MCP Contract and DHCS All Plan Letter (APL) 23-020 Requirements for Timely Payment of Claims. These requirements apply to both Partnership and its Network Providers and Subcontractors.
2. Doula services will be reimbursed in accordance with their Network Provider contract and per Medi-Cal guidelines for Doula Services.
   a. Doulas cannot double bill, as applicable, for doula services that are duplicative to services that are reimbursed through other benefits.
3. Encounter data
   a. Doulas must submit claims with diagnosis and procedure codes as outlined by DHCS. Please refer to Attachment B for the list of codes.
   b. Partnership will submit data related to doula services utilization and provider network per DHCS requirements.

L. Oversight and Quality Monitoring of the Doula Benefit:
1. Partnership monitors the doula benefit to ensure access, quality, outcomes and/or health equity needs and trends. Examples of activities for quality monitoring and oversight include, but are not limited to:
   a. Internal monitoring reports for benefit utilization and/or clinical outcomes.
   b. Member satisfaction surveys.
   c. Sample chart review identifying clinical outcomes and/or quality for a Partnership member admitted to a contracted facility for delivery who is also receiving the doula benefit.
   d. When applicable, ensure compliance with D-SNP state specific quality reporting requirements by monitoring quality measures – including but not limited to Emergency Department Behavioral Health (ED BH), Cognitive Health Assessment (CHA), and Individualized Care Plan (ICP). Refer to the D-SNP Quality and Data Reporting documentation for the complete list of measures.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-024 Doula Services (*Revised* 11/03/2023 *supersedes* APL 22-031)
B. Department of Health Care Services (DHCS) APL 22-013 Provider Credentialing / Re-credentialing and Screening / Enrollment (*Revised* 08/24/2022)
C. Department of Health Care Services (DHCS) APL 23-020 Requirements for Timely Payment of Claims (*Revised* 10/12/2023)
~~C.~~D. Department of Health Care Services (DHCS) APL 26 – 005 Maternity Services for Pregnant and Postpartum Medi-Cal Members (supersedes APLs 00-012, 18-022 and Policy Letters 98-006, 98-010, and 12-003)
~~D.~~E. State Plan Amendment (SPA) 22-0002
~~E.~~F. Title 42 Code of Federal Regulations (CFR) Section 440.130(c)
~~F.~~G. Medi-Cal Provider Manual/Guidelines: Doula Services
~~G.~~H. California Department of Public Health CPSP Program
~~H.~~I. D-SNP Quality and Data Reporting

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
01/08/25; 01/14/26; 01/13/27

Partnership Advantage (effective Jan. 1, 2028~~7~~)
01/14/26; 01/13/27

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.

Medi-Cal Doula Services Recommendation

Support for healthy pregnancies and follow-up care

If you are a Medi-Cal beneficiary…

If you are pregnant or were pregnant, you are eligible for doula services up to one year after your pregnancy. Doulas provide physical, emotional, and nonmedical support before and after pregnancy, as well as support during labor and delivery, miscarriage, and abortion. To receive doula services from Medi-Cal, you will need a recommendation from a licensed provider. You can request a recommendation form from a licensed provider[1], for example, a doctor, midwife, or nurse, and then give this signed form to your doula(s) of choice. You can ask for a recommendation even if you do not know who your doula(s) will be yet. Please see www.dhcs.ca.gov/provgovpart/Pages/Doula-Services.aspx for more information.

If you are a doula…

You must retain the record of a licensed provider's recommendation for each member prior to initiation of their doula care, storing the record in a manner consistent with HIPAA requirements.

If you are a licensed provider[1]…

By providing this recommendation of doula services, you acknowledge that the beneficiary would benefit from non-clinical doula services in addition to appropriate clinical care. A recommendation is not the same as a referral, prescription, or medical order[2]. Please use the form below or another document with the same information listed below. You may provide a recommendation without identifying the doula who will serve the member. This recommendation authorizes one initial prenatal visit; eight visits during the perinatal period, including up to one year after pregnancy; support during labor and delivery, miscarriage, or abortion; and two extended postpartum visits.

This form is an example of what can be used to access doula services through Medi-Cal. It is not necessary to use this specific form as long as a clinician's written recommendation is secured with all of the information listed below and retained by the doula.

Licensed Provider's Recommendation for Doula Services		
Beneficiary First Name:	Middle Name:	Last Name:
Beneficiary's Date of Birth:	Licensed Provider's NPI Number:	
Licensed Provider First Name:	Middle Name:	Last Name:
Date of Recommendation:	Licensed Provider's Signature:	

[1]For the doula benefit, Medi-Cal defines a "licensed provider" as a physician or other licensed practitioner of the healing arts, including nurse midwives, nurse practitioners, licensed midwives, and behavioral health providers, acting within their scope of practice under state law. The recommending licensed provider does not need to be enrolled in Medi-Cal or be a network provider within the beneficiary's managed care plan.

[2]Under Medi-Cal, a beneficiary who is pregnant within the past year, and would either benefit from doula services or who requests doula services, would meet the medical necessity criteria for a recommendation for doula services. For mor information, visit www.dhcs.ca.gov.

IMPORTANT INFORMATION ABOUT YOUR APPEAL RIGHTS

What are my rights if I do not agree with a denial of services?
If you do not agree with a denial of a recommendation for services, you can:

- Ask for a State Hearing

STATE HEARING
To ask for a State Hearing, you can fill out the "State Hearing Request" form at www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx and send it to:

California Department of Social Services
State Hearings Division
P.O. Box 944243, MS 19-37
Sacramento, CA 94244-2430

You may also call to ask for a State Hearing. The number can be very busy so you may get a message to call back later.

Toll free phone: 1-800-952-5253
TTY: 1-800-952-8349

What Are the Time Limits to Ask for a State Hearing?

- You only have 90 days to ask for a hearing. (Note: During the COVID-19 federal Public Health Emergency, you have 210 days to request a hearing.)
- The time limit starts the date of the denial.

Can I Still Get My Treatment and Ask for a State Hearing?
To still get your treatment that the denial notice is stopping or changing, you must:

- Ask for a State Hearing within 10 days from:
  - The date the notice is postmarked, or
  - The date the notice was given to you, or
  - Before the date the notice says your treatment will stop or change.
- Please say that you want to keep getting treatment during the hearing process.

It can take up to 90 days for your case to be decided and an answer sent to you.

Can I Ask for a Quick Hearing?
Yes. This is called an "expedited" hearing. If you think waiting up to 90 days may be risky for you or your child's health, ask your doctor for a letter. The letter must explain how waiting for up to 90 days could be risky for you or your child's life or health. Then you can ask for an expedited hearing. You need to send the letter with your hearing request.

You do not have to attend the State Hearing alone. You may bring someone with you. You can bring a friend, a relative, a lawyer, or anyone you choose. You can speak for yourself or have someone else speak for you.

For more information about the State Hearing process, go to http://www.dhcs.ca.gov/services/medi-cal/Pages/Medi-CalFairHearing.aspx

PARTNERSHIP HEALTHPLAN of CALIFORNIA A Public Agency

Doula Crosswalk Coding Information

Doulas need to include a “diagnosis code” on claims for services in both fee-for-service and managed care delivery systems. This is required by federal law. Under Medi-Cal’s doula policy, doulas will only use diagnosis codes that describe/identify what occurred at the service. They are not being used for medical and/or diagnostic purposes.

To assist doulas with submitting claims, the Department of Health Care Services (DHCS) created the coding crosswalk below that identifies which diagnosis codes may be billed with each CPT or HCPCS code. Claims will be denied if they do not have a diagnosis code or if they have a different diagnosis code paired with a billing code than what is shown below. The diagnosis code should be entered in field 21A on the CMS 1500 form and diagnosis code should **NOT** have a decimal point on the form.

Doula Billing Code Crosswalk				
Billing Code*	**Billing Code Service Description+**	**Diagnosis Code(s)[1]**	**Diagnosis Code Service Description(s)[2]**	**Additional Guidance[3]**
HCPCS code Z1032	Extended Initial visit	Z32.2 (prenatal)	Encounter for childbirth instruction	Any one of the four diagnosis codes can be used with HCPCS code Z1032. Please note that the initital visit can be either prenatal or postpartum.
		Z32.3 (prenatal)	Encounter for childcare instruction	
		Z39.1 (postpartum)	Encounter for care and examination of lactating mother	
		Z39.2 (postpartum	Encounter for routine postpartum follow-up	
HCPCS code Z1034	Prenatal Visit	Z32.2	Encounter for childbirth instruction	Either diagnosis code can be used with HCPCS code Z1034.
		Z32.3	Childcare instruction	
CPT code 59409	Vaginal Delivery	Z33.1	Pregnant state, incremental	Either diagnosis code can be used with CPT code 59409. Please note that diagnosis code Z39.0 is intended to be used after delivery.
		Z39.0	Encounter for care and examination of mother immedidately after delivery	
CPT code 59612	Vaginal delivery after cesarean delivery	Z33.1	Pregnant state, incremental	Either diagnosis code can be used with CPT code 59612. Please note that diagnosis code Z39.0 is intended to be used after delivery.
		Z39.0	Encounter for care and examination of mother immedidately after delivery	
CPT code 59620	Cesarean Delivery	Z33.1	Pregnant state, incremental	Either diagnosis code can be used with CPT code 59620. Please note that diagnosis code Z39.0 is intended to be used after delivery.
		Z39.0	Encounter for care and examination of mother immedidately after delivery	
CPT code 59840	Abortion	Z33.1	Pregnant state, incremental	Only diagnosis code Z33.1 should be used with CPT code 59840.
HCPCS code T1033	Miscarriage	Z33.1	Pregnant state, incremental	Only diagnosis code Z33.1 should be used with HCPCS code T1033.
HCPCS code Z1038	Postpartum visit	Z39.0	Encounter for care and examination of mother immedidately after delivery	Any of the three diagnosis codes can be used with HCPCS code Z1038. Please note that diagnosis code Z39.0 is intended to be used after delivery.
		Z39.1	Encounter for care and examination of lactating mother	
		Z39.2	Encounter for routine postpartum follow-up	
HCPCS code T1032	Postpartum Extended Visit	Z39.0	Encounter for care and examination of mother immedidately after delivery	Any of the three diagnosis codes can be used with HCPCS code T1032. Please note that diagnosis code Z39.0 is intended to be used after delivery.
		Z39.1	Encounter for care and examination of lactating mother	
		Z39.2	Encounter for routine postpartum follow-up	

For instructions on how to complete a CMS1500 form, click here

To review the Medi-Cal Provider Manual on Doula Services, click here

To view the Medi-Cal Provider Bulletin, click here

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3038 (previously UG100338 and MCUP3105)			**Lead Department: Health Services** **Business Unit**: Utilization Management	
Guideline/Procedure Title: Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled, or Subacute) Facilities			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1994		**Next Review Date:** ~~01/14/2027~~01/13/2028 **Last Review Date:** ~~01/14/2026~~01/13/2027		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~01/14/2026~~01/13/2027	

I. RELATED POLICIES:

~~A.~~ MCUP3041 – Treatment Authorization Request (TAR) Review Process
~~B.~~A. ~~MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities~~
~~C.~~B. MPUP3139 – Criteria and Guidelines for Utilization Management
~~D.~~C. MCUP3020 – Hospice Services
~~E.~~D. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
~~F.~~E. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
~~G.~~F. MPTP2501 – Transportation Policy for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
~~H.~~G. MPQP1016 – Potential Quality Issue Investigation and Resolution
~~I.~~H. MCRP4068 – Medical Benefit Medication TAR Policy
~~J.~~I. MPAP7003 – CalAIM Community Supports
J. MCAP7002 – CalAIM Enhanced Care Management (ECM)
K. MPCP2014 – Continuity of Care
L. MPPR210 – Long-Term Services and Supports Liaison
M. MPNET100 – Access Standards and Monitoring
~~K.~~N. CLPM15 – Claims Processing and Payment Standards for Partnership

II. IMPACTED DEPTS:

~~A. Health Services~~
~~B.~~A. Claims
~~C.~~B. Member Services
~~D.~~C. Enhanced Health Services (EHS)
~~E.~~D. Transportation
E. Provider Relations
F. Network Services
G. Quality and Performance Improvement

III. DEFINITIONS:

A. Custodial Care Facility: A non-medical facility (often referred to as a Long Term Care (LTC) facility) that provides basic assistance with daily living activities for individuals who cannot perform those tasks independently due to illness, injury or disability.
B. Extended Care Facility (ECF): A healthcare institution that provides on-going medical care, rehabilitation services, and assistance with activities of daily living to individuals who require prolonged or specialized care. This is an all-inclusive term for facilities providing custodial, skilled and sub-acute

services.

~~B.~~C. Skilled Nursing Facility (SNF): A facility or part of a hospital that provides short-term medically necessary skilled services provided by nurses, therapists, and/or physicians. The services aim to complete a course of treatment that is not available in lower levels of care and support an increase in function, safety and independence with activities of daily living.

~~C.~~D. Subacute Care Facility: A facility that provides ~~with~~ a level of care that is less intensive than acute care but more intensive than skilled nursing care (e.g. Members who require ventilators, tracheostomies, total parenteral nutrition, tube feeding, complex wound management care, etc.).

~~D.~~E. Subacute Contracting Unit (SCU): A unit within the California Department of Health Care Services (DHCS), responsible for contracting with providers to offer Medi-Cal subacute care services. Contracted facilities may be reimbursed for subacute care services provided to Medi-Cal subacute beneficiaries who meet subacute care criteria as defined in Medi-Cal Manual of Criteria R-15-98E (adult beneficiaries) and Welfare and Institutions Code, section 14132.25 (pediatric beneficiaries). Specific reimbursement rates have been developed for providers of subacute care who have contracted with the DHCS' SCU.

IV. ATTACHMENTS:

A. Bed Hold/Change of Status Report form
B. Skilled Nursing Facility Request Form

V. PURPOSE:

To delineate the medically necessary criteria for admission and continuing care in Extended Care Facilities for Partnership HealthPlan of California Members.

VI. GUIDELINE / PROCEDURE:

A. Identifying Members and Selecting Appropriate Extended Care Facilities (ECFs)
   1. Partnership ensures access to licensed care facilities, irrespective of location in or out-of-network, to Members in need of extended care services. These facilities may include:
      a. Custodial/Long Term Care Facilities
      b. Skilled Nursing Facilities (SNF)
      c. Subacute Care Facilities (pediatric and adult)
   2. A Member in need of extended care is identified by his/her physician, health care clinician, institution, Nurse Coordinator and/or Care Coordination staff who refers the Member to the appropriate type of facility.
   3. The primary care provider (PCP) and/or treating physician, in collaboration with hospital Discharge Planning/Care Management departments, and Partnership Utilization Management (UM) team identifies the most appropriate level of care for the Member and assures that the Member is placed in a health care facility that provides the level of care most appropriate to the Member's medical needs in a timely manner.
      a. Decisions regarding the appropriate level of care are based on the definitions set forth in Title 22, California Code of Regulations (CCR) Sections 51118, 51120, 51120.5, 51121, 51124, 51124.5, and 51124.6, and the criteria for admission set forth in Sections 51335, 51118, 51120, 51335.5, 51334, 51335.6, and referenced sections of 51003 (e).
      b. DHCS Title 22 regulations, as well as CMS regulations and other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management,* are utilized by Partnership UM Nurse Coordinators when performing reviews of authorization requests to determine the medical necessity for continued placement in an extended care facility. If care can be delivered at a lower acuity level, an alternative setting will be approved/

recommended.

c. Treatment Authorization Requests (TARs) will be approved with the revenue code that corresponds to the authorized level of care and the Member's medical necessity, supporting efficient claims processing.

4. Extended Care Classification categories include the following:
   a. Custodial/Long Term Care: These facilities assist members in meeting their activities of daily living (ADLs) such as eating, bathing, grooming, etc. Members must meet criteria showing need for this level of care. Following admission to the facility, members will continue to be reevaluated periodically to ensure medical necessity is met for continued placement.
   b. Skilled Nursing Care: The Member may need a short-term stay for a skilled nursing care need or short-term rehab services and is expected to return to their previous living arrangement or alternate level of care. Facility staff, including case managers, are responsible for coordinating discharge planning for the M~~m~~ember.
   c. Subacute Care: The Member requires subacute care, which is more intense than skilled nursing care but less intense than acute hospitalization. Members at this level of care can either ~~can~~ be ~~either be~~ short term, where there is potential for the Member eventually being transferred to a lower level of care; or custodial/long term, when there is no potential for improvement in their medical condition. ~~Treatment Authorization Requests (~~TARs ~~)~~ for these Members are authorized for time intervals based on the characteristics of the Member's medical condition.
5. The choice of an ECF for a patient is a decision that should include consideration of the following:
   a. What are the medical/ rehabilitation needs for the member and does the facility have the services available to meet the Member's needs?
   b. Is the facility a licensed Medi-Cal provider?
   c. Is the facility contracted with Partnership?
   d. Are there beds available?
   e. If more than one choice is available, is there a family preference (e.g. geographical location) that can be reasonably accommodated?
   f. Are there any benefit coverage limitations?
6. Facility Requirements
   a. An ECF must meet all of the following requirements:
      1) It must be a licensed institution
      2) It must be qualified as a provider of services under Medi-Cal
      3) It must maintain, on the premises, all facilities necessary for medical care and treatment
      4) It must provide such services under the supervision of a physician
      5) It must provide services given by or supervised by a registered nurse AND
      6) The facility must keep medical records on all patients
   b. For Members approved for subacute services, based on availability, Partnership verifies those services are received from a provider that has a contract with the DHCS' Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.

B. Members with Other Healthcare Coverage
   1. When Members have other healthcare coverage (e.g., Medicare) Partnership will work to coordinate benefits as applicable.

C. Treatment Authorization Requests (TARs) for Admission to an Extended Care Facility (ECF)
   1. In alignment with Manual of Criteria R-15-98E, an initial Treatment Authorization Request (TAR) is required with each admission to an ECF. A TAR is required when the Member:
      a. Is a new admission to the facility
      b. Has exhausted their Medicare benefits
      c. Has received a denial from Medicare or other insurance for extended care
      d. Is readmitted to an ECF from an acute care hospital

e. Returns to an ECF from an approved leave of absence beyond the approved return date
f. Is newly eligible with Partnership while residing in the ECF
   1) Partnership will provide continuity of care pursuant to H&S section 1373.96 and 28 CCR section 1300.67.1 for Members receiving services who transition from another Managed Care Plan. Partnership will also retroactively approve a continuity of care request and reimburse Providers for services that were already provided if the request meets all continuity of care requirements outlined in APL 23-022, or any superseding APL. Refer also to policy MPCP2014 Continuity of Care.

~~f.~~g. Changes level of care (e.g. Skilled to Custodial, Custodial to Skilled, Subacute to Skilled)

2. A UM Nurse Coordinator reviews the authorization request for medical necessity and level of care utilizing DHCS Title 22 regulations and/or CMS regulations and other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management*.
   a. Cases not meeting criteria for medical necessity are referred to the Chief Medical Officer (CMO) or Physician Designee for review and determination.
   b. Upon review, a UM Nurse Coordinator can approve, modify, defer (pend) or deny the TAR for non-medical necessity. Only the CMO/ Physician Designee can deny a TAR for reasons of medical necessity.
   c. A determination will be issued to the facility in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6 and according to APLs 26-010 and 26-011.
      1) Prior Authorization requests for Members transitioning from an acute care hospital are considered to be expedited and will be processed with a response time of no greater than 72 hours, including weekends.
      ~~1)~~ Non-urgent custodial requests are processed with a response time of no greater than seven (7) calendar days.
      2)
   ~~e.~~d. Partnership reserves the right to modify a request; it is the facility's responsibility to review their request against what Partnership approves.
   ~~d.~~e. The facility is responsible for verifying the Member's eligibility using Partnership's "eEligibilty" on a monthly basis. (For improved accuracy, it is recommended that eligibility be verified after the 5th of the month.) If a Partnership Member loses eligibility, the authorization will no longer be valid.
3. Extensions of Stay
   a. Extensions of stay in extended care facilities for Medi-Cal Members require re-authorization by Partnership on a case by-case basis and are approved in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6.
   b. Extension requests will be reviewed based on the facility's documentation of the Member's current clinical status and medical need of requested extension, including current services required, anticipated duration of services and progress towards goals of therapy in the prior approved stay, and current discharge disposition/ planning as noted by the facility's team.
4. Admissions on Weekends and Outside Normal Business Hours
   a. If a member is transferred to a facility on a weekend, or outside normal business hours, Partnership must be notified via phone or the Online Services (OLS) portal on the next business day for immediate review of the TAR.
   b. Upon review, if Partnership determines the Member did not meet criteria, the dates of service already provided will be authorized, but subsequent days will be denied.
5. Custodial (Long Term Care) TAR Submission Requirements:
   a. Custodial care services require prior authorization by a Partnership UM Nurse Coordinator before admission to a Custodial facility, otherwise, the stay may be denied for not meeting

medical necessity.

b. A custodial care authorization request shall be initiated by the ECF, and the following documentation must be submitted with the initial Custodial Care TAR:
   1) Completed TAR form.
      a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.
      b) If Provider is unable to utilize the OLS portal, a TAR form 20-1 may be faxed to (707) 863-4118.
   2) MC171 (Medi-Cal Long Term Facility Admission and Discharge notification)
      a) For Partnership members with Supplemental Security Income (SSI), the ECF is required to submit the MC171 form to the Social Security Administration (SSA) within two weeks of admission to the facility. A copy of the form must be sent to Partnership. The form must be filled out completely and accurately.
      b) Partnership's Long-Term Services and Supports (LTSS) Nurse Coordinators confirm the receipt of the MC171 form for all Partnership members with SSI. If a facility does not submit the MC171 form, the TAR will be sent to the CMO/Physician Designee for review and denied for "information requested not received." The facility will be notified.
   3) Medicare or other Insurance denial letter (if applicable)
   4) Completed Minimum Data Set (MDS) dated within the past 90 days
   5) PASRR (Preadmission Screening and Resident Review)

c. When a member is admitted for custodial care, a TAR submission may be approved up to a six (6) month period.

d. The Member's condition will be re-evaluated upon submission of a new TAR within 15 days of the expiration date of the previous TAR.

e. Continued Care (Reauthorization) with a new TAR must include the following:
   1) Completed new TAR form
   2) Current MDS dated within 90 days of TAR start date
   3) Social Services annual review/quarterly assessment and progress notes

6. Skilled Nursing Facility (SNF) TAR Submission Requirements:

a. Skilled level nursing is a covered level of care for Partnership Members. This level of care is short-term for the acute rehabilitation stage of treatment following an illness or injury.
   1) A member in custodial care may be considered for short-term SNF level care for Isolation Days for communicable diseases per California Department of Public Health (CDPH) guidance and per the determination of the local health officer.

b. Admission to a SNF must be coordinated with a contracted Medi-Cal licensed facility by the discharge planner.

c. Skilled nursing services require prior authorization by Partnership before a Member's admission to a SNF.

d. The following documents must be submitted with the initial SNF TAR:
   1) Completed TAR form.
      a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.
      b) If Provider is unable to utilize the OLS portal, a TAR form 20-1 may be faxed to (707) 863-4118.
   2) PASRR (Preadmission Screening and Resident Review)
   3) Acute notes
   4) Medicare or other health coverage denial letter
   5) Eligibility must be "No Other Insurance"
   6) Skilled Nursing Facility Request form (Attachment B)
   7) MD orders as applicable to facility type (see VI.C.8. and 9. below)

e. The following documents must be submitted for a SNF TAR extension:

1) MD orders from SNF
2) Nurse and attending physician/ medical provider notes showing medical need for SNF care (e.g. wound care, IV antibiotics) and anticipated duration of need
3) Therapy progress report indicating current level of participation, progress notes and goals of treatment
4) Discharge planning documents

7. Subacute Care Facility TAR Submission Requirements:
   a. The following documents must be submitted with the initial Subacute Care Facility TAR:
      1) Completed TAR form.
         a) eTAR submission through Partnership's Online Services (OLS) portal is recommended.
         b) If Provider is unable to utilize the OLS portal, a TAR form 20-1 may be faxed to (707) 863-4118.
      2) DHCS 6200 form for Authorization/Reauthorization of Subacute Care Services
         a) Adult form: DHCS 6200A
         b) Pediatric form: DHCS 6200
      3) Acute notes to include therapy notes (e.g. physical therapy, speech therapy, occupational therapy, respiratory therapy)
      ~~3)~~4) Subacute authorization does not require MDS or any additional information beyond the requirements of the DHCS 6200A or 6200 forms.
   b. Note: For Members approved for sub-acute services, based on availability, Partnership verifies those services are received from a provider that has a contract with the Department of Health Care Services' (DHCS') Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.
   c. The following documents must be submitted for a Subacute TAR extension:
      1) DHCS 6200 form for Authorization/Reauthorization of Subacute Care Services (if dates are applicable)
         a) Adult form: DHCS 6200A
         b) Pediatric form: DHCS 6200
      2) Facility progress notes
      3) MD orders
   d. Extensions of stay in subacute care facilities are reviewed in alignment with Manual of Criteria R-15-98E and require reauthorization by Partnership every two months. Prolonged care may be authorized for up to a maximum of six months.
      1) Extensions are reviewed based on medical need for the care that is provided. Facilities must provide current records showing the Member's current clinical status, participation in therapies, progress toward goals and discharge planning.
   e. 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.
8. Authorizations for Transfers from Acute Care to an Extended Care Facility (ECF)
   a. Please Note: If admission from acute care occurs without prior approval from Partnership, and the Member's condition and services do not meet criteria, Partnership will issue a denial determination to the facility.
   b. The ECF is required to notify Partnership before any admission. Prior authorization is required for all admissions.
   c. UM Nurse Coordinator will review documents and provide initial determination approval.
   d. The transfer must be coordinated by the hospital discharge planner or case worker.
9. Admission from Home to an Extended Care Facility

a. Please Note: If the admission from home occurs without prior approval from Partnership, and the Member's condition and services do not meet criteria, Partnership will issue a denial determination to the facility.
b. An ECF facility is required to notify Partnership before any admission. Prior authorization is required for all admissions from home.
   1) The following information must be submitted with the TAR:
      a) Primary Care Provider's (PCP's) orders indicating the services needed that require confinement in an ECF and the physician's certification that placement in the particular ECF is the appropriate level of care for the Member.
      b) If placement follows an acute hospital stay within the past 30 calendar days, the hospital history and physical and discharge summary must be submitted.
      c) If the Member has not been confined in an acute care hospital within the past 30 calendar days, the Primary Care Provider's progress notes for the past six (6) months must be submitted.

10. Bed Hold Change of Status Reporting
    a. This occurs when a Member residing in an ECF is transferred to an acute care hospital or has an approved leave of absence, which must be reported through the Bed Hold/ Change of Status Report form (Attachment A).
    b. The maximum bed hold is 7 calendar days per hospitalization. The facility must hold a bed vacant when requested during the entire hold period, except when notified in writing by the attending physician that the patient requires more than seven days of hospital care. The facility is then no longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days.
    c. The following documents must be submitted when reporting a Bed Hold change of status:
       1) MD orders
       2) Bed Hold/Change of Status Report form (Attachment A)
    d. When a ~~custodial~~ Member returns to the ECF prior to or on the 8th calendar day, the existing ECF TAR is still valid.
       ~~3)~~1) A separate authorization or reauthorization shall not be required when a Member who has an approved SNF, Subacute Care Facility, or other covered long-term care placement is transferred to an acute care hospital, placed on bed hold, and returns to the same facility at the same authorized level of care within seven (7) days or less. The existing authorization stays in effect on the Member's return.
       ~~4)~~2) If a Partnership Member returns to an ECF after 8 calendar days, a new ECF TAR and all required attachments must be submitted (see initial TAR submission requirements described above according to facility type.)
       3) NOTE: The ECF must notify Partnership when a Member is readmitted to the ECF. Claims will not be paid if the readmission is not appropriately reported to Partnership.
    e. Partnership offers ongoing education and support to LTSS providers on leave of absence and bed hold requirements, including clinical documentation, MD orders, notifications, authorizations, and Member rights. Provider Education sessions may include provider training, written guidance, LTSS Liaison outreach and activities, and other appropriate methods. Partnership regularly shares a handout with instructions for completing the Partnership Bed Hold/ Change of Status form (Attachment A).
    ~~d.~~f. Denials

1. Cases determined not to meet ECF admission criteria or continued stay criteria based on DHCS Title 22 regulations, CMS regulations, other applicable criteria as described in policy MPUP3139 *Criteria and Guidelines for Utilization Management,* and the information available at the time of review, are managed as follows:

a. If the UM Nurse Coordinator has concerns regarding a case, the case is discussed with the appropriate facility representative to determine if there is any additional pertinent information available.
b. Denials of medical necessity are determined only by the Partnership CMO/ Physician Designee.
c. UM staff will ensure the Member, provider, and facility are notified verbally and/or in writing as appropriate. Notice of Action letters will include the applicable appeal rights as described in policy MCUP3037 *Appeals of Utilization Management/ Pharmacy Decisions*.

E. Criteria for Ending or Modifying an Active TAR
1. Partnership staff will end or modify an existing valid TAR in the system under the following circumstances:
a. Member's death (Partnership must be notified within 24 hours of Member expiring)
1) If the day of discharge or death is the same day as admission, the day is payable regardless of the hour of discharge or death. If the day of death/discharge is not the same day as admission, the day is not payable
2) Notification of a Member's death should include whether the death occurred within the ECF or in an acute care facility.
b. Exhausted 7 calendar day bed hold
c. Discharge to other health insurance payor (e.g., Medicare)
d. Discharge to hospice care (see policy MCUP3020 Hospice Services for requirements)
e. Discharged to home or transfer to another ECF
f. Change in level of care (e.g. Custodial to Skilled or Skilled to Custodial)
2. For all of the above, Partnership recommends that the ECF submits a Bed Hold/Change of Status Report form (Attachment A).
a. For all circumstances except death (which requires notification within 24 hours), a Bed Hold/Change of Status form (Attachment A) should be submitted within seven (7) days.

F. Quality Monitoring and Review
1. The UM Nurse Coordinator assists the Quality Improvement (QI) Coordinator with data collection for QI focused studies as requested.
2. If, in the course of routine case review, the Nurse Coordinator finds a potential quality of care issue, the case is referred to Partnership's Member Safety Investigations Team for investigation through the Potential Quality Issue referral process. See policy MPQP1016 Potential Quality Issue Investigation and Resolution.

G. Policies for Other Services or Supports
1. Facility Therapy Services
a. Federal Law states that "each resident must receive, and the facility must provide, the necessary care and services to attain or maintain the highest practicable physical, mental and psychological well-being, in accordance with the comprehensive assessment and plan of care." In many cases, however, these therapy services can, and should be, performed as part of the nursing facility inclusive services (covered under the facility's per diem rate) and, therefore, are not separately reimbursable.
1) Therapy services provided to the Member that are covered by the per diem rate include, but are not limited to:
a) Keeping recipients active and out of bed for reasonable periods of time, except when contraindicated by a physician's order
b) Supportive and restorative nursing and personal care needed to maintain maximum functioning of the recipient
c) Care to prevent formation and progression of decubiti, contractures and deformities, including:
i. Changing position of bedfast and chairfast recipients

ii. Encouraging and assisting in self-care and activities of daily living
iii. Maintaining proper body alignment and joint movement to prevent contractures and deformities

2. Durable Medical Equipment (DME)
   a. For requests for DME for residents residing in an ECF, it is the responsibility of the facility and its staff to meet the patient's needs for activities of daily living including assistance with mobility. (This includes, but is not limited to, mobility components such as rollators, 4 wheel walkers, commodes, etc.) Please refer to Department of Health Care Services (DHCS) All Plan Letter (APL) 15-018 of July 9, 2015, *Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components*, regarding provision of wheel-chairs for Members residing in a skilled nursing facility.
   b. The ECF is responsible for providing wheelchairs that are properly maintained at all times unless the Member demonstrates the need for a custom wheelchair [as per Title 22 section 51321(h)] in which case a TAR should be submitted to Partnership for consideration.
3. Transportation
   a. For all transportation needs, please refer to Partnership's policy MPTP2501 Transportation Policy for Non-Medical (NMT) and Non-Emergency Medical Transportation (NEMT).
4. Enhanced Care Management / Community Supports
   a. Members who are currently in a Skilled Nursing Facility may be eligible for the Enhanced Care Management (ECM) benefit. Refer to Partnership policy MCAP7002 CalAIM Enhanced Care Management (ECM) for further details.
   b. Community Supports are medically appropriate and cost-effective alternatives to traditional medical services or settings that are designed to address social drivers of health, which are factors in people's lives that influence their health. For Members currently in a LTC setting who may benefit from Community Supports, please refer to Partnership policy MPAP7003 CalAIM Community Supports (CS)
5. Partnership has a Long-Term Services and Supports (LTSS) Liaison who assists facilities in addressing claims and payment inquiries and coordinates support for LTSS providers to best meet Members' needs. Contact information for Partnership's LTSS Liaison can be found on this webpage: https://www.partnershiphp.org/providers/medi-cal/dhcs-directed-payments-programs~~https://www.partnershiphp.org/Providers/Medi-Cal/Pages/DHCS%20Directed-Payments-Programs.aspx~~

VII. REFERENCES:

A. Medi-Cal Guidelines/Provider Manual:
   1. Subacute Care Programs: Level of Care for Adults and Children (*subacut lev*)
   2. Subacute Care Programs: Adult *(subacute adu)*
   3. Subacute Care Programs: Pediatric (*subacut ped*)
   4. Leave of Absence, Bed Hold, and Room and Board *(leave)*
   5. TAR for Long Term Care: 20-1 Form *(tar ltc)*
   6. TAR for Long Term Care (Form 20-1): Inpatient Services *(tar ltc ip)*
   7. TAR Completion for Long Term Care *(tar comp ltc)*

~~B. InterQual® criteria~~

~~C.~~B. Department of Health Care Services (DHCS) Contract: Exhibit A, Attachment III, Section 5.3.7 G. Services for All Members / Long-Term Care (LTC) Services

~~D.~~C. Title 22 California Code of Regulations (CCR) Sections 51003(e), 51118, 51120, 51120.5, 51121, 51124, 51124.5, 51124.6, 51134, 51335, 51335.5, 51335.6, 51321(h), 51535, 51535.1, 72520

~~E.~~D. Title 42 Code of Federal Regulations (CFR) Section 483.15e

~~F.~~E. Welfare and Institutions Code (WIC) §14132.25

F. Health and Safety Code (HSC) § 1373.96
G. Title 28, CCR § 1300.67.1 *Continuity of Care*
H. DHCS All Plan Letter (APL) 15-018 dated 07/09/2015 -Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components
I. All County Welfare Director's Letter ACWD 25-02 2025 Statewide Average Private Pay Rate for Nursing Facility Services (01/22/2025)
J. DHCS APL ~~24-009~~26-010 Skilled Nursing Facilities - Long Term Care Benefit ~~Standardization and Transition of Members to~~Under Managed Care (~~09/16/2024~~06/10/2026)
K. DHCS APL ~~24-010~~26-011 Subacute Care Facilities - Long Term Care Benefit ~~Standardization and Transition of Members to~~ Under Managed Care (~~09/16/2024~~06/10/2026)
L. DHCS Subacute Care Program and Manual of Criteria R-15-98E
M. California Department of Public Health Healthcare-Associated Infections Program: Recommendations for Prevention and Control of COVID-19, Influenza, and Other Respiratory Viral Infections in California Skilled Nursing Facilities (2025 – 2026)

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

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

X. REVISION DATES: 06/21/00; 04/18/01; 03/20/02; 03/19/03; 04/21/04; 02/16/05; 03/15/06; 08/20/08; 03/21/12; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 09/11/19; 03/11/20; 03/10/21; 05/11/22; 04/12/23; 06/12/24; 11/13/24; 01/14/26; 01/13/27

*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:
MCUP3105 - Coordination of Services for Members Requiring Long Term Care

REGULATOR APPROVAL:
DHCS – last approved on 04/02/2025 for APL 24-009
DHCS – approved on 02/14/2025 for APL 24-010
DHCS – approved on 09/23/2024 for APL 23-027

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

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

The materials provided are guidelines used by Partnership to authorize, modify or deny services for persons

with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under Partnership.

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

Partnership HealthPlan of California
4665 Business Center Dr.
Fairfield, CA 94534
(707) 863-4133 / (707) 863-4118 FAX

BED HOLD & CHANGE OF STATUS REPORT

MCUG3038 Attachment A
MCUG3058 Attachment B
01/13/2027

FACILITY NAME: _____

NO.	MONTH -	DAY OF THE WEEK																													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31
1	NAME: TAR NUMBER:																															

Please note, member discharge /transfer to acute requires a MD order.

Fax to **707 - 863 - 4118**

Facilities shall maintain and submit clinical documentation supporting any leave of absence or bed hold request in accordance with Partnership requirements and applicable DHCS guidance.

REMARKS:

NO.	

LEGEND:

A - Discharge to Acute (use after 7 day BH)
B - Discharge to B & C
B/H - Bed Hold
E - Expired
E/A - Expired in Acute
TL - Therapeutic Leave
H - Discharge to Home
I - Discharge to ICF
M - Discharge to Medicare Bed
P - Discharge to Private Pay
R - Return to Medi-Cal Bed
S - Discharge to Other SNF
X - Discharge to Hospice

Prepared By: _____

Telephone #: _____

Fax #: _____

Date Prepared: _____

Please note, report will not be processed without a signed Physician's order

Skilled Nursing Facility Request Form

Member Information

First Name:_____ MI:_____ Last Name:_____

Partnership Member ID:_____ Date of Birth:_____

Requestor Information

Facility:_____ NPI Number:_____

Facility Contact Name:_____ Phone Number:_____

Reason for Admission:_____

Admission Date:_____ Requested Length of Service:_____

Anticipated Discharge Plan:_____

Requested Services (Check all that apply)

Custodial Services Only: ☐

Requested Skilled Therapy Code (check specific modalities below):_____

Was a verbal authorization given for this request? Yes ☐ No ☐

	Ordered	Frequency	Duration (Days)	Additional Information
Physical Therapy				
Occupational Therapy				
Speech Therapy				
IV Antibiotics				
Wound Care				
Additional Therapies				

Additional Comments:

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3003 (previously UP100303)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: ~~Rehabilitation~~ Guidelines for Acute ~~and Skilled Nursing Inpatient~~Rehabilitation Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/25/1994</td><td colspan="3">Next Review Date: ~~01/14/2027~~01/13/2028
Last Review Date: ~~01/14/2026~~01/13/2027</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~01/14/2026~~01/13/2027</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
B. MCUG3038 - Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities
C. MCUG3024 - Inpatient Utilization Management
D. MPUG3011 - Criteria for Home Health Services
E. MCUP3114 - Physical, Occupational and Speech Therapies

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Medical Necessity - Medical necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
B. UM Nurse Coordinator – This is the Partnership HealthPlan of California nurse in the Utilization Management department who is assigned to a case and who performs reviews for medical necessity and coordinates services covered by Partnership within the health plan and with the staff at the treating facility.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To provide guidelines for review of rehabilitation facility admissions and define the criteria for authorization of rehabilitation services at ~~either a skilled nursing facility or~~ an acute care facility to ensure that services ~~that are~~ delivered are medically appropriate and consistent with diagnosis and level of care required for each individual.

VI. POLICY / PROCEDURE:

A. Overview

Policy/Procedure Number: MCUP3003 (previously UP100303)		**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Rehabilitation Guidelines for Acute and Skilled Nursing InpatientRehabilitation Services		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994	**Next Review Date: 01/14/202701/13/2028** **Last Review Date: 01/14/202601/13/2027**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

1. Acute rehabilitation is an interdisciplinary process under the direction of a physician skilled in rehabilitation medicine. It is intended to help the physically or cognitively impaired Member achieve or regain maximum functional potential for mobility, self-care, and independent living. Certification for inpatient acute rehabilitation services is contingent on ~~upon~~ the presence of one or more major physical or cognitive impairments ~~which~~ that significantly interfere with function and which require intensive interdisciplinary rehabilitation ~~complex therapeutic~~ interventions to restore function.
2. Rehabilitative services for the physically and/or cognitively impaired Member are covered in the following circumstances:
   a. Immediately post hospitalization for acute trauma or other disease resulting in impairment
   b. Maintenance therapy for chronically impaired Members is expected to be provided in long-term care facilities or subacute hospitals and is included in the facility's per diem rate
   c. In-home care for homebound Members
3. The Member must demonstrate a need for an interdisciplinary therapeutic program to reach the goals established by the initial evaluation. A severe functional deficiency must be present in one or more of the following areas:
   a. Self-care skills - including drinking, feeding, dressing, hygiene, grooming, bathing, perineal care, and/or use of upper or lower extremity prosthesis or orthosis. (Activities of Daily Living or ADLs)
   b. Mobility skills - including dependence upon an assistant or supervision in transferring to and from chair, toilet, tub or shower, upright ambulation and/or use of wheelchair
   c. Bladder control and management - needing assistance in urination and in developing and/or maintaining a bladder program due to lack of bladder control
   d. Bowel control and management - needing assistance in excretion and in developing and/or maintaining a bowel program due to lack of bowel control
   e. Pain management - pain so severe as to markedly limit functional performance
   f. Safety - needing instruction because of impaired judgment, impulsive behavior, or physical deficits in the proper and safe management of self-care and/or avoidance of complications such as contractures, decubiti or urinary tract infections
   g. Cognitive functioning - needing speech and /or language therapy in association with another primary problem listed above
   h. Communication - needing speech and/or language therapy in association with another primary problem listed above
4. Members are not eligible for rehabilitative services unless the Member's other medical problems are stable and will not interfere substantially with the rehabilitation program. The Member must also demonstrate a cognitive ability to understand the program and the motivation to participate in all aspects of the program. The Member must have adequate endurance to actively participate in the program. The degree of endurance required will vary depending on the therapeutic setting.
5. The attending physician must refer the Member to the rehabilitation program for an initial evaluation. For Members not currently inpatient, either the Member's primary care provider (PCP) must make the referral or concur with the physician who made the referral. After the rehabilitation program has completed the initial evaluation, a treatment plan must be developed in consultation with the referring physician as indicated.
6. A Treatment Authorization Request (TAR) must be submitted by the rehabilitation program indicating the services requested, a description of medical need, level of rehabilitation services, and a copy of the treatment plan. The referring physician must sign the treatment plan. In order to expedite care, Partnership will accept the TAR with an unsigned treatment plan, however; the

rehabilitation program must obtain the required physical signature as soon as possible.

a. The written treatment plan shouldmust include the following information:
   1) Date of onset of the illness
   2) Medical diagnosis necessitating the service, with severity and duration of condition
   3) Related medical conditions
   4) Impairments necessitating an inpatient or skilled nursing admission for rehabilitation services
   5) Functional limitations including cognitive abilities, mobility and self-care limitations, emotional problems, and communication difficulties
   6) History and results of previous rehabilitation services and outcomes of treatment
   7) Prognosis
   8) Therapeutic goals to be achieved by each discipline and anticipated time to achieve goals
   9) Types of services to be rendered by each discipline related to the problem
   10) Description of plan to instruct household members or other caregivers to provide needed care after discharge from the rehabilitation program.
   11) Documentation that the Member has sufficient strength and endurance to actively participate in the proposed treatment.

7. The UM Nurse Coordinator reviews the TAR for medical necessity and consults with the referring physician or rehabilitation staff as indicated. Definition of "medical necessity" states that necessary health care services are those needed to protect life and to prevent significant illness or significant disability, or to alleviate pain. The Chief Medical Officer or physician designee is the only individual who can deny TARs for inpatient or skilled nursing rehabilitation services.
8. If additional days are needed beyond the initial TAR, a progress report must be submitted to Partnership documenting that significant improvement has occurred with the initial therapy and that continued therapy will further improve the Member's function, although not necessarily restoration of full capacity. The progress report must indicate plans for discharge and measured progress in each problem area being treated. In addition, the report must detail the Member's active participation in therapy and that the Member still requires close supervision in an inpatient or skilled setting.
9. Requests for extension of inpatient rehabilitation services are denied for medical necessity for the following reasons:
   a. Therapeutic goals have been attained or the prospect of further incremental improvement is so small that an additional expense is not justified
   b. Lack of progress toward attaining goals, with further progress unlikely
   c. Inability or unwillingness of Member or family to cooperate with the Member's program
   d. Goals can be achieved at a lower level of care

B. Admission Criteria

All statements in Section VI.B.1. Patient Selection and Section VI.B.2. Admission below must apply to the patient (Partnership Member).

1. Patient Selection
   a. The patient must have a physical disability of which the medical condition and functional performance can be realistically improved through intensive, accepted rehabilitation measures.
   b. The patient must have the potential to be medically and emotionally behaviorally stable for management on a rehabilitation nursing service and be capable of active participation in a rehabilitation program.
   c. The patient must be in need of close daily medical supervision by a physician with specialized training or experience in rehabilitation and must require 24-hour rehabilitation nursing or other

rehabilitation services.

d. Primary admitting diagnosis must include one of the following:
   1) Stroke
   2) Spinal cord injury
   3) Amputation
   4) Major multiple trauma
   5) Fracture of femur (hip)
   6) Brain injury
   7) Polyarthritis - including rheumatoid arthritis
   8) Neurological disorder, including multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy, and Parkinson's Syndrome
   9) Burns
   10) Other conditions requiring intensive rehabilitative care

2. Admission
   a. Skilled rehabilitation services, as ordered by a physician, must be required and provided on a daily basis. For purposes of rehabilitation services, daily participation generally means ~~Daily may be defined to be~~ at least five (5) days a week. A break of a day or two in service where rehabilitation services are not furnished, and discharge is not indicated, is also permissible.
   b. The medical director of the rehabilitation unit or the physician designee must perform patient evaluation and final determination regarding transfer of the patient to the rehabilitation service.
   c. Admission medical record (admission physical examination) must include all of the following:
      1) Treatment goals - what functional improvements might be realistically expected from rehabilitation
      2) Potential - what is the realistic possibility of achieving above stated goals - excellent, good, fair, guarded
      3) Treatment plan - how will treatment goals be achieved. Specifically what therapies will be utilized - Physical Therapy, Occupational Therapy, Speech, Psychology, Social Service
      4) Duration of stay - realistic estimate of time required to achieve stated goals

C. CONTINUED STAY CRITERIA

(These criteria will only be applied up to the limit of rehabilitation coverage.)

1. A treatment plan, as outlined on admission physical examination, must be reviewed and revised as needed, at least weekly, in consultation with rehabilitation nursing, all involved therapies and social services.
2. There must be documented, weekly continued improvement in one or more functional abilities in at least one therapy.
3. If there is development of a complicating medical or ~~emotional~~ behavioral problem which requires temporary suspension of rehabilitation therapies, but which is of such a nature as to expect a return to an active rehabilitation program within one week (seven days), then rehabilitation services may be continued.

D. DISCHARGE CRITERIA

1. Must meet ~~either a., b., c., or d.~~one of the following criteria below:
   a. The patient has met the goals established at, and subsequent to, the time of admission.
   b. The patient no longer requires rehabilitative nursing and is receiving treatment in only one therapy area, i.e., occupational therapy, physical therapy, speech therapy, psychology, neuropsychology.
   c. There is no evidence of progress toward documented goals.
   d. There are intercurrent medical conditions that require acute care and suspension of rehabilitative

services.

2. A weekend pass may be ~~given~~ considered the week prior to planned discharge to determine problems or issues that might exist that would need to be addressed before patient is sent home.

E. CASE REVIEW CONFERENCES

1. Partnership Members in acute rehabilitation facilities are regularly reviewed as follows: ~~in case review conferences.~~
   a. Extended Length of Stay (ELOS) meetings are held weekly or bi-weekly as needed to review Members with a length of stay greater than 7 days, or who have barriers to discharge.
      1) Participants include, but are not limited to, Inpatient and Outpatient UM Leadership, LTSS Complex Team Nurse Coordinator, Care Coordination nurse, and a Medical Director.

   ~~a. Partnership Members in acute rehabilitation facilities are reviewed in case review conferences.~~

   b. ~~Weekly review conferences are held~~ For facilities that do not participate in ELOS meetings, ~~to discuss select hospitalized Members.~~weekly rounds are held to review Members with a length of stay greater than 7 days, or who have barriers to discharge.
      1) Participants include, but are not limited to, Inpatient UM Leadership, Nurse Coordinators, ~~Care Coordination staff, UM Team Manager, Chief Medical Officer and/or Regional~~and Medical Director~~s and the Associate Director of UM~~.
2. The purpose of these meetings is to collaborate and facilitate timely medical services and transitions to the next level of care.

~~3. UM Nurse Coordinators are expected to follow the review guidelines outlined in policy MCUG3024 Inpatient Utilization Management, including, but not limited to, admission review and concurrent review.~~

~~NOTE: The above criteria are neither mutually inclusive nor exclusive. The final judgment must be reached using professional nursing judgment of the variety of the care needs and the availability of other care alternatives to determine the need for rehabilitation level of care.~~

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: TAR Criteria for Acute Inpatient Intensive Rehabilitation *(tar crit aiir)*
B. California Code of Regulations (CCR) Title 22 Health Care Services

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

03/23/95; 08/98; 06/21/00; 04/18/01; 01/16/02; 08/20/03; 09/15/04; 10/19/05; 08/20/08; 05/19/10; 11/28/12; 01/20/16; 08/17/16; 06/21/17; *08/08/18; 08/14/19; 08/12/20; 08/11/21; 10/12/22; 10/11/23; 10/09/24, 01/14/26; 01/13/27

*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

Policy/Procedure Number: MCUP3003 (previously UP100303)		**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Rehabilitation Guidelines for Acute and Skilled Nursing InpatientRehabilitation Services		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994	**Next Review Date: 01/14/202701/13/2028** **Last Review Date: 01/14/202601/13/2027**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

****

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: MCUP3102</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Vision Care</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/21/2010</td><td colspan="4">Next Review Date: ~~01/14/2027~~01/13/2028
Last Review Date: ~~01/14/2026~~01/13/2027</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="3">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~01/14/2026~~01/13/2027</td></tr>
</table>

I. RELATED POLICIES:
CMP36 – Delegation Oversight and Monitoring

II. IMPACTED DEPTS:
~~A. Health Services~~
~~B.~~A. Member Services
~~C.~~B. Claims
~~D.~~C. Compliance

III. DEFINITIONS:
A. Optical Low Vision Aids: Low vision optical devices include a variety of devices, such as stand and handheld magnifiers, strong magnifying reading glasses, loupes, and small telescopes. Magnifying devices are generally either handheld or mounted on a stand, with zoom ranges from 2x to 10x.
B. Optometry Services: Services provided by optometrists acting within the scope of their practice under California law. Orthoptics and pleoptics may be part of optometry services but are not covered benefits.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
To describe the means for providing vision care services to Members of Partnership HealthPlan of California.

VI. POLICY / PROCEDURE:
A. Provision of Services
1. Partnership contracts with a vision care insurance organization, Vision Services Plan (VSP), for the provision of Medi-Cal vision care services to eligible Members. Members assigned to VSP must go to a VSP Medi-Cal participating provider for refraction services and eye glass frames.
2. Members not assigned to VSP may obtain services from any Medi-Cal vision provider willing ~~are bill~~to bill~~ed directly to~~ Partnership directly. The provider shall bill Partnership for covered services.

B. Examination
1. Benefits include one eye examination with refraction every 24 months.
2. A second eye examination with refraction will be covered if the Member has a sign or symptom indicating medical necessity.
a. Authorization and referral requirements are administered in accordance with applicable Partnership vision services procedures and Member eligibility category requirements.

3. The reimbursement rates of optometric services shall not exceed charges made to the general public.

C. Eye Appliances
   1. A written prescription is required.
   2. The reimbursement rates for appliances shall not exceed charges made to the general public.
   3. Lenses and frames are covered every 24 months. Lenses may be covered more often if medically necessary.
      a. Lost, stolen, broken or significantly damaged eye appliances may be replaced within 24 months if damage was beyond the recipient's control. Recipient must submit a signed statement describing the circumstances of replacement.
   4. All fabrication of optical lenses is provided by the Prison Industry Authority (PIA) optical laboratories except when a Member requires lenses not available through PIA or when otherwise excluded under applicable Medi-Cal requirements. The Department of Health Care Services (DHCS) is responsible for reimbursement for the fabrication of the ophthalmic lenses in accordance with the Interagency Agreement between DHCS and PIA.
   5. Elective contact lenses are not a covered benefit.
      a. In certain cases, contact lenses may be covered if medically necessary. Prior authorization is required.

D. Optical low vision aids may be covered when medically necessary for those with vision impairment that is not correctable by standard glasses, contact lenses, medicine, or surgery and the subnormal vision interferes with the Member's ability to perform everyday activities. Prior authorization is required.

E. Delegation Oversight and Monitoring
   1. Partnership delegates the administration of vision care services to a vision care insurance organization.
   2. A formal agreement is maintained and inclusive of all delegated functions.
   3. Oversight/Regular monitoring activities include, but are not limited to, an audit conducted no less than annually.
   4. Results from the annual delegation oversight audit shall be presented to Partnership's Delegation Oversight Review Sub-Committee (DORS) for review and approval.

VII. REFERENCES:

A. Title 22 California Code of Regulations (CCR) Sections 51306, 51317, 51518, 51519, 51519.1 and 51519.2
B. DHCS Contract Exhibit A, Attachment III, D.
C. Medi-Cal Provider Manual/ Guidelines: Eye Appliances *(eye app)*; Low Vision Aids *(low vision)*; TAR Completion for Vision Care (*tar comp vc*); PIA Optical Laboratories *(pia)*

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
03/21/12; 01/21/15 (effective 02/01/15); 01/20/16; 01/18/17; *02/14/18; 02/13/19; 02/12/20; 01/13/21; 01/12/22; 01/11/23; 01/10/24; 01/08/25; 01/14/26; 01/13/27

*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: MCUP3102			**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Vision Care			☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/21/2010		**Next Review Date: 01/14/202701/13/2028** **Last Review Date: 01/14/202601/13/2027**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**

PREVIOUSLY APPLIED TO: N/A

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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<tr><td colspan="3">Policy/Procedure Number: MCUP3106</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Waiver Programs</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/21/2010</td><td colspan="4">Next Review Date: ~~01/14/2027~~01/13/2028
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</table>

I. RELATED POLICIES:
MPUG3011 – Criteria for Home Health Services

II. IMPACTED DEPTS:
A. ~~Health Services~~Care Coordination
B. Claims
C. Member Services
D. Provider Relations

III. DEFINITIONS:
A. DDS: California Department of Developmental Services
B. Developmentally Disabled (DD): Throughout this document, the term "developmentally disabled" is used to match current California Code of Regulations (CCR) language. However, it is acknowledged that this terminology is not person-centered and does not align with more contemporary language such as "people with intellectual and other developmental disabilities."
C. DHCS: California Department of Health Care Services
D. Electronic Visit Verification (EVV): A federally mandated telephone and computer-based application program that electronically verifies the date, time, and type of in-home service visits for Medicaid-funded personal care services and home health care services for in-home visits by a provider. In California, this is known as CalEVV.
E. HCBS: Home and Community Based Services
F. Personal Care Services (PCS): Services supporting individuals with their activities of daily living, such as movement, bathing, dressing, toileting, and personal hygiene. PCS can also offer homemaker services support for instrumental activities of daily living, such as meal preparation, money management, shopping, and telephone use.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
State and Federal Waiver Programs ensure Members who may benefit from Medi-Cal Home and Community Based Services (HCBS) Waiver Programs are identified and referred for medical care coordination and care management.

Policy/Procedure Number: MCUP3106		Lead Department: Health Services
Policy/Procedure Title: Waiver Programs		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/21/2010	**Next Review Date: 01/14/202701/13/2028** **Last Review Date: 01/14/202601/13/2027**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

VI. POLICY / PROCEDURE:

A. The Department of Health Care Services (DHCS) administers a number of HCBS Waiver Programs. These waiver programs include:
   1. Medi-Cal Waiver Program (MCWP) (formerly known as the AIDS Medi-Cal Waiver Program)
   2. Home and Community--Based Services Waiver for the Developmentally Disabled (HCBS-DD) – Section 1915(cC)
   3. Self-Determination Program (SDP)
   4. Assisted Living Waiver (ALW)
   5. Home and Community-Based Alternatives (HCBA) Waiver (formerly Nursing Facility/Acute Hospital (NF/AH)Waiver)
   6. Multipurpose Senior Services Program (MSSP) Waiver

B. Electronic Visit Verification (EVV) Requirements:
   1. Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal personal care services and home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa. Partnership monitors compliance with EVV requirements through oversight activities, periodic audits, and provider education, as applicable.
   2. Please refer to policy MPUG3011 Home Health Services for further information on EVV requirements.

C. Criteria Used for Identification
   1. Primary Care Providers (PCP), Specialists, and/or Partnership Care Coordination/ Utilization Management Departments refer Members to Waiver Programs.
   2. Members with intellectual and developmental disabilities are identified through coordination with the Regional Centers and in the course of utilization and case management services. (Title 22, CCR §51340; Welfare and Institutions Code §4684-4699.) Members with developmental disabilities who may meet the requirements for participation in this waiver are referred to the HCBS administered by the State Department of Developmental Services (DDS).

D. General Referrals and Authorization Requirements
   1. The PCP or other treating provider requests prior authorization for services or enrollment consideration from the appropriate State Waiver Program and provides all appropriate medical information. The PCP may request assistance from the Care Coordination department for the following:
      a. Facilitating authorization from appropriate Waiver Program(s)
      b. Completion of the Waiver Program application
      c. Follow up on status of acceptance to appropriate Waiver Program(s)
      d. Medical care coordination of Member while awaiting acceptance and/or placement into a Waiver Program
   2. No Members may not be enrolled in more than one HCBS Waiver Program at a time. 42 CFR §441.301(c)(4); DHCS Policy Guidance, HCBS Waiver Enrollment Criteria, 2024.)
   3. Partnership maintains the responsibility to provide comprehensive care management and authorize all medically necessary covered services for Members including those accepted into the Waiver Programs. The PCP will continue to treat and coordinate treatment for the Member.

E. Referrals to Specific Programs
   1. For the Medi-Cal Waiver Program (MCWP), patients should be referred to a MCWP Provider in their county (or if their county does not have an MCWP provider, they may be referred to a nearby county that participates in the MCWP). A list of MCWP Providers can be found here: https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_MCWP_Provider_List.aspx
   Information for the Office of AIDS Medi-Cal Waiver Program is posted on this website:

https://www.cdph.ca.gov/Programs/CID/DOA/Pages/OA_care_mcwp.aspx
Through this waiver program, local agencies provide home and community based services as an alternative to nursing facility care or hospitalization. The agencies are under contract with the
California Department of Public Health
Office of AIDS
(916) 449-5900

2. Members who may qualify for services through the Home and Community Based Services Waiver for the Developmentally Disabled or the Self-Determination Program are referred to the Regional Center responsible for their geographic area as follows:
   a. Alta California Regional Center (provides services in Alpine, Colusa, El Dorado, Nevada, Placer, Sacramento, Sierra , Sutter, Yolo, and Yuba counties)

      4151 E. Commerce Way, Suite 100
      Sacramento, CA 95834
      (916) 978-6400

   b. Far Northern Regional Center (provides services in Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama and Trinity counties)

      Redding Office
      1900 Churn Creek Road, Suite 114
      Redding, CA 96002
      (530) 222-4791

      Chico Office
      1377 E. Lassen Avenue
      Chico, CA 95973
      (530) 895-8633

   c. Golden Gate Regional Center (provides services in Marin county)
      4000 Civic Center Drive, Suite 310
      San Rafael, CA 94903
      (415) 446-3000

   d. North Bay Regional Center (provides services in Solano, Napa, and Sonoma counties)

      Solano/ Napa
      610 Airpark Road
      Napa, CA 94558
      (707) 256-1100

      Sonoma
      520 Mendocino Avenue
      Santa Rosa, CA 95401
      (707) 569-2000

   e. Redwood Coast Regional Center (provides services in Del Norte, Humboldt, Lake, and Mendocino counties)

      Del Norte County
      1301-A Northcrest Drive
      Crescent City, CA 95531
      (707) 464-7488

      Humboldt County
      525 2nd Street, Suite 300
      Eureka, CA 95501
      (707) 445-0893

      Lake County
      180 3rd Street
      Clearlake, CA 95453
      (707) 262-0470

      14888 Olympic Drive
      Clearlake, CA 95422
      (707) 621-6169

      Mendocino County
      1116 Airport Park Blvd

      ~~270 Chestnut Street, Suite A~~ 121-A Boatyard Drive

Ukiah, CA 95482
(707) 462-3832

Fort Bragg, CA 95437
(707) 964-6387

f. Contact information for the State agency is as follows:
California Department of Developmental Services (DDS)
1215 O Street
Sacramento, CA 95814
Mailing Address:
P. O. Box 944202
Sacramento, CA 94244-2020
Info: (833) 421-0061
TTY: 711

3. The SDP Waiver serves as an alternative to the traditional, vendored Home and Community-Based Services for the Developmentally Disabled (HCBS-DD) waiver. It grants eligible consumers of California Regional Centers greater freedom, flexibility, and control over their individual service budgets. Members who qualify should refer to the Regional Center responsible for their geographic area as stated in VI.E.2. More information can be found on this page: https://www.dhcs.ca.gov/services/self-determination-program/

~~3.~~4. The Assisted Living Waiver (ALW) program is only offered in certain counties. Sonoma County is currently the only county in Partnership's covered service area that is participating in the ALW. A list of all participating facilities can be found at this webpage: https://www.dhcs.ca.gov/services/ltc/Pages/List-of-Approved-RCFE-ARF.aspx
Additional downloadable forms related to the ALW program can be found at this website: http://www.dhcs.ca.gov/services/ltc/Pages/Assisted-Living-Waiver-Provider-Resources.aspx

a. How to enroll: Medi-Cal Members do not submit applications. Medi-Cal Members are enrolled through Care Coordination Agencies, which are providers within the ALW program. Full scope Medi-Cal Members must contact a Care Coordination Agency, which determines each individual's care needs. Assessments are done by registered nurses employed by a Care Coordination Agency (CCA). A list of these agencies by county can be found on this webpage: https://www.dhcs.ca.gov/services/ltc/Pages/List-of-Approved-CCAs.aspx

b. Contact Information for State Program:
Department of Health Care Services
Long-Term Care Division, Monitoring & Oversight Section
Assisted Living Waiver Program
1501 Capitol Avenue, MS 4503
PO Box 997437
Sacramento, CA 95899-7437
ALW Hotline (916) 552-9322

~~4.~~5. The Home and Community-Based Alternatives (HCBA)Waiver (previously titled Nursing Facility/Acute Hospital Waiver) provides care management services at home to Medi-Cal beneficiaries with high level needs who would otherwise receive care in a facility. Some of the services that may be provided to support Waiver participants in the community include, but are not limited to: in-home nursing services, waiver personal care services, family/caregiver training, home or facility respite, habilitation services, community transition services, environmental accessibility adaptation, medical equipment operating expenses, personal Emergency Response System (PERS) installation, testing, and operation. (42 CFR §441.300-441.310.) Application information for the program can be found here: https://www.dhcs.ca.gov/services/ltc/Pages/Home-and-Community-Based-(HCB)-Alternatives-Waiver.aspx

~~5.~~6. Referrals for the Multipurpose Senior Services Program (MSSP) Waiver program are made by sending the Medi-Cal Member (who is 65 years or older) to a local MSSP site in the county where the Member resides. (Welfare and Institutions Code §9560 et seq.) MSSP site staff will make a certification determination based upon Medi-Cal criteria. A list of MSSP sites can be found here: https://www.aging.ca.gov/ProgramsProviders/MSSP/Contacts/

~~6.~~

VII. REFERENCES:

A. California Department of Health Care Services (DHCS) Contract: Exhibit A, Attachment III Subsections 4.3.15 *(Services for Persons with Developmental Disabilities)*, 4.3.20 (*Home and Community-Based Services Programs*), 4.4.2 E. (*Populations of Focus for Enhanced Care Management*)
B. Medi-Cal Provider Manual/Guidelines: Home and Community-Based Services (HCBS) *(home)*
C. Partnership Memoranda of Understandings (MOUs) with Regional Centers for specific geographical areas
D. DHCS APL 22-014 Electronic Visit Verification Implementation Requirements (07/21/2022)
E. Welfare & Institutions Code §4684-4699, 9560 et seq.
F. DHCS Home and Community-Based Services Waiver Program Overview (2024)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 11/28/12; 01/20/16; 11/16/16; *06/13/18; 02/13/19; 02/12/20; 01/13/21; 01/12/22; 01/11/23; 01/10/24; 01/08/25; 01/14/26; 01/13/27

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

PREVIOUSLY APPLIED TO: N/A

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

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

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

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

Policy/Procedure Number: MCUP3106		**Lead Department: Health Services**
Policy/Procedure Title: Waiver Programs		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/21/2010	**Next Review Date: 01/14/202701/13/2028** **Last Review Date: 01/14/202601/13/2027**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPUP3144 (previously MCUP3144, MCCP2028)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Residential Substance Use Disorder Treatment Authorization			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 11/13/2019 (MCCP2028) Effective Date: 07/01/2020 (MCCP2028) **Program End Date**: 12/31/2026		**Next Review Date:** ~~06/10/2027~~01/13/2028 **Last Review Date:** ~~06/10/2026~~01/13/2027		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐~~☒~~ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~06/10/2026~~01/13/2027	

I. RELATED POLICIES:

A. MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
B. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
C. MPUD3001 – Utilization Management Program Description
D. CGA024 – Medi-Cal Member Grievance System
E. MPQP1016 – Potential Quality Issue Investigation and Resolution
F. MCUP3113 – Telehealth Services
G. CMP41 – Wellness and Recovery Records

II. IMPACTED DEPTS:

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

III. DEFINITIONS

A. American Society of Addiction Medicine (ASAM) Criteria - As defined in the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Intergovernmental Agreement, pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient. Currently using ASAM Criteria 3rd Edition.
B. Discharge – The process to prepare the program beneficiary for referral into another level of care, post treatment return or re-entry into the community, and/or the linkage of the individual to essential community treatment, housing, and human services.
C. Behavioral Health Clinical Director – The Partnership HealthPlan of California (Partnership) Behavioral Health Clinical Director is a Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), clinical Doctor of Philosophy (PhD), or Doctor of Psychology (PsyD) who is actively involved in the behavioral health aspects of Partnership activities. This Director provides clinical oversight of Partnership's behavioral health activities including substance use services and the activities of Partnership's delegated organization for the administration of certain mental health services. The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for substance use disorder treatment related services.

D. Licensed Practitioner of the Healing Arts (LPHA): Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacist, Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians.

E. Medical Necessity – Medical Necessity means those treatment services that are reasonable and necessary to protect life, prevent significant illness or significant disability, or alleviate severe pain through the diagnosis or treatment of disease, illness or injury consistent with Title 42 Code of Federal Regulations (CFR) 438.210 (a) (4).

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

G. Non-Urgent Request – A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the Member or the Member's ability to regain maximum function and would not subject the Member to severe pain.

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

~~I.~~H. Program Beneficiary – Prior to January 1, 2027, a~~A~~ person who: (1) has been determined eligible for full scope Medi-Cal; (2) is not institutionalized; (3) meets criteria for authorization as described in section VI. A. below; (4) meets the admission criteria to receive Drug Medi-Cal (DMC) covered services; and (5) resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano County.

~~J.~~I. Residential Treatment – As defined for Drug Medi-Cal (DMC) purposes, Residential Treatment means a non-institutional, 24-hour non-medical, short-term residential program of any size that provides rehabilitation services to beneficiaries. Each program beneficiary shall live on the premises and shall be supported in their efforts to restore, maintain, and apply interpersonal and independent living skills and access community support systems. Programs shall provide a range of activities and services. Residential treatment shall include 24-hour structure with available trained personnel, seven days a week, including a minimum of five hours of clinical service a week to prepare beneficiary for outpatient treatment.

~~K.~~J. Urgent Request – A request for medical care or services where application of the timeframe for making routine or non-life threatening care determinations:

1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, or
2. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

Effective January 1, 2027, Partnership HealthPlan of California no longer administers the Wellness & Recovery benefit on behalf of Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano Counties

and ~~will~~does not cover or authorize the services described in this policy after December 31, 2026. This policy will remain ~~posted~~available during the claims runout period for reference and processing of services authorize prior to January 1, ~~in~~ 2027.

The purpose of this policy is to describe the procedures used by Partnership HealthPlan of California (Partnership) to process Treatment Authorization Requests (TARs) for residential substance use disorder treatment services. Individuals seeking residential substance use disorder treatment services on or after January 1, 2027 should contact their county behavioral health plan or Drug Medi-Cal Organized Delivery System (DMS-ODS) program for information regarding eligibility, authorization, and ongoing services.

VI. POLICY / PROCEDURE:

A. Criteria for Authorization of Residential Treatment Services for Substance Use Disorders (SUD)

1. Prior to January 1, 2027, Partnership HealthPlan of California (Partnership) authorizeds residential treatment services for substance use disorders according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements specified in Title 22, Section 51303 and the coverage provisions of the approved State Medi-Cal Plan for Medi-Cal eligible beneficiaries as described below:
   a. Adults (Age 21 or older)
      1) Must have at least one diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM) for Substance-Related and Addictive Disorders (with the exception of Tobacco Related Disorders and Non-Substance Related Disorders).
      2) Must meet the ASAM criteria definition of medical necessity for services based on the ASAM Criteria, 3rd Edition. An LPHA at the residential facility (provider) will assess the Medi-Cal eligible beneficiary using a multi-dimensional assessment based on the ASAM criteria. A summary of the assessment findings must be submitted with the Treatment Authorization Request (TAR) to Partnership.
   b. Adolescents up to the twenty-first [21st] birthday)
      1) These Medi-Cal eligible beneficiaries are also eligible to receive Medicaid services under the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) program. Under the EPSDT mandate, they are eligible to receive all appropriate and medically necessary services needed to correct and ameliorate health conditions that are coverable under section 1905(a) Medicaid authority.
      2) Must meet the ASAM criteria definition of medical necessity for services based on the ASAM adolescent criteria. An LPHA at the residential facility (provider) will assess the Medi-Cal eligible beneficiary using a multi-dimensional assessment based on the ASAM adolescent criteria. A summary of the assessment findings must be submitted with the TAR to Partnership.
   ~~c. Program beneficiaries (as defined in III.I.) who are also Partnership Advantage Members (as defined in III.H), are eligible for residential SUD treatment under their Medi-Cal benefit as described in this policy.~~
2. Partnership utilizes InterQual® Behavioral Health Criteria to ensure that the services are medically necessary and provided in sufficient amount, duration, or scope to reasonably achieve the purpose for which the services are furnished.
3. Partnership shall not arbitrarily deny or reduce the amount, duration, or scope of a medically necessary service solely because of the diagnosis, type of illness, or condition of the beneficiary. This does not exclude use of industry standard utilization management practices.

B. Initial Authorization Process Overview

1. When the Medi-Cal eligible beneficiary~~)~~ presents to the residential substance use disorder treatment facility (provider), an LPHA will conduct an assessment to determine if the Medi-Cal eligible beneficiary meets medical necessity criteria for admission.
2. Within one business day of the intake, the residential provider shall submit a TAR with a summary

of the assessment findings and a treatment plan to the Partnership Health Services Department for review.

a. TAR determinations cannot be made by Partnership until all required documents and information are received.
b. TARs should be submitted electronically via Partnership's Online Services portal as electronic submission will allow for more expedient processing. If online submission is not possible, the TAR may be submitted via fax number (707) 863-4118 to Partnership's Health Services Department for review.

3. Partnership's Utilization Management (UM) staff reviews the documentation submitted with the TAR using the non-urgent preservice review time frame and notifies the provider of the determination within 7 calendar days of receipt of the request.
   a. Partnership's UM staff includes nurse coordinators who are Registered Nurses (RNs) with specialized ASAM training who can approve and defer (pend) the TAR, or deny the TAR for administrative reasons (e.g. TAR not required, duplicate request, or invalid code). Any decision requiring medical necessity determination will be referred to a Physician as per 3.b. below. The nurse coordinator reviews the information received from the residential treatment provider utilizing the approved review guidelines as described in section VI.A. above.
   b. Requests that do not meet review guidelines are referred to the Behavioral Health Clinical Director (described in section III.C. above) or Physician Designee for further evaluation. When a TAR requires clinician review, the nurse coordinator attaches all relevant documentation, InterQual criteria and the Medical Director Worksheet.
   c. Notification of approved TARs will be provided to the provider at the time of decision, but no later than 24 hours from the date of decision.
4. A TAR submission may be initially approved from date of intake up to 30 days for adults and up to 15 days for adolescents.

C. Continued Stay/Reauthorization Process
   1. For services prior to January 1, 2027, Partnership ~~will~~ reviewed the program beneficiary's progress periodically throughout their length of stay as appropriate.
   2. The provider submits a summary of the updated assessment findings, an updated treatment plan and a TAR or discharge plan to Partnership no later than five business days prior to the expiration of the previous authorization.
      a. Continued stay residential SUD treatment authorizations do not meet the definition of "urgent care." These requests are classified as non-urgent preservice review, and Partnership will review and notify the provider of the determination (approved, modified, deferred/pended, or denied) within 7 calendar days of receipt of the request.
   2. Adults (Age 21 or older)
      a. The duration of stay in a residential treatment center is not expected to exceed 90 days. Any length of stay beyond 90 days requires prior approval from Partnership.
      b. After completing 90 days of treatment, Partnership may approve extensions of the stay based upon medical necessity and the treatment plan.
   3. Adolescents up to the twenty-first [21st] birthday)
      a. Adolescent beneficiaries receiving residential treatment shall be stabilized as soon as possible and moved down to a less intensive level of treatment.
      b. EPSDT beneficiaries may receive a longer length of stay based on medical necessity.
   4. Pregnant/Post-Partum Beneficiaries
      a. Pregnant beneficiaries may receive residential treatment services during pregnancy and up to 60 days during the post-partum period (which begins on the last day of pregnancy). Extension beyond 60 days will require prior approval from Partnership and must be to a non-perinatal level of care.
      b. Providers will be required to provide proof of pregnancy or delivery date with each new TAR

submitted to Partnership.

D. Notification of Denials/Modifications/Appeals Process
   1. Only the Behavioral Health Clinical Director or Physician Designee can deny for reasons of medical necessity.
   2. For any decision to deny a TAR or to authorize a service in an amount, duration, or scope that is less than requested, electronic or written notification of the decision and how to initiate an appeal, if applicable, is communicated to the provider within 24 hours of the decision and written notification is mailed to the Medi-Cal eligible beneficiary within two (2) business days of the decision. Please refer to policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions for further information on the appeals process.

E. Behavioral Health Clinical Director Residential SUD TAR Reviews
   1. The Behavioral Health Clinical Director may be consulted by UM nurses to review any case for which their expertise may be necessary, as determined by UM nurses upon review of case materials from provider.
   2. The Behavioral Health Clinical Director will review for medical necessity any request for residential SUD treatment episode exceeding 3 episodes in the prior 365 days.
   3. The Behavioral Health Clinical Director will review for medical necessity any request for extension of residential SUD treatment exceeding 90 contiguous days (adults), or 45 days (adolescents).

VII. REFERENCES:

A. County Behavioral Health and Drug Medi-Cal Organized Delivery System (DMC-ODS) Contacts
~~A.~~B. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
~~B.~~C. Drug Medi-Cal Organized Delivery System (DMC-ODS) webpage
~~C.~~D. Title 42 Code of Federal Regulations (CFR) Section 438.210 (a)(4)
~~D.~~E. Title 22 California Code of Regulations (CCR) Sections 51303 and 51340.1
~~E.~~F. Department of Health Care Services (DHCS) Behavioral Health Information Notice (BHIN) No: 21-021 Drug Medi-Cal Organized Delivery System – Updated Policy on Residential Treatment Limitations (May 14, 2021)
~~F.~~G. InterQual® Behavioral Health Criteria
~~G.~~H. National Committee for Quality Assurance (NCQA) Guidelines UM 1 Program Structure Element A, UM 2 Clinical Criteria for UM Decisions Element A and UM 4 Appropriate Professionals Element A
~~H.~~I. DHCS All Plan Letter (APL) 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2021)
~~I.~~J. DHCS "CalAIM Dual Eligible Special Needs Plan (D-SNP) Policy Guide - Contract Year 2026" (Re-release date February 2026) https://www.dhcs.ca.gov/provgovpart/Documents/DHCS-CalAIM-D-SNP-Policy-Guide.pdf

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Behavioral Health Clinical Director

X. REVISION DATES:

MPUP3144 (06/11/2025)

06/11/25; 06/10/26; 01/13/27

PREVIOUSLY APPLIED TO:
Medi-Cal MCUP3144 (05/11/2022 – 06/10/2025):
05/11/22; 06/14/23; 06/12/24

MCCP2028 (11/13/2019 – 05/10/2022)
04/08/20; 04/14/21; 09/08/21

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- 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="3">Policy/Procedure Number: MPTP2501 (previously MCCP2016)</td><td colspan="4">Lead Department: Transportation</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)</td><td colspan="4">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 10/21/2015 (MCCP2016)</td><td colspan="4">Next Review Date: ~~01/14/2027~~01/13/2028
Last Review Date: ~~01/14/2026~~01/13/2027</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="3">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="3">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~01/14/2026~~01/13/2027</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MPTP2503 – Transportation-Related Travel Expenses: Lodging, Meals, Attendants, Parking and Tolls
C. MCCP2022 – Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
D. MCCP2024 – Whole Child Model for California Children's Services (CCS)
E. MCUG3118 – Prenatal & Perinatal Care
F. CMP09 – Investigating & Reporting Fraud, Waste and Abuse
G. CMP26 –Verification of Caller Identity and Release of Information
H. CGA024 – Medi-Cal Member Grievance System
I. CMP36 – Delegation Oversight and Monitoring
J. MPCR20 – Medi-Cal Managed Care Plan Provider Screening and Enrollment
K. MPAP7005 – Street Medicine

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Grievance & Appeals
E. Finance
F. Provider Relations

III. DEFINITIONS:

A. NEMT: Non-Emergency Medical Transportation
B. Door-to-Door Service: Member is picked up from the entrance of their pick-up location, receives assistance loading in and out of the vehicle, and is dropped off at the appropriate entrance of the designated drop off location.
C. Door-through-Door Service: Member is provided assistance inside the pick-up location, receives assistance loading in and out of the vehicle, and is dropped off inside the designated drop off location.
D. NMT: Non-Medical Transportation
E. PCS: Provider Certification Statement prescribing the level of transportation necessary based upon the functional and medical limitations of the Member. (See Attachment A)
F. Provider: Any individual or entity that is engaged in the delivery of services, or ordering or referring for those services, and is licensed or certified to do so.
G. Transportation ~~provider~~Provider: The entity that will ~~actually~~ be transporting the Member.
H. Private Vehicle: Any motor vehicle, other than a motor truck, truck tractor, or a bus, and used or maintained for the transportation of persons (Defined by VEH Section 465)

I. California Driving Requirements: Defined by California Vehicle Code (VEH Section 12500, 4000, and 16020)

J. Round Trip: Transport from the Member's county of record, as noted in State files, to the scheduled appointment address and back.

K. Short Notice Request: Any request for transport ~~not allowing five calendar day notice.~~with five (5) or less calendar days' notice.

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

IV. ATTACHMENTS:

A. Provider Certification Statement (PCS) form

V. PURPOSE:

To outline the circumstances and utilization controls by which Partnership HealthPlan of California (Partnership) will pay for and/or facilitate Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services to Members in accordance with state and federal regulations as cited.

VI. POLICY / PROCEDURE:

A. GENERAL TRANSPORTATION PROGRAM RULES

1. Non Partnership Members are not eligible for transportation services.
   a. ~~Exceptions will be made for those eligible to receive services through the Wellness and Recovery benefit.~~
2. Authorization shall be granted and/or Medi-Cal reimbursement shall be approved only for the lowest cost type of transportation that is adequate for the Member's medical needs~~,~~ and is available at the time transport is required.
3. Transportation shall be authorized only to the nearest facility capable of meeting the Member's medical needs.
   a. Consideration will be made to ensure access to care within Department of Health Care Services (DHCS) approved time and distance standards
4. Transportation will be provided for all Medi-Cal services, including those not covered by Partnership.
   a. Transport is not covered if the ~~care to be obtained~~service is not a Medi-Cal benefit.
   b. Transportation between a Member's home and an Adult Day Health Care (ADHC) center is included in the per diem reimbursement rate paid to an ADHC center and is not separately reimbursable.
   c. Transportation to obtain medically necessary services for major organ transplants is covered for transplant recipient Members as well as living donors and medically necessary attendants.
      1) Living donors requesting NEMT services are not required to have a PCS on file, nor is a PCS required to approve the NEMT service.
   d. Transportation to ~~pick up~~pick up ~~drug prescriptions~~ prescription medications that cannot be mailed directly to the Member is covered.
   e. Transportation is covered for Members picking up medical supplies, prosthetics, orthotics, and other equipment when said supplies and/or equipment is covered by Medi-Cal.

~~g.~~f. Transportation is covered to all Medi-Cal covered street medicine providers including those serving as Primary Care Providers (PCPs).
   1) Members using a street medicine provider as a ~~Primary Care Provider~~ PCP will still be provided transport to a traditional ~~Primary Care Provider~~ PCP if requested, provided the request meets all other applicable criteria.

~~h.~~g. Discharge from an inpatient ~~stay~~ admission at a hospital, long-term care, or any other Medi-Cal covered institutional setting to the Member's residence is covered.
   1) Requests for transport services of this nature must be made by the discharging or receiving facility.
   2) Transport to an alternate location can also be provided if permission from the alternate location has been granted and the alternate location is within the Member's county of ~~residence~~record.
   3) Requests for transport outside the Member's county of ~~residence~~ record will be reviewed on a ~~case by case~~ case-by-case basis.

5. All requests for transportation services made to Partnership must be submitted five (5) calendar days prior to the date of service.
   a. Partnership will review short notice requests on a ~~case by case~~case-by-case basis based on the following criteria:
      1) If the appointment is life threatening/sustaining, Partnership will attempt to secure transportation.
      2) If the appointment is not life threatening/sustaining, has been scheduled with the provider, but the Member waited to request transportation and did not ~~allow~~ provide ~~five~~ 5 calendar days, the request ~~will~~ can be denied.
      3) If the appointment was scheduled by the provider within 5 calendar days, Partnership will attempt to secure transportation.
   b. Exceptions for gas mileage reimbursement (GMR)
      1) Non-advance funds GMR requests will be accepted regardless of days' notice.
      2) Advance funds GMR requests must be made two (2) ~~business days~~calendar days in advance. If the request is made with less than two (2) business days' notice, regular GMR can be requested.
      3) Retroactive requests will not be accepted.
6. All approved transports will be scheduled to ensure the Member is dropped off within fifteen (15) minutes of their scheduled appointment and Members will be informed of their pick-up/drop-off time when the transport is scheduled.
   a. If the ~~transportation provider~~Transportation Provider does not arrive at the pick-up location in time to ensure the Member arrives at their appointment within 15 minutes of the scheduled appointment time, the Member can call Partnership and transport with an alternate ~~transportation provider~~Transportation Provider will be approved.
7. If an approved transport experiences any disruption due to the assigned Transportation Provider arriving late or failing to arrive, Partnership will provide urgent authorization for a replacement ride to be scheduled.
8. With the written consent of a parent or guardian, a minor between the ages of 12-18 may receive transportation unaccompanied ~~as long as~~ if Partnership and the ~~transportation provider~~Transportation Provider accepts the necessary written consent forms and agrees to provide unaccompanied transport. Certain appointments will not require written consent or parent/legal guardian permission to travel unaccompanied as described below:
   a. All Members under age ~~21~~eighteen (18)
      1) Pregnancy and pregnancy-related services
      2) Family planning services
      3) Sexual assault services

b. All Members at least age 12 and under age ~~21~~18
   1) Sexually transmitted diseases treatment
   2) Drug and alcohol abuse treatment and counseling
   3) Outpatient mental health treatment and counseling

9. All requests for transportation to medical appointments are subject to appointment verification by Partnership.
10. Transportation for Partnership covered services to Out of Network (OON) providers will be provided with prior authorization and if all other utilization control requirements are met.
11. Transportation for Medi-Cal covered services, carved out of Partnership's responsibility, will be provided and are not subject to Partnership's utilization controls or time and distances standards related to reviewing requests for medical services. Transportation requests to carved out services will only be reviewed in accordance with the rules and regulations listed in this policy.
12. Partnership will store Transportation Provider information, including the name of the driver based on service date, time, pick-up/drop-off location, and Member name. If a Partnership Member files a grievance, this information will be made available to them.

B. NON-EMERGENCY MEDICAL TRANSPORTATION (NEMT)

Ambulance, litter van and wheelchair van medical transportation services are covered when the Member's medical and physical condition is such that transportation by ordinary means of public or private conveyance is medical contraindicated, and transportation is required for the purpose of obtaining needed medical care.

1. Transportation Providers are required to provide door-to-door or door-through-door service for all authorized NEMT services.
2. NEMT ~~PRIOR AUTHORIZATION REQUIREMENTS~~Prior Authorization Requirements:
   a. Both a Treatment Authorization Request (TAR) and Partnership's DHCS approved Provider Certification Statement (PCS) (~~see~~ Attachment A) are required for all NEMT services that have an identified TAR requirement ~~in order~~ to be processed. All TARs received without a PCS are subject to Partnership's standard Utilization Management (UM) TAR review process as outlined in policy MCUP3041 Treatment Authorization Request (TAR) Review Process. Once submitted to Partnership, prescribed NEMT services and the corresponding PCS cannot be changed or altered.
   ~~policy MCUP3041 Treatment Authorization Request (TAR) Review Process. Once submitted to Partnership, prescribed NEMT services and the corresponding PCS form cannot be changed or altered.~~
      1) In urgent situations, when a PCS form cannot reasonably be obtained prior to the requested NEMT service, Partnership can authorize one-time NEMT and accept the PCS post-service. This authorization can be made via phone; however, the service still requires a ~~Treatment Authorization Request (~~TAR~~)~~ to be submitted by the Medi-Cal Certified NEMT Provider once a valid PCS can be obtained.
      2) A copy of the PCS ~~form~~ will remain on file for all Members receiving NEMT services.
      3) If needed, Partnership can provide a copy of the PCS to the Medi-Cal Certified NEMT Provider via fax or encrypted email.
   b. Providers and Members can call Partnership ~~or any Medi-Cal Certified NEMT Provider directly~~ to request NEMT services. Providers and Members can also call Partnership or the scheduled Medi-Cal Certified NEMT provider to receive status updates on NEMT rides.
   c. Only Partnership's DHCS approved PCS form ~~(Attachment A)~~ will be accepted and must include, at a minimum, the components listed below. All fields must be completed by the provider.
      1) Function Limitations Justification: ~~For NEMT, the~~ The provider is required to document the Member's limitations and provide specific physical and medical limitations that preclude the Member's ability to reasonably ambulate without assistance or be transported by public or

private vehicles.

1) Dates of Service Needed: Provide start and end dates for NEMT services; authorizations may be for a maximum of 12 months.
2) Modality of Transportation Needed: List the modality of transportation that is to be used when receiving these services (ambulance/gurney van, litter van, wheelchair van or air transport).
    a) The modality of NEMT provided will match the modality prescribed on the PCS. Partnership will not downgrade the modality. If multiple modalities are selected on the PCS, the modality provided will be the lowest cost modality.
3) Certification Statement: Provider's statement certifying that medical necessity was used to determine the type of transportation being requested.

d. Providers who can authorize NEMT are physicians, podiatrists, dentists, physician assistants, nurse practitioners, certified nurse midwives, licensed midwives, physical therapists, speech therapists, occupational therapists, optometrists, mental health providers, substance use disorder providers or chiropractors.
    1) Authorization must be made by a licensed practitioner consistent with their scope of practice.
e. NEMT services are exempt from ~~prior authorization~~ requiring more than 5 calendar days' notice when provided to a Member being transferred from an emergency room to an inpatient setting, or from an acute care hospital, immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility or imbedded psychiatric units, free-standing psychiatric inpatient hospitals, psychiatric health facilities, or any other appropriate inpatient acute psychiatric facilities.
f. NEMT services from an acute care hospital immediately following an inpatient stay at the acute level of care, to a skilled nursing facility, an intermediate care facility, an imbedded psychiatric unit, a free standing psychiatric inpatient hospital, a psychiatric health facility, or any other appropriate inpatient acute psychiatric facility requested to Partnership by a provider, will be provided within three (3) hours of the request. If NEMT services are not provided within the three-hour timeframe, the discharging facility may arrange transport, and ~~the~~ Partnership must cover, out-of-network NEMT services.
    1) Services arranged by the acute care hospital are payable at no more than the Medi-Cal rate for the corresponding service. If the accepting ~~transportation provider~~Transportation Provider is contracted with Partnership, payment will be made at the rate identified in their contract.

3. NEMT ~~OPTIONS~~Options
    a. AMBULANCE services are covered when the Member's medical condition contraindicates the use of other forms of medical transportation. This service may be used for:
        1) Transfers between facilities for Members who require continuous intravenous medication, medical monitoring or observation.
        2) Transfers from an acute care facility to another acute care facility.
        3) Transport for Members who have recently been placed on oxygen (not chronic emphysema recipients who carry their own oxygen for continuous use).
        4) Transport for Members with chronic conditions who require oxygen if monitoring is required.
    b. LITTER VAN ~~service may be used~~services are covered when the Member's medical and physical condition does not meet the need for NEMT ambulance services, but meets both of the following:
        1) Requires that the Member be transported in a prone or supine position, because the Member is incapable of sitting for the period of time needed to transport.
        2) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.

c. WHEELCHAIR VAN ~~service may be used~~services are covered when the Member's medical and physical condition does not meet the need for litter van services, but meets any of the following:
   1) Renders the Member incapable of sitting in a private vehicle, taxi or other form of public transportation for the period of time needed to transport.
   2) Requires that the Member be transported in a wheelchair or assisted to and from a residence, vehicle and place of treatment because of a disabling physical or mental limitation.
   3) Requires specialized safety equipment over and above that normally available in passenger cars, taxicabs or other forms of public conveyance.
   4) Members with the following conditions may qualify for wheelchair van transport when their providers submit a signed Physician Certification Statement (PCS) form:
      a) Members who suffer from severe mental confusion
      b) Members with paraplegia
      c) Dialysis recipients
      d) Members with chronic conditions who require oxygen but do not require monitoring

d. AIR TRANSPORT for NEMT ~~will be provided~~is covered only when transportation by air is necessary because of the Member's medical condition or because practical considerations render ground transportation not feasible. The necessity for transportation by air shall be substantiated in a written order of a physician, dentist, podiatrist, or a mental health or substance use disorder provider.

C. NON-MEDICAL TRANSPORTATION (NMT)

NMT does not include transportation of the sick, injured, invalid, convalescent, infirm, or otherwise incapacitated Members who need to be transported by ambulances, litter vans, or wheelchair vans licensed, operated, and equipped in accordance with state and local statutes, ordinances, or regulations. Physicians may authorize NMT for Members if they are currently using a wheelchair but the limitation is such that the Member is able to ambulate without assistance from the driver. Please refer to the Medi-Cal Member Handbook for further details.

1. ~~SERVICE CONDITIONS FOR NON-MEDICAL TRANSPORTATION SERVICES~~Service Conditions for NMT Services:
   a. NMT coverage includes transportation costs for the Member and one attendant such as a parent, guardian, or spouse able to accompany the Member in a vehicle or on public transportation, which is subject to review and prior authorization at the time of the initial NMT authorization request.
      1) The level of transportation accommodation needed will be based upon the limitations of the Member being transported. Any attendants must be able to safely accompany the Member and not require additional assistance.
   b. The Member cannot be the driver for ~~NMT~~Gas Mileage Reimbursement (GMR), unless the Member is eligible to California Children's Services (CCS) and legally allowed to drive.
   c. NMT does not cover trips to a non-medical location or for appointments that are not medically necessary.
   d. Transportation to an emergency room or from an emergency room to home or other housing resource is not included in the benefit.
   e. NMT services include roundtrip transportation for a Member by passenger car, taxi cab, or any other form of public or private conveyance (private vehicle), including by ferry, as well as mileage reimbursement when conveyance is in a private vehicle arranged by the Member and not through a transportation broker, bus passes, taxi vouchers or train tickets.
      1) Round Trip Transportation is defined as transport from the Member's county of record, as noted in State files, to the scheduled appointment address and back.
      2) Limited exceptions may apply if the Member is homeless.

f. All Partnership Members requesting NMT will receive an assessment to determine eligibility to NMT and the most appropriate mode of transport for the Member.
   1) The Member/Member's guardian must attest, either in person, electronically, or over the phone, that other transportation resources have been reasonably exhausted and they have no other way to get to their medical appointment. The attestation is required at each request.
   2) Exceptions to the use of public transportation will be made as follows:
      a) Member's residence and the appointment site are over three-quarters (3/4) of a mile from a bus line.
      b) Member is under the age of sixteen (16) if traveling alone.
      c) Member is 16 years of age or older and is traveling with more than two (2) children under the age of five (5).
         i. Subject to criteria for additional passengers as stated in section VI.C.1.h. below.
      d) Member is in the third trimester of pregnancy and/or Member has a ~~high risk~~high-risk pregnancy.
      e) Bus line is not operational on day and/or time of appointment.
      f) Bus route requires more ~~than two (2)~~2 transfers and/or the duration of transport via bus will be over ~~two (2)~~ 2hours.
      g) Member is undergoing chemotherapy, radiation or dialysis.
      h) Member is a transplant patient.
      i) Member is age seventy (70) or older.
      j) Any other exception for public transportation will need to be medically justified by the PCP or servicing provider.

g. Additional passenger rules:
   1) Members under the age of twenty-one (21) are allowed ~~two (2)~~ 2 additional passengers if the passengers are parents or legal guardians to the Member.
      a) If the parent or legal guardian is a single caregiver, transport can be provided for additional minor children under the care of the parent or legal guardian. The number of additional passengers allowed is based on the ~~transportation provider's~~Transportation Provider's standard vehicle capacity.
   2) All other Members are allowed one (1) additional passenger
      a) If the Member is a single caregiver, transport can be provided for additional minor children under the care of the Member. The number of additional passengers allowed is based on the transportation provider's standard vehicle capacity.

h. NMT services will be provided in a form and manner that is accessible, in terms of physical and geographic accessibility, for the Member and consistent with applicable state and federal disability rights laws.

2. ~~PARENT/LEGAL GUARDIAN ONLY NMT~~Parent/Legal Guardian Only NMT:
   a. In emergent situations when a Member under the age of 21 is transferred to a facility via emergency medical transport, Partnership will authorize parent/guardian only transport services on a case-by-case basis.
      1) If the request is for gas mileage reimbursement (GMR), Members and their guardians have 30 days from the date of service to request this type of reimbursement.
   b. For Members under the age of 21, Partnership may authorize parent/guardian-only transport on a case-by-case basis upon hospital discharge from an inpatient setting if the medically necessary transport provided for the Member cannot also provide transport for one parent or guardian.
      1) If the request is for GMR, Members and/or their guardians have 30 days from the date of service to request this type of reimbursement.

c. Further parent or guardian-only transports for Members under the age of 21 will be reviewed on a case-by-case basis and in compliance with provisions described under Partnership policy and procedure MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.

3. NMT ~~PRIVATE VEHICLE AUTHORIZATION REQUIREMENTS~~ Private Vehicle Authorization Requirements:
   a. GMR requires prior authorization Partnership.
      1) Non-advance funds GMR requests will be accepted regardless of days' notice.
      2) ~~Advance funds GMR requests must be made 48 hours in advance. If the request is made with less than 48 hours' notice, regular GMR can be requested.~~Advance funds GMR requests must be made at least two (2) calendar days in advance. If the request is made with less than 2 days' notice, regular GMR can be requested.
      3) Retroactive requests will not be accepted.
   b. In order to receive GMR for use of a private vehicle, the driver must be compliant with all California driving requirements, which include the following:
      1) Valid driver's license
      2) Valid vehicle registration
      3) Valid vehicle insurance
   c. Partnership will only reimburse the driver.
   d. ~~Members may not receive reimbursement for driving themselves, unless the Member is eligible to CCS and legally allowed to drive.~~The Member cannot be the driver for GMR, unless the Member is eligible to California Children's Services (CCS) and legally allowed to drive.
   e. Mileage reimbursement rate~~s~~ for gas is consistent with the Internal Revenue Service (IRS) standard mileage rate for medical transportation when conveyance is in a private vehicle arranged by the Member.
   f. The form of reimbursement offered is decided by Partnership and may be in the form of cash, check, gas cards, or other forms of prepaid cards.
   g. In order for Partnership to issue payment for GMR requests, the Member or Member's parent/legal guardian must provide the following:
      1) Credentials verifying the driver/payee is in compliance with all California driving requirements as listed above in section VI.C.3.b.
      2) Attendance verification issued by the treating provider on facility letterhead or via the facility's online member portal or mobile application.
   h. Partnership will allow the Member ninety (90) calendar days from the date of service to submit all required credentials.

4. ~~SUBMITTING NMT TRANSPORTATION REQUESTS~~Submitting NMT Transportation Requests
   a. Requests for transportation can be made by the Member, the Member's authorized representative (AR), or the Member's provider by calling Partnership. Partnership will assess the eligibility and the modes of transportation available within the Member's county of record.
      1) Pursuant to DHCS APL 24-002, American Indian Members may elect to receive NMT from Indian Health Services also known as tribal health programs in lieu of those services offered by Partnership.~~.~~

D. CALIFORNIA CHILDREN'S SERVICES (CCS)/WHOLE CHILD MODEL (WCM)

1. For a CCS/WCM eligible Member who is currently hospitalized due to the CCS eligible condition:
   a. Partnership may authorize up to two (2) round trips per Member hospitalization if the hospital stay is projected to be less than seven (7) days in duration based on InterQual® criteria.
   b. If a hospital stay extends beyond seven days, then Partnership may authorize one (1) additional round trip for every ~~seven~~ 7 calendar days of hospitalization
   c. This assistance is not intended to sustain a parent or guardian at a hospital for the Member's entire stay or to pay for the parent or guardian's frequent trips to visit a child while hospitalized. Post discharge if the client's discharge plan documents the need for daily medical visits for treatment of the CCS-eligible condition, and the distance precludes making the trip to the hospital in one twelve-hour day, lodging and meals may be authorized for the Member and parent or guardian.
2. For a CCS/WCM eligible Member and/or the Member's parents(s)/legal guardian(s) choosing to go to a facility/provider that is not the closest CCS approved facility/paneled provider, the transportation costs beyond those to reach the closest provider capable of delivering the level/type of service required by the Member's CCS-eligible condition are the responsibility of the Member and/or parent(s)/legal guardian(s).
3. Transportation may be a benefit for CCS authorized medical care provided outside California. Consultation must be sought from the State Regional Office consultant staff before out-of-state services are authorized.
4. For CCS eligible children, Transportation to a Medical Therapy Unit (MTU) for physical or occupational therapy or to attend a Medical Therapy Conference may be considered if a transportation need has been identified jointly by the family and the MTU treating therapist as necessary for the Member's access to therapy services when transportation is not included in the child's Individualized Education Plan (IEP).
5. CCS eligible ~~children~~ members that are legally allowed to drive are eligible to receive gas mileage reimbursement (GMR) and can be reimbursed directly by Partnership.

E. NEMT/NMT SERVICES FOR MEMBERS TRANSITIONING TO/FROM ANOTHER MANAGED CARE PLAN (MCP)

1. For Members transitioning to Partnership from another Managed Care Plan (MCP) or from Partnership to another MCP, Partnership will work with the previous/new MCP to support continuation of NEMT/NMT services for transitioning Members by:
   a. The previous MCP will provide authorization ~~data~~ data, or Partnership will provide authorization data as outlined in section VI.G. or the 2024 Medi-Cal Managed Care Plan Transition Policy Guide.
   b. The previous MCP or Partnership will transmit all NEMT/NMT schedule data and Physician Certification Statement (PCS) forms to Partnership or new MCP prior to the effective date and on the agreed upon schedule.

~~2.~~ If a network provider is not available to provide the transitioning Member's scheduled NEMT/NMT service, then Partnership will make a good faith effort to allow the transitioning Member to keep the scheduled transportation services with an Out-of-Network (OON) NEMT/NMT provider.

F. SCREENING & ENROLLMENT

1. Partnership follows the criteria described in policy MPCR20 Medi-Cal Managed Care Plan Provider Screening and Enrollment, for the screening and enrollment of Transportation Providers.

G. REGULATORY REQUIREMENT

Partnership captures and submits data from the Provider Certification Statement (PCS) form to DHCS as instructed and is obligated to meet the contractually required timely access standards.

VII. REFERENCES:

A. California Code of Regulations (CCR) Title 22 Section 51323
B. DHCS APL 22-008 Non-Emergency Medical and Non-Medical Transportation Services and Related Travel Expenses (05/18/2022)
C. DHCS Transportation Workgroup Frequently Asked Questions (FAQs) re: APL22-008 (05/18/2022)
D. DHCS Numbered Letter (N.L.): 03-0810 Maintenance and Transportation for CCS Clients to Support Access to CCS Authorized Medical Services (8/19/2010)
E. DHCS APL 24-002 Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (02/08/2024)
F. Medi-Cal Provider Manual/Guidelines: Medical Transportation – Ground *(mc tran gnd)* and Air *(mc tran air)*
G. Welfare and Institutions Code (WIC) Section 14132
H. California Health and Safety Code Section 1250
I. DHCS APL 21-015 Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (10/18/2021) Attachment 2 Major Organ Transplant Requirements (*Revised* 10/14/2022)
J. DHCS APL 22-013 Provider Credentialing / Recredentialing and Screening / Enrollment (07/19/2022 and *Revised for FAQs 08/24/2022*)
K. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (08/31/2021)
L. DHCS APL 22-023 Street Medicine Provider: Definitions and Participation in Managed Care (11/08/2022)
M. DHCS 2024 Medi-Cal Managed Care Plan Transition Policy Guide (11/07/2023)

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: 01/20/16; 08/16/17; *11/14/18; 02/12/20; 08/12/20; 08/11/21; 02/09/22; 10/12/22; 02/08/23; 04/12/23; 02/14/24; 01/08/25; 01/14/26, 01/13/27

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

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

PREVIOUSLY APPLIED TO:
N/A

Policy/Procedure Number: MPTP2501 *(previously MCCP2016)*			**Lead Department: Transportation**
Policy/Procedure Title: Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)			☒ **External Policy** ☐ **Internal Policy**
Original Date: 10/21/2015 (MCCP2016)		**Next Review Date:** ~~01/14/2027~~01/13/2028 **Last Review Date:** ~~01/14/2026~~01/13/2027	
Applies to:	**Employee**	☒ **Medi-Cal**	☒ **Partnership Advantage**

****

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

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

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

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

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Provider Certification Statement (PCS)

For Non-Emergency Medical Transportation (NEMT)

In order to appropriately evaluate your request, **complete all form fields** below including **provider signature** and **date** of **signature**. If any field is incomplete, further documentation may be requested. **This form constitutes a prescription.** [References: California Code of Regulations (CCR), Title 22, Sections 51003, 51303, 51323, Partnership policy MPTP2501, APL 22-008 and the Medi-Cal Provider Manual]

1. Patients Name	2. Medi-Cal I.D. number

3. Dates of Service (DOS)

From: _____ To: _____

Please complete for the desired date range of NEMT justification. Not to exceed 12 months and dependent on member eligibility.

4. Patient mobilizes via: Wheelchair ☐ Walker ☐ Cane ☐ Other (describe):

5. Functional limitations, (specific *physical* or *mental*), that preclude the patient's ability to ambulate without assistance or to be transported by private or public conveyance: *(If patient can utilize taxi, public transport or gas mileage reimbursement please indicate this here.)*

☐ Patient is wheelchair bound and unable to self-transfer ☐ Dialysis ☐ Other (describe):

6. Based on 4 and 5, above, the required mode of transport is:

- ☐ Public Transport – Member is capable of utilizing local bus or para-transit system without assistance
- ☐ Taxi – Member can get from their home to the vehicle and transfer without assistance
- ☐ Wheelchair Van – Member must be transported by wheelchair because of disabling physical or mental limitation or is unable to self-transfer
- ☐ Gurney Van – Member must be transported in a prone or supine position because member is incapable of sitting upright
- ☐ Ambulance – Member's medical condition prevents the use of other forms of medical transportation (Member requires specialized equipment and/or personnel)
- ☐ Air Ambulance – Member's medical condition prevents the use of ground transport (describe):

7. Provider signature (Acceptable signatures: MD, DO, DPM, PA, NP, DDS, CNM, LM, Physical, Speech or Occupational Therapists, and Mental Health/Substance use disorder providers. Personal signature only. No proxy. No stamps) *I certify that the information contained above represents an accurate assessment of the patient's medical condition on the date of service.*	8. Date 9. Medi-Cal Certified? ☐ Yes ☐ No

10.Physician Name (print or type)	11. NPI number
12. Provider specialty (print or type)	13. Telephone number (With area code)
14. Provider address (number, street, city, zip code)	15. Fax Number (With area code)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPTP2502 (previously MCCP2029)</td><td colspan="3">Lead Department: Transportation</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Emergency Medical Transportation</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: (MCCP2016) 10/21/2015
(Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)</td><td colspan="4">Next Review Date: ~~01/14/2027~~01/13/2028
Last Review Date: ~~01/14/2026~~01/13/2027</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>☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~01/14/2026~~01/13/2027</td></tr>
</table>

I. RELATED POLICIES:

A. CGA024 - Medi-Cal Member Grievance System
B. CMP09 - Investigating and Reporting Fraud, Waste and Abuse

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Emergency medical condition: Defined by Federal Statute 420.5.C.S 1396b (v)(3) means a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.
B. Emergency medical transportation (EMT): Ground or air transportation staffed with an Emergency Medical Technician and used to transport a patient with an emergency medical condition to a hospital or acute care facility.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To outline the circumstances and utilization controls by which Partnership HealthPlan of California (Partnership) will facilitate emergency transportation services to members in accordance with state and federal regulations as cited.

VI. POLICY / PROCEDURE:

A. EMERGENCY MEDICAL TRANSPORTATION (EMT)

Emergency medical transportation (EMT) is provided for emergency medical conditions.

Policy/Procedure Number: **MPTP2502** (previously MCCP2029)		Lead Department: **Transportation**
Policy/Procedure Title: Emergency Medical Transportation		☒ **External Policy** ☐ **Internal Policy**
Original Date: (MCCP2016) 10/21/2015 (Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)	**Next Review Date:** **01/14/202701/13/2028**	**Last Review Date:** **01/14/202601/13/2027**
Applies to:	☒ **Medi-Cal**	☐ **Employees**

1. AIR emergency transportation is covered under the following conditions:
   a. The medical condition of the member precludes other means of medical transport.
2. GROUND emergency transportation is covered when ordinary public or private medical transportation is medically contraindicated and transportation is needed to obtain care.
3. A Treatment Authorization Request (TAR) is not required for emergency air or ground transportation.
4. Emergency transportation must be to the nearest hospital capable of meeting the medical needs of the patient. When the geographically nearest facility cannot meet the needs of the patient, transportation to the closest facility that can provide the necessary medical care is appropriate.
5. Medical transportation which represents a continuation of an original emergency transportation event is also covered without prior authorization, such as transportation from an emergency room of one hospital ~~on~~ to a second hospital for admission or for emergency services when the initial emergency room cannot provide the appropriate emergency medical treatment.
   a. The transfer is not considered a continuation of the initial emergency if the emergency ~~conveyor~~ conveyance leaves the facility to return to its place of business or accepts another call.
6. Emergency transportation provided for the purposes of evaluating a psychiatric crisis and/or for admission to a psychiatric facility is a covered service without a TAR. Counties directly performing this service are eligible providers, and the mode of transportation should be appropriate to the patient's medical and psychiatric needs.
7. Medi-Cal claims billed for out-of-state emergency air medical transportation services are not reimbursable unless a TAR is obtained. This policy is based on the following:
   a. Emergency air medical transportation is a Medi-Cal benefit only when transporting a recipient to the nearest available facility capable of treating a recipient's medical needs.
   b. Only emergency hospital services are Medi-Cal benefits for recipients while they are in Mexico or Canada.
   c. Out-of-state emergency air medical transportation services are Medi-Cal benefits without authorization only to or from specific border communities within the states of Arizona, Nevada or Oregon.
8. Transportation services to or from a foreign country, including Mexico and Canada, are not covered and will not be reimbursed.

VII. REFERENCES:

A. California Code of Regulations (CCR) Title 22 Section 51323
B. Manual of Criteria for Medi-Cal Authorization, Chapter 12.1
C. Medi-Cal Provider Manual: Medical Transportation guidelines (various)

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: 01/14/26; 01/13/27

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

Policy/Procedure Number: MPTP2502 (previously MCCP2029)		**Lead Department: Transportation**
Policy/Procedure Title: Emergency Medical Transportation		☒ **External Policy** ☐ **Internal Policy**
Original Date: (MCCP2016) 10/21/2015 (Effective 01/08/2020 – Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) Policy split)	**Next Review Date: 01/14/202701/13/2028**	**Last Review Date: 01/14/202601/13/2027**
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PREVIOUSLY APPLIED TO:
MCCP2029 (01/08/2020 – 01/13/2026)
MCCP2016 (10/21/2015 – 01/07/2020)*
*This policy topic was separated from policy MCCP2016 Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) as of 01/08/2020

****

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

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

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

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

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Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Nov. 18, 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.

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]

MPCP2034 Transitional Care Services (TCS)		**Pages 181 – 196**
Policy Owner: Care Coordination – A*lyssa Beard, RN, Manager of Care Coordination Regulatory Compliance*		
Notice required outside of Originating Department: Health Services, Behavioral Health, Claims, Member Services, Provider Relations		
☐ 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):* ***Care Coordination desktops are in progress of being updated to align with new APL language, in coordination with policy edits.***
☐ Configuration of HRP and/or Claims Editor System (CES)	☐ Configuration of Essette/Jiva	

Summary of Revisions
(why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)

This policy is updated to align with All Plan Letter (APL) 26-005 (Maternity Service for Pregnant and Postpartum Members)
and **to remove Wellness & Recovery program (W&R) language.**

Section I. added MCUG3118 Prenatal & Perinatal Care to Related Policies *at Nov. 10 Internal Quality Improvement (IQI) Committee.*
Section III: added definitions for Partnership HealthPlan Perinatal Services (PHPS) and The Comprehensive Perinatal Services Program (CPSP).
Section III: updated Partnership Advantage definition by adding a new last sentence "Coverage criteria apply on implementation of D-SNP, effective January 1, 2028, and subject to CMS and DHCS approval."
Section III. removed Wellness & Recovery program (W&R) definition
VI.A.1.d. added: Ensuring that moderate-intensity TCS is available for Members through routine perinatal providers as part of normal perinatal care practices, with additional support from Partnership through the dedicated TCS Call Line when needed.
VI.B.1-2 added:

1. In accordance with DHCS requirements, Partnership shall provide Transitional Care Services for Members undergoing a care transition based on the following categories:
   a. High-Risk TCS (Not Pregnant or Postpartum)
   b. Lower-Risk TCS (Not Pregnant or Postpartum)
   c. High-Intensity Pregnancy and Postpartum TCS
   d. Moderate-Intensity Pregnancy and Postpartum TCS
2. These categories establish the level and intensity of Transitional Care Services required and shall be applied consistent with DHCS PHM guidance and applicable clinical criteria.

VI.B.3.c updated: All Non-Partnership Advantage members receiving TCS are differentiated by High-and Low-risk designations, unless population has been identified in section B.1.a-d.

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

VI.B.4 added: Special Populations

a. Pregnant & Postpartum Members
   1) Pregnant and postpartum Members are defined as any member who is pregnant or within 12 months postpartum, starting from the last day of pregnancy, regardless of whether the pregnancy ended in live or stillbirth, or spontaneous or therapeutic abortion.
   2) Effective July 1, 2026, Partnership shall provide pregnancy and postpartum TCS in addition to the existing high-risk and lower-risk TCS categories, in accordance with DHCS PHM program requirements.
   3) Pregnancy & Postpartum Categories
      a) High-Intensity Pregnancy and Postpartum
      b) Moderate-Intensity Pregnancy and Postpartum
   4) Birthing Supports Checklist

VI.B.4.a.4)c) *modified at Nov. 10 IQI*: Partnership monitors delivery of TCS by contracted providers including but not limited to the following: *CPSP provider and/or existing* PHPS enrollment application and agreement/contracting and policy review, ongoing monitoring of utilization and quality reporting including facility site review and medical record review, and targeted interventions in provider support through training and education.

VI.B.5.a. added: Partnership may also identify pregnant Members, as early as possible but no later than the third trimester, through care coordination interactions, direct Member engagement, referrals from providers, and data available to the plan.

VI.D.1 revised: Partnership monitors members' eligibility for TCS and identifies a TCS Care Manager in accordance with the Member identification of risk level per section VI.B. Partnership shall assign a TCS Care Manager, in a timely manner, who shall serve as the single point of contact for the Member to provide longitudinal support and who ensures completion of all TCS services outlined in section VI.A.

Section VI.G.4 removed statement: After the Member's treatment at the behavioral health facility is complete and the Member is ready to be discharged or transferred, Partnership must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

VI.G.5 removed Partnership's Wellness and Recovery services

VI.G.5.a removed statement: For Members needing SUD services in counties participating in Partnership's Wellness & Recovery program (Regional Model), Partnership will be responsible for all TCS during the transfer/discharge to the behavioral health facility.

VI.G.5.a added statement: Effective January 1, 2027, DMC services will be administered through the applicable county Behavioral Health Plan (BHP) or its delegate. For Members requiring SUD services, the county BHP or delegate will be responsible for care coordination activities related to transfers and discharges to behavioral health facilities.

References Added:

- DMC-ODS MOU Template (SUD Treatment Services in Drug Medi-Cal Organized Delivery System (ODS) Counties)
- DHCS APL 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members (03/25/2026)

References Updated:

- CalAIM Population Health Management Policy Guide (July 2026)

2

Synopsis of Changes to Discussion Policies

MCUP3125 Gender Dysphoria/Surgical Treatment		**Pages 197 – 201**
Policy Owner: Utilization Management - *Tony Hightower, CPhT, Associate Director, UM Regulations*		
Notice required outside of Originating Department: Compliance, Member Services, Provider Relations, Claims, Configuration		
☐ 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	

Summary of Revisions
(include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)

This policy was updated to align with APL 26-018 from 09/30/2026 for Ensuring Access to Transgender Services

Section VI.A.1. Statement was added to say, "Coverage, authorization, and reimbursement will be administered in accordance with current DHCS requirements and any future California funding structures.
Section VI.A.2 *Statement amended at Nov. 10 IQI:* "**A**s outlined in DHCS APL 26-018, requests for gender-affirming care services for Medi-Cal Members under the age of 18 and Children's Health Insurance Program (CHIP) Members under the age of 19 may be subject to federal reimbursement restrictions and state-specific requirements related to funding, continuity of care, appeals, and coverage determinations."
Section VI.E.3. Statement was added to say "Members and their authorized representatives shall be provided notice of appeal rights and grievance rights in accordance with applicable DHCS requirements, including for circumstances where a requested service is affected by federal reimbursement limitations or alternative state funding limitations."
Section VI.G.5. Statement was added to say, " Nothing in this policy shall be interpreted to require coverage of services that are excluded, restricted, or otherwise administered pursuant to applicable law, regulation, DHCS guidance, or funding requirements."
Section VII References:
Reference B was added for the Medi-Cal Provider Manual/Guidelines for Gender Affirming Care.
Reference D was added to reflect the 26-018 APL.
Reference I was updated to "Assembly Bill 113, Chapter 248, Statutes of 2026 (Cal. 2026)"
Reference J was added for HCAI's Gender Affirming Care and Reproductive Health Programs.

MPUP3116 Positron Emission Tomography (PET) and Brain SPECT Scans		**Pages 203 – 206**
Policy Owner: Utilization Management - *Tony Hightower, CPhT, Associate Director, UM Regulations*		
Notice required outside of Originating Department: Configuration		
☐ 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	

Summary of Revisions

Synopsis of Changes to Discussion Policies

(include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)		
Policy Title - The name of this policy was updated to include "Brain SPECT" **Section V:** Purpose statement updated to include language regarding criteria for "dopamine transporter imaging in the evaluation of suspected parkinsonian syndromes and dementia with Lewy bodies." **Section VI.D.** A new section was added to this policy to include criteria and coverage for Dopamine transporter-photon emission computed tomography (DaT-SPECT) imaging. **Section VII. E.-G.:** References E-G were added for research articles on DaT-SPECT.		
MPPR210 Long-Term Services and Support Liaison		**Pages 207 – 214**
Policy Owner: Provider Relations – *Alaina Elder, Manager of Provider Network Teams*		
Notice required outside of Originating Department:		
☒ **Important Provider Notice (IPN)**	☐ Provider Education/Training	☒ **Provider Fax Blast** *(specify)**: LTC Facilities***
☐ 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	

Summary of Revisions
(why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)

This policy was reviewed and updated in accordance with All Plan Letters 26-010, 26-011, and 26-012.

Historically, this policy was internal, but it is now external to outline the role of Partnership's Long-Term Services and Supports (LTSS) Liaison, including contact information, training received, and responsibilities. This policy was pulled from Sept. 8 IQI consideration to further align with UM policies.

Section I. Related Policies: Removal of CalAIM policies as the LTSS Liaison does not interact with Enhanced Care Management (ECM) or Community Supports (CS) providers. Updated MCCP2014 policy name to MPCP2014 Continuity of Care. Added policies MCUP3106 Waiver Programs and MPPRO1102 Contracted Provider Education.
Sextion III. Definitions: Added Long-Term Care (LTC) and Long-Term Services and Supports (LTSS) in alignment with DHCS. Added definitions of LTC facilities types to align with our UM policies and Network Provider.
Section V. Purpose: Updated LTSS administrative aspects.
Section VI. Policy/Procedure: Revised to provide a concise overview, with operational details relocated to the applicable sections of the policy.
Section VI.A. Updated to provide how the LTSS liaison may be contacted, where the contact information is available publicly, and commit to a timeline of notification if there are any changes to the LTSS Liaison.
Section VI.B. Updated to provide an overview of the training that our LTSS Liaison receives.
Section VI.C. Provides examples of the responsibilities of our LTSS Liaison, including the DHCS required facilitation of quarterly "office hours" webinars for all eligible Network Providers furnishing LTC services.
Section VII. DHCS APLs 26-010, 26-011, and 26-012 are now included.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPCP2034 (previously MCCP2034)</td><td colspan="3">Lead Department: Health Services
Business Unit: Care Coordination</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Transitional Care Services (TCS)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 06/12/2024
Effective Date: 01/01/2023</td><td colspan="4">Next Review Date: ~~06/10/2027~~01/13/2028
Last Review Date: ~~06/10/2026~~01/13/2027</td></tr>
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~06/10/2026~~01/13/2027</td></tr>
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I. RELATED POLICIES:

A. MPCD2013 – Care Coordination Program Description
B. MPCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
C. MPCP2007 – Complex Case Management
D. MCAP7002 – CalAIM Enhanced Care Management (ECM)
E. MPAP7003 – CalAIM Community Supports (CS)
F. MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
G. MPND9001 – Population Health Management Strategy & Program Description
H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
I. MPUD3001 – Utilization Management Program Description
J. MCUP3106 – Waiver Programs
K. MPUG3011 – Criteria for Home Health Services
L. MPBP8003 – Mental Health Services
M. MPBP8007 – Screening and Treatment for Substance Use Disorders
N. MCUP3013 – Durable Medical Equipment (DME) Authorization
O. MPCP2018 – Advice Nurse Program
P. MPAP7004 – Community Health Worker (CHW) Services Benefit
Q. MCUP3012 – Discharge Planning (Non-capitated Members)
R. MCUP3141 – Delegation of Inpatient Utilization Management
S. MCUG3118 – Prenatal & Perinatal Care

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

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

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

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

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

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

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

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

~~Q.~~R. 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 below)*

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

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

U. Risk Stratification and Segmentation (RSS)**:** Partnership's Risk Stratification/Segmentation (RSS) and Risk Tier process leverages data from multiple data sources to separate its Member populations into different risk groups and/or meaningful subsets using information collected through a proprietary algorithm and other data sources that include population and Member assessments, demographic data, and utilization data. Partnership's RSS results in the categorization of Members with care needs at all levels and intensities. When available, Partnership will also incorporate the standardized risk tier criteria provided through DHCS's PHM Service, which will include a single, statewide, open-source RSS methodology for risk stratification that will place all Medi-Cal Members into high, medium-rising, and

low-risk tiers.

~~T.~~

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

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

W. 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 above)*

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

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

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. Transitional Care Services (TCS):

1. Partnership shall ensure Transitional Care Services are provided to Members/Enrollees transferring from one setting, or level of care, to another in accordance with 42 CFR section 438.208, other applicable federal and state laws and regulations, and DHCS guidance. Settings include, but are not limited to, discharges from hospitals, institutions, acute care facilities, and Skilled Nursing Facilities (SNFs) to home or community-based settings, Community Supports (CS) placements (including

Sobering Centers, Recuperative Care, and Short-Term Post Hospitalization), post-acute care facilities, or Long-Term Care (LTC) settings. Across these settings, TCS shall prioritize member-centered care by:

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

B. TCS Member Eligibility & Identification:
1. In accordance with DHCS requirements, Partnership shall provide Transitional Care Services for Members undergoing a care transition based on the following categories:
   a. High-Risk TCS (Not Pregnant or Postpartum)
   b. Lower-Risk TCS (Not Pregnant or Postpartum)
   c. High-Intensity Pregnancy and Postpartum TCS
   d. Moderate-Intensity Pregnancy and Postpartum TCS
2. These categories establish the level and intensity of Transitional Care Services required and shall be applied consistent with DHCS PHM guidance and applicable clinical criteria.
~~1.~~3. As part of Partnership's Risk Stratification/Segmentation (RSS) and Risk Tier process, Partnership Members shall be proactively identified for TCS services.
   a. For more information on Partnership's Population Health Management Program and/or Risk Stratification/Segmentation process, see Partnership policy *MPND9001 Population Health Management Strategy & Program Description.*
   b. All Partnership Advantage Enrollees.
      1) For the purpose of identifying TCS for Partnership Advantage, Enrollees receive all services in Section VI.B. and VI.C. required for High Risk members.
   c. All Non-Partnership Advantage members receiving TCS are differentiated by High- and Low-risk designations, unless population has been identified in section B.1.a-d.~~.~~
   d. High-risk transitioning Members means all Members that meet~~s~~ criteria under *MPCP2019 Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services* Section VI.D.1 and other Members assessed as high-risk by Partnership RSS and Risk Tier Process. Noting for TCS purposes, pregnant individuals include individuals hospitalized during pregnancy, admitted during the 12-month period post-partum, and discharges related to the delivery.
   e. In addition to these groups, and in recognition of high-risk of poor outcomes in transition for Partnership Members enrolled in multiple payors, those transitioning from SNFs, and those at high-risk who are potentially not captured in criteria mentioned in section VI.C.1.c, Partnership must also consider the following Members high-risk for the purpose of TCS:

1) Any Member who has been served by county Special Mental Health Services (SMHS) and/or DMC or DMC-ODS (if known) within the last 12 months, or any Member who has been identified as having a specialty mental health need or substance use disorder by Partnership or discharging facility
2) Any Member transitioning to or from a SNF
3) Any Member that is identified as high-risk by the discharging facility and thus is referred or recommended by the facility for high-risk TCS

f. Lower-risk transitioning Members are defined as ~~those~~ Members ~~not included in the~~who do not meet the criteria for high-risk ~~transitioning~~ TCS ~~Members~~ described ~~noted~~ above.

4. Special Populations
   a. Pregnant & Postpartum Members
      1) Pregnant and postpartum Members are defined as any member who is pregnant or within 12 months postpartum, starting from the last day of pregnancy, regardless of whether the pregnancy ended in live or stillbirth, or spontaneous or therapeutic abortion.
      2) Effective July 1, 2026, Partnership shall provide pregnancy and postpartum TCS in addition to the existing high-risk and lower-risk TCS categories, in accordance with DHCS PHM program requirements.
      3) Pregnancy & Postpartum Categories
         a) High-Intensity Pregnancy and Postpartum
            i. Members that have an admission to a hospital that is unrelated to their delivery at any point during pregnancy or within 12 months after the end of their pregnancy.
            ii. Are assessed as high-risk by Partnership Risk Stratification and Segmentation (RSS) process and/or DHCS Risk Stratification, Segmentation, and Tiering (RSST) methodology.
            iii. Having any one of the following risk criteria including:
               a. Medical Risk
                  i. Any Member who has an Obstetric Comorbidity Index (OCI) Score of >6
               b. Behavioral Health Risk
                  i. Any Member determined eligible for or received services by county SMHS and/or DMC/DMC-ODS services in the last 24 months
                  ii. Any Member who has known/suspected significant mental health or substance use disorder conditions based on claims in the past year.
                  iii. Please see Partnership policy *MPBP8007 Screening and Treatment for Substance Use Disorders* for more information.
               c. Social Risk
                  i. Any Member with a Medi-Cal Connect flag indicating potential qualification for ECM or Community Supports.
                  ii. Please see Partnership policies *MCAP7002 CalAIM Enhanced Care Management (ECM)* and *MPAP7003 CalAIM Community Supports (CS)* for more information.
         b) Moderate-Intensity Pregnancy and Postpartum
            i. Pregnant or postpartum Member does not meet high-intensity criteria and therefore receives moderate-intensity TCS.
      4) Birthing Supports Checklist
         a) Through TCS for high-intensity pregnancy and postpartum Members, Partnership ensures that pregnant and postpartum Members receive assessment and screening through the TCS Birthing Supports Checklist, or through other required assessments or care management activities that document equivalent information (e.g., CPSP assessments).

b) For moderate-intensity pregnancy and postpartum Members, TCS, including the TCS Birthing Supports checklist or equivalent assessment, is provided through Partnership's contracted providers or their routine perinatal providers – implemented as part of normal perinatal care practices – with additional support as needed from Partnership's TCS Call Line

c) Partnership monitors delivery of TCS by contracted providers including but not limited to the following: ~~existing~~ CPSP provider and/or existing PHPS ~~(CPSP provider)~~ enrollment application and agreement/contracting and policy review, ongoing monitoring of utilization and quality reporting including facility site review and medical record review, and targeted interventions in provider support through training and education

5. Partnership utilizes Admission, Discharge and Transfer (ADT) data feeds to assist in Member identification for TCS services and for assistance with timely authorizations for services that require prior authorization (e.g. acute in-patient care setting requests, etc.).
   ~~g.~~a. Partnership may also identify pregnant Members, as early as possible but no later than the third trimester, through care coordination interactions, direct Member engagement, referrals from providers, and data available to the plan.

~~2.~~6. Partnership utilizes the ADT feed, PointClickCare (PCC) formerly Collective Medical Technologies (CMT), to receive timely notifications within 24 hours of a Member's admission, transfer or discharge.
   a. When ADT feeds are not available, Partnership shall utilize other mechanisms to identify Members who may be eligible for TCS. This includes but is not limited to: fax notifications from facilities/institutions, Treatment Authorization Requests (TAR) for services, existing data-sharing agreements with providers/vendors, direct referrals to the Health Services department, and/or internal reports. Notification is necessary within 24 hours of Partnership being aware of any planned admission, or of any admissions, discharges, or transfers. However, this notification time frame will not apply if the care manager responsible for TCS is notified of the admission, discharge, or transfer through an ADT feed directly.

C. Transitional Care Services shall include the following:
   1. Ensuring collaboration and partnership with discharging facilities, including ensuring hospitals provide patient-centered discharge planning as required by federal and state requirements. Partnership must ensure discharging facilities complete a discharge planning process that:
      a. Engages the Member/legal guardian/caregiver(s)/legal representative/authorized representative, as appropriate, when being discharged from a hospital, institution, or facility.
      b. Focuses on the Member's goals and treatment preferences during the discharge process, and that these goals and preferences are documented in the medical record.
      c. Uses a consistent assessment process and/or assessment tools to identify Members who are likely to suffer adverse health consequences upon discharge without adequate discharge planning, in alignment with hospitals' current processes. Hospitals are currently required to identify these Members and complete a discharge planning evaluation on a timely basis, including identifying the need and availability of appropriate post-hospital services and documenting this information in the medical record for establishing a discharge plan.
         1) For high-risk Members, Partnership must ensure the discharging facility shares this information with Partnership's TCS Care Manager and that the discharging facilities have processes in place to refer Members to Enhanced Care Management (ECM) or CS, as needed. Partnership Advantage Enrollees shall be evaluated for participation ~~will include those who are Partnership Advantage Enrollees~~ in California Integrated Care Management (CICM), as applicable.

2) For Members not already classified as high-risk by Partnership per Section VI.C.1, the discharging facility must have processes in place to leverage the assessment to identify Members who may benefit from high-risk TCS services. This process must include referrals to Partnership for:
   a) Any Member who has a specialty mental health need or SUD.
   b) Any Member who is eligible for an ECM Population of Focus.
   c) Any Partnership Advantage Enrollee who is eligible for CICM Population of Focus.
   d) Any Member whom the clinical team feels is high-risk and may benefit from more intensive transitional care support upon discharge.

d. Ensures appropriate arrangements for post-discharge care are made, including needed services, transfers, and referrals, in alignment with facilities' current requirements.

2. As defined above in Section III.C, closed loop referrals to CS and/or coordination with county social service agencies and waiver agencies for In-Home Support Services (IHSS), Long Term Services and Supports (LTSS) and/or Home and Community Based Waiver (HCBS) services and programs.
3. Ensuring that medication reconciliation is conducted both pre- and post-transition, including education and counseling about the Member's medications.
4. Ensuring all necessary prior authorizations required for a Member's discharge are completed in timeframes consistent with the Member's condition and regulatory requirements. Examples include, but are not limited to, authorizations for:
   a. Therapy
   b. Home care / Home Health
   c. Medical supplies
   d. Prescription medications
   e. Durable Medical Equipment (DME)
5. Coordination to ensure appropriate follow-ups are completed for post-discharge appointments includes:
   a. Ensuring the post-discharge providers are notified and receive necessary clinical information, including a discharge summary in the medical record that outlines the care, treatment, and services provided, the patient's condition and disposition at discharge, information provided to the patient and family, and provisions for follow-up care.
   b. Confirming hospital has secured necessary follow-up appointments prior to discharge.
   c. Assisting with scheduling/arranging transportation when necessary for follow-up appointments.
   d. Ensuring needed post-discharge services are provided and follow-up visits are scheduled, including, but not limited to, follow-up provider appointments, SUD and/or mental health treatment initiation.
6. Follow-up with Member and/or their legal guardian/caregiver(s)/legal representative/authorized representative to ensure that services are coordinated and post-discharge needs have been met.
7. Members may choose to have limited or no contact with the identified TCS Care Manager. In such cases, the TCS Care Manager must, at a minimum, act as a liaison to coordinate care among the discharging facility, the Primary Care Provider (PCP), and Partnership.
8. Coordination and verification that the Member is receiving all appropriate services regardless of setting.
9. Ensuring collaboration, communication and coordination with the Member, their legal guardian/caregiver(s)/legal representative/authorized representative and the care team including, but not limited to, hospitals, physicians (including the Member's PCP), LTSS providers, discharge planners, social workers, and/or other case managers to ensure and facilitate a safe and successful transition.
10. A core responsibility of the TCS Care Manager is to coordinate with discharging facilities to fully understand the Member's potential needs and follow-up plans. Additionally, the TCS Care Manager

must ensure the Member participates in the care plan and receives and comprehends the information about their required care. To achieve this, the TCS Care Manager must complete the following:

a. Risk Assessment: The TCS Care Manager must assess Members' risk for adverse outcomes to inform needed TCS. This must include reviewing information from the discharging facility's assessment(s) and discharge planning process (e.g., the discharge summary). The TCS Care Manager may supplement this risk assessment through Member engagement as needed. During this process, the TCS Care Manager must also identify Members who may be newly eligible for ongoing care management (ECM/CCM), or for Partnership Advantage~~A~~ ~~Members~~ Enrollees (CICM), and/or Community Supports and make appropriate referrals.
b. Discharge Instructions: The TCS Care Manager must receive and review a copy of the discharging facility's discharge instructions given to the Member, including the medication reconciliation completed upon discharge by the discharging facility. After discharge, upon Member engagement, the TCS Care Manager must review the discharge instructions with the Member and ensure that Member can have any questions answered. A best practice (not required) is for the TCS Care Manager to work with the facility to ensure that the TCS Care Manager's name and contact information are integrated into the discharge documents.
c. Discharge Summary and Clinical Information Sharing: The TCS Care Manager must receive and review a copy of the discharging facility's discharge summary once it is complete. The TCS Care Managers must ensure all follow-up providers have access to the clinical information needed from the discharging facility, including the discharge summary.
d. Preadmission Status: Includes living arrangements, physical and mental function, SUD needs, social support, DME usage, and other services received prior to admission.
e. Pre-discharge Support Needs: Includes the Member's medical condition, physical and mental function, financial resources, and social supports at the time of discharge.
f. Discharge Location: The hospital, institution, or facility to which the Member was admitted.
g. Specific Agency or Home: Recommended by the hospital, institution, or facility after the Member's discharge based on the Member's needs and preferences.
h. Specific Services Needed After the Member's Discharge: A specific description of the type of placement preferred by the Member, the type of placement agreed to by the Member, the agency or Member's return to home agreed to by the Member, and recommended pre-discharge counseling.
i. Summary of Participation in the Discharge Planning Process: A summary of the nature and outcome of the participation of the Member/legal guardian/caregiver(s)/legal representative/authorized representative in the discharge planning process.
j. Anticipated Problems and Further Actions: Anticipated problems in implementing post-discharge plans and further actions contemplated by the hospital, institution, or facility to be included in the Member's Medical Record.
k. Information on Post-Discharge Care and Services: Information regarding available care, services, and supports that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.
l. TCS Care Manager Information: The TCS Care Manager's name and contact information, along with a description of TCS, should also be included.

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

D. TCS Care Manager, Care Manager Assignment, & TCS Team
1. Partnership monitors members' eligibility for TCS and identifies a TCS Care Manager in accordance

with the Member identification of risk level per section VI.B, Partnership shall assign a TCS Care Manager~~Once a high-risk Member has been admitted, Partnership shall identify a TCS Care Manager~~, in a timely manner, who shall serve as the single point of contact for the Member to provide longitudinal support and who ensures completion of all TCS services outlined in section VI.A.

a. For Members enrolled in Partnership's Complex Case Management (CCM) program, the Partnership Case Manager shall serve as the TCS Care Manager and perform all TCS services for the Member.

b. For Members enrolled in the ECM benefit, the ECM Lead Care Manager shall serve as the TCS Care Manager and perform all ECM services for the Member.

1) For more information regarding the ECM benefit, see Partnership Policy *MCAP7002 CalAIM Enhanced Care Management (ECM).*

~~b.~~

2. For high-risk Members identified for TCS, the Member shall be referred to Partnership's CCM program, ECM benefit, or for PA Members; CICM benefit, as appropriate.
3. Partnership Advantage Enrollees are assigned a Primary Case Manager for all of the member's care coordination, including TCS. The PA primary case manager is the primary responsible person for longitudinal support and to collaborate with the staff involved with member transitions and will invite participation to the ICT based on a prioritized and active need in the ICP addressing transitions. Transitions of care involved staff (not all inclusive of inpatient review nurse coordinators, LTSS nurse coordinators, for example) provide clinical support and expertise related to transitions between care settings including LTSS.
4. For lower-risk Members identified for TCS, Partnership is required:
   a. To ensure Member has access to a dedicated contact to provide assistance for any TCS need (at Partnership or a delegate) for a period of at least 30 days from discharge.
   b. To ensure Member can reach a dedicated telephonic support service. See Partnership Policy *MPCP2018 Advice Nurse Program* and latest Member Handbook for more details.
   c. To facilitate Members' ambulatory follow-up within 30 days of discharge for necessary post-discharge service, as needed.
5. For all other Members identified for TCS, Partnership shall evaluate and identify an appropriate TCS Care Manager. Examples include, but are not limited to, Partnership Health Services staff, hospital staff, PCPs, and/or other contracted agencies.
   a. Facility staff who help with discharge planning should work with, but not take the place of the responsible TCS Care Manager, unless Partnership has formally assigned the facility to act as the TCS Care Manager.
6. The TCS Care Manager is notified of the Member's admission, discharge and/or transfer status including the location of admission and facility contact information.
7. Partnership will notify the discharging facility of the name and contact information, including phone number, of the identified TCS Care Manager for the facility to include in the discharge planning document.
8. Partnership will provide the TCS Care Manager's contact information to the Member, legal guardian/caregiver(s)/legal representative/authorized representative, as part of the TCS engagement.
9. The TCS Care Manager must obtain permission from the Member, legal guardian/caregiver(s)/legal representative/authorized representative, as appropriate, to share information with providers to facilitate transitions, in accordance with federal and state privacy laws and regulations (ex: Release of Information (ROI), etc.)
10. The TCS Care Manager must also ensure non-duplication of services provided through other programs such as ECM, CCM, CICM Targeted Case Management, etc.

11. The assigned TCS Care Manager shall ensure that all TCS are provided in a culturally and linguistically appropriate manner for the duration of the transition, including follow-up and post-discharge.
12. High-Risk Member Outreach: The identified TCS Care Manager is responsible for contacting the Member within 7 calendar days of discharge and supporting the Member in all needed TCS care identified at discharge, as well as addressing any new needs identified through engagement with the Member or their care providers.
13. Low-Risk Member Outreach: Partnership must make best efforts to ensure Members receive direct communication about the dedicated TCS team and phone line, and how to access it, no later than 24 hours after the plans are notified of the discharge. Acceptable methods of communication include automated phone calls, incorporating information into discharge documents, and letters (either as supplemental to other efforts or if no other effort was effective). More than one method of notification can be utilized.

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

appropriate.

3. Partnership may utilize Community Health Workers (CHW's) when available through the CHW benefit to facilitate Member outreach and engagement.
   ~~c.~~a. For more information, see Partnership policy ~~Refer to Partnership policy~~ *MPAP7004 Community Health Worker (CHW) Services Benefit*~~ for details.~~

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

G. TCS For Partnership Members with Other Health Insurance/ Multiple Payers
   1. Partnership is responsible for providing TCS to Partnership assigned Members even for services or benefits carved-out from Partnership's Medi-Cal contract. (e.g., hospitalization for a Medicare FFS dual-eligible Member, in-patient acute psychiatric admissions, etc.)
   2. For Members who have multiple payers (other health insurance) and are undergoing any transition, Partnership will make a good faith attempt to obtain necessary ADT information from the corresponding facility. For these Members, Partnership shall notify existing CCM and/or ECM care managers of the admission, discharge and/or transfer in the manner outlined above in section VI. C.
   3. For Members who are admitted for an acute psychiatric hospital, psychiatric health facility, adult residential or crisis residential stay where the county Mental Health Plan is the primary payer, the county Mental Health Plan has the primary responsibility to coordinate the Member's care upon discharge. Partnership and the county Mental Health Plan must share necessary data and information to coordinate care for TCS per ~~*APL 23-029*~~*APL 23-029* *Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (08/11/2025).*
      a. Partnership will be responsible for all TCS during the transfer/discharge to the behavioral health facility.
      b. Partnership shall identify a TCS Care Manager for these Members to coordinate with county behavioral health and/or county case managers to ensure physical health follow-up needs are

met, assessed for, and additional care management needs such as CCM, ECM, CICM, or CS are addressed.

c. TCS for this transfer/discharge end once the Member is admitted to the behavioral health facility and connected to all needed services, including care coordination.

4. ~~After the Member's treatment at the behavioral health facility is complete and the Member is ready to be discharged or transferred, Partnership must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.~~ For Partnership M~~m~~embers who have Medicare as primary coverage for inpatient, acute, and/or skilled nursing services:
   a. The M~~m~~ember's Medicare Medi-Cal Plan (MMP) or the M~~m~~ember's Dual-Eligible Special Needs Plan (D-SNP) is responsible for coordinating the delivery of all benefits covered by both Medicare and Partnership. Partnership is not responsible for providing TCS or assigning a transitional care manager for Member enrolled in a Medicare Medi-Cal Plan or Dual-Eligible Special Needs Program (D-SNP).
      1) Effective January 1, 2028, members enrolled in Partnership's Partnership Advantage program for D-SNP will have transitions of care coordinated under the Partnership Advantage plan.
5. Drug Medi-Cal Organized Delivery System (DMC-ODS) ~~or Partnership's Wellness and Recovery services~~:
   a. ~~*For*~~ *Effective January 1, 2027*, DMC services will be administered through the applicable county Behavioral Health Plan (BHP) or its delegate. For Members requiring SUD services, the county BHP or delegate will be responsible for care coordination activities related to transfers and discharges to behavioral health facilities.~~Members needing SUD services in counties participating in Partnership's Wellness & Recovery program (Regional Model), Partnership will be responsible for all TCS during the transfer/discharge to the behavioral health facility.~~
   b. For Members needing SUD services in the counties ~~not participating in Partnership's Wellness & Recovery program~~, Partnership shall identify a TCS Care Manager ~~for these Members~~ to coordinate with county behavioral health and/or county case managers to ensure physical health follow-up needs are met, assessed for, and additional care management needs such as CCM, ECM, CICM or Community Supports (CS) are addressed.
   c. TCS for this transfer/discharge end once the Member is admitted to the behavioral health facility and connected to all needed services, including care coordination.
   d. After the Member's treatment at the behavioral health facility is complete and the Member is ready to be discharged or transferred, Partnership must follow the same transitional care requirements as either psychiatric admission or residential SUD treatment facility admission listed above.

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

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment III – 4.3, Population Health Management and Coordination of Care
B. DHCS APL 22-024 Population Health Management Policy Guide (11/28/2022)

C. DHCS APL 23-006 Delegation and Subcontractor Network Certification (03/28/2023)
D. DHCS APL 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (*Revised* 08/31/2022)
E. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (*Revised* 08/11/2025)
   1. Specialty Mental Health Services MOU template (DHCS contract Attachment E)
   ~~1.~~2. DMC-ODS MOU Template (SUD Treatment Services in Drug Medi-Cal Organized Delivery System (ODS) Counties)
F. Title 42 Code of Federal Regulations (CFR) Section 438.208
G. ~~CalAIM Dual Eligible Special Needs Plans Policy Guide~~CalAIM Dual Eligible Special Needs Plans Policy Guide - Contract Year 2026 (February 2026)
H. CalAIM Population Health Management Policy Guide (July 2026~~4~~)
~~H.~~I. DHCS Birthing Care Pathway
~~I.~~J. Medicare Advantage Options for Dual Eligible Beneficiaries
~~J.~~K. DHCS BHIN 26-001 Inpatient Criteria SMHS
   https://www.dhcs.ca.gov/Documents/BHIN-26-001-Inpatient-Criteria.pdf
~~K.~~L. DHCS BHIN 26-002 Criteria for Medi-Cal Member Access to SMHS
   https://www.dhcs.ca.gov/Documents/BHIN-26-002-Access-Criteria.pdf
~~L.~~M. DHCS APL 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members (03/25/2026)

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

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

X. REVISION DATES:
Medi-Cal
06/11/25; 06/10/26; 01/13/27

Partnership Advantage (Program effective January 1, 2028)
06/10/26; 01/13/27

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.

Policy/Procedure Number: MPCP2034 (previously MCCP2034)			**Lead Department:** Health Services Business Unit: Care Coordination
Policy/Procedure Title: Transitional Care Services			☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/12/2024 **Effective Date:** 01/01/2023			**Next Review Date:** 01/13/2028~~06/10/2027~~ **Last Review Date:** 01/13/2027~~06/10/2026~~
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3125</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Gender Dysphoria/Surgical Treatment</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 08/21/2013</td><td colspan="4">Next Review Date: ~~01/14/2027~~01/13/2028
Last Review Date: ~~01/14/2026~~01/13/2027</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 colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ 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: ~~01/14/2026~~01/13/2027</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MPUP3039 - Direct Members
C. MCUP3114 - Physical, Occupational and Speech Therapies
D. MCCP2022 - Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services
E. MPND9002 - Cultural & Linguistic Program Description
F. MPQG1005 - Adult Preventive Health Guidelines

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Gender Dysphoria is a formal diagnosis used by psychologists and physicians to describe persons who experience significant dysphoria, describing the emotional distress over a marked incongruence between one's experienced/expressed gender and assigned gender. These individuals are commonly referred to as transgender or gender nonconforming (TGNC).
B. Medical Necessity (Age 21 and over): As defined per Partnership HealthPlan of California's (Partnership's) contract with the Department of Health Care Services (DHCS), medically necessary means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
C. Medical Necessity (Under Age 21): In addition to the definition noted in III. B above, medical necessity for Members under age 21 is also defined as services necessary to correct or ameliorate defects and physical and mental illnesses that are discovered by the screening services (per Section 1396d(r)(5) of Title 42 of the United States Code)
D. Medi-Cal Rx: The program title established by the State of California Department of Health Care Services (DHCS) for the new system of administering Medi-Cal pharmacy benefits through the fee-for-service (FFS) delivery system effective January 1, 2022.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the criteria and process by which Partnership HealthPlan of California will provide benefits for the

surgical treatment of gender dysphoria.

VI. POLICY / PROCEDURE:

A. A Treatment Authorization Request (TAR) is required for all procedures related to gender dysphoria and shall be reviewed on a case-by-case basis.

1. Coverage, authorization, and reimbursement will be administered in accordance with current DHCS requirements and any future California funding structures.

~~1.~~2. As outlined in DHCS APL 26-018, Federal Reimbursement Limitation on Gender-Affirming Care Services for Youth, r~~R~~equests for gender-affirming care services for Medi-Cal Members under the age of 18 and Children's Health Insurance Program (CHIP) Members under the age of 19 may be subject to ~~shall be administered in accordance with DHCS , including any limitations relating to~~ federal reimbursement restrictions ~~,~~and state-specific requirements related to funding, continuity of care, appeals, and coverage determinations~~.~~.

B. Continuity of care requests will be reviewed by the Partnership Medical Director or Physician Designee for medical necessity and continued care. There must be a clearly established relationship with the provider and the willingness of the provider to continue care.

C. When reviewing a request for the surgical treatment of gender dysphoria, Partnership HealthPlan of California utilizes the most recent criteria as outlined by the World Professional Association for Transgender Health (WPATH) and as defined as a covered benefit according to the All Plan Letter (APL) 20-018 issued by the California Department of Health Care Services (DHCS). All requests will be reviewed by the Chief Medical Officer or Physician Designee for medical necessity.

1. According to the APL 20-018 (excerpted):
   a. Managed care health plans (MCPs) must also provide reconstructive surgery to all Medi-Cal beneficiaries, including transgender or gender nonconforming beneficiaries. Reconstructive surgery is "surgery performed to correct or repair abnormal structures of the body, to create a normal appearance to the extent possible" and for transgender Members, may consider gender dysphoria as a developmental abnormality. In the case of transgender or gender nonconforming beneficiaries, normal appearance is to be determined by referencing the gender with which the beneficiary identifies.
   b. MCPs are not required to cover cosmetic surgery. Cosmetic surgery is "surgery that is performed to alter or reshape normal structures of the body in order to improve appearance."
2. Gender reassignment/ affirming surgery is a covered benefit according to APL 20-018 and will be reviewed according to most recent WPATH criteria for the surgery. The requesting provider must submit evidence in demonstration of meeting either medical necessity or reconstructive surgery criteria consistent with WPATH criteria. This may include, but is not limited to:
   a. Persistent, well-documented gender dysphoria
   b. Capacity to make a fully informed decision and consent for treatment
   c. Consent for gender reassignment/ affirming surgery must be in compliance with current California consent policies and statutes.
   d. If significant medical or mental health concerns are present, they must be reasonably well controlled
3. The list of surgical procedures may include:
   a. For Male to Female (MtF, also known as transfeminine) patients or gender nonconforming patients desiring surgery for de-masculinization
      1) Breast / chest surgery: augmentation mammoplasty (implants / lipofilling)
      2) Genital surgery: penectomy, orchiectomy, vaginoplasty, clitoroplasty, vulvoplasty
   b. For Female to Male (FtM, also known as transmasculine) patients or gender nonconforming patients desiring surgery for de-feminization
      1) Breast/ chest surgery: subcutaneous mastectomy, creation of a male chest (excluding pectoral implants)

2) Genital surgery: hysterectomy/salpingo-oophorectomy, reconstruction of the fixed part of the urethra, which can be combined with metoidioplasty or with a phalloplasty (employing a pedicled or free vascularized flap), vaginectomy, scrotoplasty, and implantation of erection and/or testicular prostheses.

c. It is suggested that health care professionals consider gender-affirming genital procedures in eligible transgender and gender diverse adults seeking these interventions when there is evidence the individual has been stable on their current treatment regime (which may include at least 6 months of hormone treatment or a longer period if required to achieve the desired surgical result unless hormone therapy is either not desired or is medically contraindicated).

d. Specific considerations: Partnership does not categorically limit any services or the frequency of services available to a transgender or gender nonconforming Member, however, the following services are evaluated using the criteria stated below:

1) For mastectomy and creation of a male chest – no hormone therapy is required.
2) For breast augmentation – hormone therapy may be required to achieve the desired surgical result unless hormone therapy is either not desired or is medically contraindicated.
3) For hysterectomy, oophorectomy, salpingo-oophorectomy and for orchiectomy – hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated, not desired, or are contraindicated for the individual) – to introduce a period of reversible estrogen or testosterone suppression before the patient undergoes irreversible surgical intervention. Other surgery specific preauthorization criteria must be met.
4) For metoidioplasty or phalloplasty (including testicular prostheses) and for vaginoplasty – hormone therapy as appropriate to the patient's gender goals (unless hormones are not clinically indicated, not desired, or are contraindicated for the individual).
5) Non-genital, Non-breast surgery or treatments that may be considered non-reconstructive and may be considered cosmetic surgery and therefore not a covered benefit will be considered on a case by case basis including: facial feminization surgery, thyroid cartilage reduction, hair reconstruction/removal.
6) Prior to any pitch changing surgery, speech therapy as conversational therapy should be considered, and for FtM, hormone therapy should be included. Voice training should be part of a comprehensive program to develop either feminine or masculine communication that goes beyond change in pitch to also include intonation, resonance, intensity, syntax, rate of speech, vocabulary, and non-vocal communication. The Member must be able to achieve stimulable conversation. (See also policy MCUP3114 Physical, Occupational and Speech Therapies)
7) Rhinoplasty may be considered using the guidelines noted in Section VI.C.1.a. and b. above. In order to determine medical necessity, submit the following information:
   a) Photos of the Member's face and nose (two views) are required.
8) Liposuction, lipofilling (with the exception of breast augmentation), gluteal augmentation (implants/liposuction/lipofilling), facelift, facial lip augmentation/ reduction, and blepharoplasty are evaluated on a case-by-case basis based on the principles listed in Section VI.C.1. above.
9) Repeat reconstructive surgery in the absence of physiologic dysfunction (e.g. second breast enhancement) may be considered cosmetic and if so, not a benefit.
10) Gender nonconforming surgical requests will be reviewed on a case-by-case basis.

4. Pharmaceutical treatment for gender dysphoria: Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal fee-for-service (FFS) as described in All Plan Letter(APL) 25-013 and all medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/DHCS-contracted pharmacy administrator instead of Partnership. This includes medications used for the treatment of gender dysphoria. Refer to the Partnership website page for pharmacy authorization criteria:

http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx
The State Medi-Cal Contract Drugs List (CDL) can be found in both the Medical and Pharmacy provider manual sections of the website at https://medi-calrx.dhcs.ca.gov/home/cdl/

D. Treatment Authorization Review (TAR)
   1. TARs must be submitted prior to any surgical procedure referenced in section VI.C.3. and should demonstrate either medical necessity or reconstructive surgery criteria that is consistent with WPATH criteria and the covered benefit according to DHCS APL 20-018.
   2. Requests received will be forwarded to the Chief Medical Officer or Physician Designee for review and determination. Requests for surgical treatment of gender dysphoria shall be reviewed for reconstructive surgery criteria, the standard of care as advised by WPATH, and medical necessity requirements.
      a. Review of reconstructive surgery criteria and medical necessity are considered separate and distinct and may independently serve as the basis for approval of a request.
      b. Where medical necessity is not met, Partnership must review the TAR to determine if criteria for reconstructive surgery is met, taking into consideration the gender with which the Member identifies.
      c. Denial of a TAR, in whole or part, must describe the basis for denial for both reconstructive surgery criteria and medical necessity.
   3. Members and their authorized representatives shall be provided notice of appeal rights and grievance rights in accordance with applicable DHCS requirements, including for circumstances where a requested service is affected by federal reimbursement limitations or alternative state funding limitations.

E. Claims Submission
   1. Intersex surgery should not be requested or billed using CPT code 55970 (intersex surgery; male to female) or CPT code 55980 (intersex surgery; female to male). Due to the serial nature of surgery for the gender transition, CPT coding should be specific for the procedures performed during each operation.

F. Statement of Non-Discrimination
   1. Partnership does not discriminate against transgender individuals and treats beneficiaries in a manner consistent with their gender identity.
   2. 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 or gender nonconforming 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 exclusively available.
   3. 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.
   4. See also policy MCED6001 Healthy Equity and Community Reinvestment Strategy and Program Description~~MPND9002 Cultural & Linguistic Program Description~~ for more information on Partnership's Diversity, Equity and Inclusion (DEI) training programs for contracted network providers.
   ~~4.~~5. Nothing in this policy shall be interpreted to require coverage of services that are excluded, restricted, or otherwise administered pursuant to applicable law, regulation, DHCS guidance, or funding requirements.

VII. REFERENCES:

A. World Professional Association for Transgender Health (WPATH) criteria, current version.

https://www.wpath.org/soc8

B. Medi-Cal Provider Manual/Guidelines: Gender Affirming Care Services *(gender)*

~~B.~~C. DHCS All Plan Letter (APL) 20-018: Ensuring Access to Transgender Services (10/26/2020)

~~C.~~D. DHCS All Plan Letter (APL) 25-013 "Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage" (09/18/2025)

E. DHCS APL 26-018 Federal Reimbursement Limitation on Gender-Affirming Care Services for Youth (09/30/2026)

~~D.~~F. Title 45 Code of Federal Regulation (CFR) Sections 92.207 (b) (3) and (5)

~~E.~~G. Title 42 United States Code (USC) Section 1396d(r)(5)

~~F.~~H. Insurance Gender Nondiscrimination Act (IGNA) Health and Safety Code (HSC) Section 1365.5

I. Assembly Bill 113, Chapter 248, Statutes of 2026 (Cal. 2026).

~~G.~~J. California Department of Health Care Access and Information (HCAI) Gender Affirming Care and Reproductive Health Programs

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

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

X. REVISION DATES: 01/20/16; 02/15/17; 04/19/17; *06/13/18; 09/11/19; 09/09/20; 01/13/21; 09/08/21; 10/12/22; 01/10/24; 01/08/25; 01/14/26; 01/13/27

*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.

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPUP3116			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Positron Emission Tomography (PET) and Brain SPECT ~~Scans (PET~~ Scans~~)~~			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 09/19/2012 Effective 01/01/2013		**Next Review Date:** ~~11/12/2026~~11/04/202701/13/2027 **Last Review Date:** ~~11/12/2025~~11/04/202601/13/2027		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~11/12/2025~~01/13/2027	

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
C. MPUP3139 – Criteria and Guidelines for Utilization Management

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Medical Necessity - Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
B. Standard of Care – The level and type of care that a reasonably competent and skilled health care professional, with a similar background and in the same medical community, would provide under the same circumstances.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To adopt evidence-~~-~~based criteria from the National Comprehensive Cancer Network (NCCN) for use in evaluating the medical necessity of positron emission tomography (PET) scans for Members diagnosed with a malignancy. This policy ~~will~~ also addresses the use of PET Scans in other areas besides oncology and sets criteria for dopamine transporter imaging in the evaluation of suspected parkinsonian syndromes and dementia with Lewy bodies.

VI. POLICY / PROCEDURE:

A. Treatment Authorization Requests (TARs) for PET scans for those Members diagnosed with cancer or being evaluated for possible diagnosis of cancer are reviewed using the current guidelines from the National Comprehensive Cancer Network which may be found on these webpages: https://www.nccn.org/professionals/physician_gls/default.aspx or

https://www.NCCN.org/professionals/imaging/content

1. If the clinical situation is not covered in NCCN, InterQual® Positron Emission Tomography (PET) Whole Body is a reliable resource.
2. Requests for PET Scans related to cancer can be approved by Utilization Management Nurse Coordinators without referral to the Chief Medical Officer (CMO) or Physician Designee for further evaluation in the following circumstances:
   a. The request is part of the initial work up for a malignancy and there has been a biopsy that is positive for a malignancy. This is part of the initial staging for a malignancy.
   b. The request is part of a re-staging of a malignancy following treatment such as chemotherapy or radiation therapy or post-operative after resection of a tumor. There must be a minimum of three months between PET Scans and there must have been active treatment during that time.
   c. The request is part of a routine screening for a malignancy following treatment. There must have been at least six months of time elapsed since the end of treatment.
   d. Requests for PET Scans that do not fit these criteria will be referred to the CMO/Physician Designee for review.

B. PET Scan authorization requests for clinical problems other than malignancies will be reviewed on a case-by-case basis by the Partnership CMO/ Physician Designee.
   1. Decisions about appropriate use of PET Scans will be based on existing Standard of Care and/or reasonableness of the procedure for advancing the diagnosis and treatment of a clinical problem.
      a. Standard of Care can be developed using policies from other healthcare providers and consultation with experts in the field as well as review of current and relevant medical literature and on-line references including UpToDate.
   2. Review decisions will be based on the definition of Medical Necessity.

C. When a PET Scan is paired with another imaging modality, such as Three-dimensional Computerized Tomography (CT) or Magnetic Resonance Imaging (MRI), the associated modality will be reviewed along with the PET Scan.

D. Dopamine transporter single-photon emission computed tomography (DaT-SPECT), is a covered adjunct to, but not a substitute for, the standard evaluation of a suspected parkinsonian syndrome or dementia with Lewy bodies (DLB).
   1. In the absence of InterQual® guidelines for DaT-SPECT requests, authorization is based on the following:
      a. Specialist history and examination stating the clinical question
      b. Medication review
      c. Brain MRI or CT where indicated; and
      d. Where dopaminergic treatment is appropriate, the observed response to it
         1) Levodopa or beta-blocker trial is not a prerequisite and is not expected where there is no parkinsonism to treat, where a medication cause can be stopped, or where a trial is inappropriate (e.g., suspected DLB)
   2. DaT-SPECT *may* be authorized when, after that evaluation, a dopaminergic deficit remains uncertain and the result will change management:
      a. Degenerative versus drug-induced, vascular, or functional parkinsonism
      b. Early or clinically ambiguous parkinsonism
      c. DLB versus Alzheimer's disease
      d. A deep brain stimulation candidate whose diagnosis determines the target
   3. Current research supports that DaT-SPECT is not medically necessary for a typical presentation of Parkinson's disease; for screening, monitoring, or repeat studies without a new question; for clinical-trial eligibility; or to distinguish Parkinson's disease from Multiple System Atrophy (MSA), Progressive Supranuclear Palsy (PSP) or corticobasal syndrome (all show reduced uptake; brain fluorodeoxyglucose (FDG)-PET or cardiac metaiodobenzylguanidine (MIBG) scintigraphy after

MRI may be considered for that question according to section VI.B. above).

~~D.~~E. For any request, denials for medical necessity will only be made by a physician. All medical necessity denials are subject to Partnership's appeals process (see policy MCUP3037 Appeals of Utilization Management/Pharmacy Decisions).

VII. REFERENCES:

A. National Comprehensive Cancer Network (NCCN) criteria
B. InterQual® Criteria
C. Medi-Cal Provider Manual/Guidelines
D. UpToDate: (*Topic specific to the disease process being evaluated)*
E. Rissardo JP, Patino J, Caprara ALF, McGarry A. Clinical utility of DaTscan in clinically uncertain parkinsonian syndromes: a systematic review and meta-analysis. J Clin Neurosci 2026.
F. Hastings A, Cullinane P, Wrigley S, et al. Neuropathologic validation and diagnostic accuracy of presynaptic dopaminergic imaging in the diagnosis of parkinsonism. Neurology 2024.
G. Postuma RB, Berg D, Stern M, et al. MDS clinical diagnostic criteria for Parkinson's disease. Mov Disord 2015;30:1591–1601.

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
01/20/16; 11/11/16; 11/15/17; *02/13/19; 02/12/20; 01/13/21; 01/12/22; 11/09/22; 11/08/23; 11/13/24; 11/12/25;~~11/04/26~~ 01/13/27

*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 MPUP3116 (Healthy Kids program ended 12/01/2016)
01/20/16; 11/11/16 to 12/01/2016

PartnershipAdvantage
MPUP3116 – 09/19/2012 to 01/01/2015

Healthy Families
MPUP3116– 09/19/2012 to 03/01/2013

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Policy/Procedure Number: MPUP3116		**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Positron Emission Tomography (PET) and Brain SPECT Scans (PET Scans)		☒ **External Policy** ☐ **Internal Policy**
Original Date: 09/19/2012 Effective 01/01/2013	**Next Review Date: 11/12/202611/04/202701/13/2027** **Last Review Date: 11/12/202511/04/202601/13/2027**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPPR210</td><td colspan="3">Lead Department: Provider Relations</td></tr>
<tr><td colspan="3">Policy/Procedure Title: ~~Long Term Support Services Liaison~~Long-Term Services and Supports Liaison</td><td colspan="3">☒~~☐~~ External Policy
☐~~☒~~ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 07/31/2024</td><td colspan="4">Next Review Date: ~~05/12/2027~~11/10/2027
Last Review Date: ~~05/12/2026~~11/10/2026</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐~~☒~~ CREDENTIALS</td><td colspan="2">☒ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: ~~Robert Moore, MD, PhD, MPH, MBA~~Aaron Brincko, MPH</td><td colspan="3">Approval Date: 11/10/2026</td></tr>
</table>

I. RELATED POLICIES:

~~A. MCUG3038 - Review Guidelines for Member Placement in Long Term Care (LTC) Facilities~~

A. ~~MCCP2014 - Continuity of Care~~ MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities

B. MCUP3115 Community Based Adult Services

C. MCUG3038 Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities

D. MCUP3106 Waiver Programs

E. MPCP2014 Continuity of Care

~~B.~~F. MPPRO1102 Contracted Provider Education

II. IMPACTED DEPTS:

A. Claims

~~B. Utilization Management~~

~~C.~~B. ~~Quality Improvement~~Health Services

III. DEFINITIONS:

A. Long-Term Care (LTC): Specialized rehabilitative services and care provided in a Skilled Nursing Facility (SNF), subacute facility, pediatric subacute facility, custodial care favility, Intermediate Care Facility/Developmentally Disabled (ICF/DD), ICF/DD-Habilitative (ICF/DD-H), or ICF/DD-Nursing (ICF/DD-N) homes. See definitions below for additional details on these types of long-term care facilities:~~N/A~~

1. Custodial Care Facility: A non-medical facility (often referred to as a Long-Term Care [LTC] facility) that provides basic assistance with daily living activities for individuals who cannot perform those tasks independently due to illness, injury or disability.
2. Intermediate Care Facility (ICF): A health facility/home that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care.
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4. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative
5. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing
6. Skilled Nursing Facility (SNF): A facility or part of a hospital that provides short-term medically necessary skilled services provided by nurses, therapists, and/or physicians. The services aim to

complete a course of treatment that is not available in lower levels of care and support an increase in function, safety and independence with activities of daily living.

7. Subacute Care Facility: A facility with a level of care that is less intensive than acute care but more intensive than skilled nursing care (e.g. Members who require ventilators, tracheostomies, total parenteral nutrition, tube feeding, complex wound management care, etc.).

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

~~A.~~C. Network Provider: Any Provider or entity that has an Agreement with Partnership and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services to Partnership member.

IV. ATTACHMENTS:
N/A

V. PURPOSE:
To outline the role and responsibilities of Partnership HealthPlan of California (Partnership) regarding Long-Term ~~Support~~ Services and Supports Liaison requirements and expectations.

VI. POLICY / PROCEDURE:
The ~~PHC~~ Partnership Long Term Services and Supports~~Long Term Support Services~~ (LTSS) Liaison is dedicated to working with each ~~Long Term~~Long-Term Care (LTC) location within the ~~PHC~~ Partnership service area. Thise Liaison will be responsible for a range of functions to improve ~~the~~ communication between these locations and the health plan to best assist ~~the~~ ~~PHC~~ Partnership members.

A. The LTSS Liaison serves as the Health Plan's point of contact for LTSS providers.
   1. Inquiries can be sent to the designated LTSS inbox: ltssliaison@partnershiphp.org
   2. Contact information can be found on Partnership's DHCS Directed Payments Program webpage
   3. Network Providers and DHCS will be notified of any changes to the LTSS Liaison no later than the date of change

B. The LTSS Liaison receives training on the full spectrum of rules, regulations, policies and procedures pertaining to Medi-Cal covered Long-Term Care (LTC), including but not limited to:
   a. Payment and coverage policies
   b. Prompt claims payment requirements
   c. Provider dispute resolution policies and procedures (P&Ps)
   d. Care management
   e. Care coordination
   f. Transitional Care Services (TCS) policies

~~A.~~C. The ~~Long Term~~LTSS ~~Support Services~~ Liaison is responsible for activities, including but not limited to~~'s essential duties and responsibilities include~~:
   1. Providing education to Network Providers regarding availability of community resources and how to access these resources
   ~~1. Assists providers and facilities with transitions of care to support the member's needs.~~
   2. M~~Serves as a point of contact for LTSS providers at the health plan to address~~ anaging and responding to inquiries received through the centralized LTSS program inbox, including but not

limited to questions ~~for~~ related to payment, claims, and~~/or~~ Partnership contract language.

3. Coordinating interdepartmentally to connect Network Providers with the appropriate resources and departments on:
   a. Authorization, care coordination, and/or transitional care needs
   b. Benefit standardization
   c. Process improvement and network performance
4. Identifying learning opportunities for hospitals, providers, and/or topics for community partners
5. Collaborating with Partnership's Quality department to support new and ongoing quality programs and initiatives that impact LTSS providers
6. Staying informed of changes related to benefits, regulations, and/or Partnership policies related to long-term services and supports.
7. Facilitating quarterly "office hours" webinars for all eligible Network Providers furnishing LTC services
   a. Network Providers can participate virtually via telephone and optionally via an online teleconference service
   b. Network Providers will have the capability and opportunity to ask live questions
   c. Quarterly office hours will be published publicly, at least 30 days before each webinar

~~3. Coordinates with clinical staff within Health Services to address authorization, care coordination, and/or transitional care needs for Partnership members.~~
~~4. Maintains benefit standardization and surface issues or questions to the appropriate staff for process improvement.~~
~~5. Provides education to providers regarding availability of community resources and how to access these resources.~~
~~6. Identifies learning opportunities for hospitals, providers and/or topics for community partners.~~
~~7. Progresses new strategic partnerships with key stakeholders and identifies opportunities to expand outreach and educational efforts collaborates with Partnership's quality department to support new and ongoing quality programs that impact LTSS providers such as the Quality Assurance and Performance Improvement (QAPI).~~
~~8. Works in conjunction with internal counterparts to proactively support network performance and process improvement.~~
~~9. Develops structures, relationships, and processes to promote active partnerships with providers, community stakeholders, and/or other healthcare professionals to meet and support key organizational initiatives.~~
   ~~a. Stays informed of changes related to benefits, regulations and/or Partnership policies related to long term support services.~~
~~10. Receives training on the full spectrum of rules, regulations, policies and procedures pertaining to Medi-Cal covered Long Term Care (LTC), including:~~
   ~~a. Payment and coverage~~
   ~~b. Prompt claims payment requirements~~
   ~~c. Provider resolution~~
   ~~d. Care management~~
   ~~e. Care coordination~~
   ~~f. Transition of care~~

VII. REFERENCES:

A. ~~Department of Health Care Services (DHCS) All Plan Letter (APL) Medi-Cal Managed Care Plan Responsibilities for Indian Health Care Providers and American Indian Members (02/08/2024)~~Department of Health Care Services (DHCS) All Plan Letter (APL) 26-006 Skilled Nursing

Facility Workforce Quality Incentive Program (March 30, 2026 *supersedes* APL 25-002)

B. DHCS APL 26-010 Skilled Nursing Facilities — Long Term Care Benefit Under Managed Care (June 10, 2026 *supersedes* APL 24-009)

C. DHCS APL 26-011 Subacute Care Facilities – Long-Term Care Benefit Under Managed Care (June 10, 2026 *supersedes* APL 24-010)

~~A.~~D. DHCS APL 26-012 Intermediate Care Facilities for Individuals with Developmental Disabilities – Long-Term Care Benefit Under Managed Care (June 10, 2026 *supersedes* APL 24-011)

VIII. DISTRIBUTION:

A. ~~PHC~~ Partnership Department Directors

B. ~~PHC~~ Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

~~Senior~~ Director of~~,~~ Provider Relations

X. REVISION DATES:

02/16/26, 05/12/26, 11/10~~04~~/26~~N/A~~

PREVIOUSLY APPLIED TO:

N/A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPPR210</td><td colspan="3">Lead Department: Provider Relations</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Long-Term Services and Supports Liaison</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 07/31/2024</td><td colspan="3">Next Review Date: 11/10/2027
Last Review Date: 11/10/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☐ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☐ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☒ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Aaron Brincko, MPH</td><td colspan="3">Approval Date: 11/10/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
B. MCUP3115 Community Based Adult Services
C. MCUG3038 Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities
D. MCUP3106 Waiver Programs
E. MPCP2014 Continuity of Care
F. MPPRO1102 Contracted Provider Education

II. IMPACTED DEPTS:

A. Claims
B. Health Services

III. DEFINITIONS:

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Director of Provider Relations

X. REVISION DATES:

02/16/26, 05/12/26, 11/10/26

PREVIOUSLY APPLIED TO:

N/A

HEDIS Scores MY2025/RY2026

Max Possible MCAS= 180

HEDIS MCAS = 180

*Contra Costa Health Plan (**156**)*

*Kaiser Permanente (**155**)*

*Central California Alliance for Health (**152**)*

*Santa Clara Family Health Plan (**149**)*

*Health Plan of San Mateo (**148**)*

*San Francisco Health Plan (**147**)*

*CenCal Health (**147**)*

*Gold Coast Health Plan (**145**)*

HEDIS MCAS = 140

*Community Health Group Partnership Plan (**135**)*

North Bay Area (134)

*CalOptima (**131**)*

*Alameda Alliance for Health (**130**)*

*CalViva Health (**127**)*

*Blue Shield of California Promise Health Plan (**127**)*

*Inland Empire Health Plan (**120**)*

*Community Health Plan of Imperial Valley (**120**)*

*L.A. Care Health Plan (**112**)*

*Health Net Community Solutions, Inc. (**109**)*

*Kern Family Health Care (**109**)*

PHC weighted score = 107

*Partnership HealthPlan of California (**107**)*

*Molina Healthcare of California (**105**)*

HEDIS MCAS = 100

*Health Plan of San Joaquin (**97**)*

*Anthem Blue Cross Partnership Plan (**91**)*

Rural Upper North (91)

Rural Upper Central Rating (80)

HEDIS MCAS = 60

HEDIS MCAS = 30

Significant Change from 2024 to 2025

Marin County (141 pt)

Sonoma County (138 pt)

Napa County (134 pt)

Yolo County (124 pt)

Lake County (119 pt)

Sutter County (114 pt)

Mendocino County (107 pt)

Humboldt County (106 pt)

Solano County (107 pt)

Colusa County (105 pt)

Yuba County (89 pt)

Shasta County (84 pt)

Siskiyou County (80 pt)

Glenn County (80 pt)

Placer County (79 pt)

Del Norte County (70 pt)

Tehama County (69 pt)

Butte County (69 pt)

Nevada County (66 pt)

Lassen County (61 pt)

Modoc County (61 pt)

Sierra County (58 pt)

Trinity County (54 pt)

Plumas County (46 pt)

QIP Scores 2025 – Clinical Only

Weighted Average for Parent Organizations

QIP = 100% of Clinical Points

Marin CC QIP 100%

La Clinica QIP 97%

Sonoma Valley CHC QIP 94%

Santa Rosa CHC QIP 92%

Petaluma HC QIP 87%

Ole Health DBA CommuniCare Ole 81%

QIP = 75% of Clinical Points

Fairchild Medical QIP 70%

West County HC QIP 69%

Mendocino CHC QIP 68%

Open Door CHC QIP 57%

Weighted Average PCP Clinical Score 56%

QIP = 50% of Clinical Points

Northern Valley Indian Health 47%

Community MC QIP 45%

Adventist Health QIP 44%

Ampla Health 41%

Shasta CHC QIP 35%

Mountain Valley HC QIP 30%

PeachTree Healthcare 30%

QIP = 25% of Clinical Points

Harmony Health 25%

QIP = 0% of Clinical Points

WellSpace Health 1%

Solano County HSS QIP 0%

*** Please note that the MCAS Plan-Wide result is based on a sample of 411, while the rating regions are calculated from a weighted average of the larger oversampled county populations for the hybrid measures*

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Member (Patient) Experience CAHPS® MY2025 | RY2026

Member Experience Department
November 2026

Agenda

- Purpose & Survey Methodology
- Member Experience Performance Highlights
- MY 2025 | RY 2026 CAHPS Results
- Member Experience Department Initiatives
  - Organizational Focus
  - Improvement Priorities & Next Steps

Sustained Improvement Driving Results

- Multi-year Member Experience strategy is yielding measurable results.
- Adult performance improved across 7 of 9 CAHPS® Measures.
- Child performance maintained strong overall results.
- Cross-functional improvement efforts remain a key performance enabler.
- Post-expansion results provide an early baseline for monitoring member experience and health outcomes across our expanded service area.
- Access to care remains the most significant opportunity moving forward.

Survey Methodology

Each year Partnership HealthPlan of California partners with an NCQA accredited survey vendor, Press Ganey, to conduct member experience surveys.

Adult CAHPS	
Population	18 years and older
Sample size	2,700
Number of respondents	380
Response rate	14.2%
Margin of error	± 1.88
Survey method	Mail, Phone & Online
Look back period	6 months
Field dates	2/13/26 - 5/1/26

Child CAHPS	
Population	17 years and younger
Sample size	5,000
Number of respondents	703
Response rate	14.1%
Margin of error	± 1.37
Survey method	Mail, Phone & Online
Look back period	6 months
Field dates	2/13/26 - 5/4/26

Results reflect 380 adult and 703 child responses collected through mail, phone and online surveys.

How did our members rate us? *Global Ratings* *%9 &10*

Members are asked to rate their experience from 0-10, 0 being worst and 10 being the best experience in the last 6 months.

Rating of the Health Plan

	MY25	%tile[1]	Δ 90th %tile	MY25 Star Rating
Adult	64.2 ▲ 8.4	50th	6.9	★ ★ ★
Child	69.9 ▼ 3.0	33rd	8.9	★ ★ ★

Rating of the Personal Doctor

	MY25	%tile[1]	Δ 90th %tile
Adult	64.5 ▼ 1.2	5th	14.4
Child	76.8 ▼ 1.8	25th	7.3

Rating of the Healthcare

	MY25	%tile[1]	Δ 90th %tile	MY25 Star Rating
Adult	54.7 ▼ 0.7	25th	8.8	★ ★
Child	68.0 ▲ 1.6	10th	12.2	★ ★

Rating of the Specialist

	MY25	%tile[1]	Δ 90th %tile
Adult	65.2 ▼ 5.1	10th	14.0
Child	77.5 ▲ 3.7	75th	4.2

Adult plan rating rose 8.4 points, while adult provider ratings declined. Rating of specialist continues to be a strength among child population.

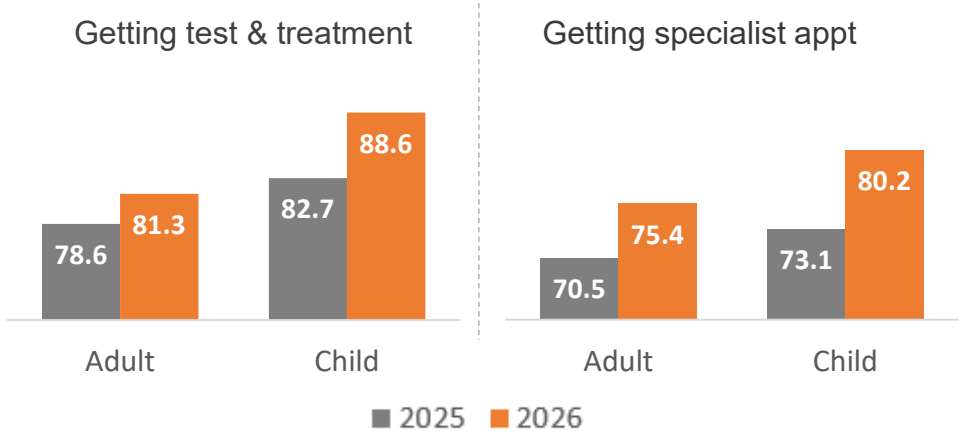
★ *NCQA Star Rating results; [1]Quality Compass Percentile ranking amongst Medicaid Health Plans nationally*

How did members rate their access to care?

%Usually & Always

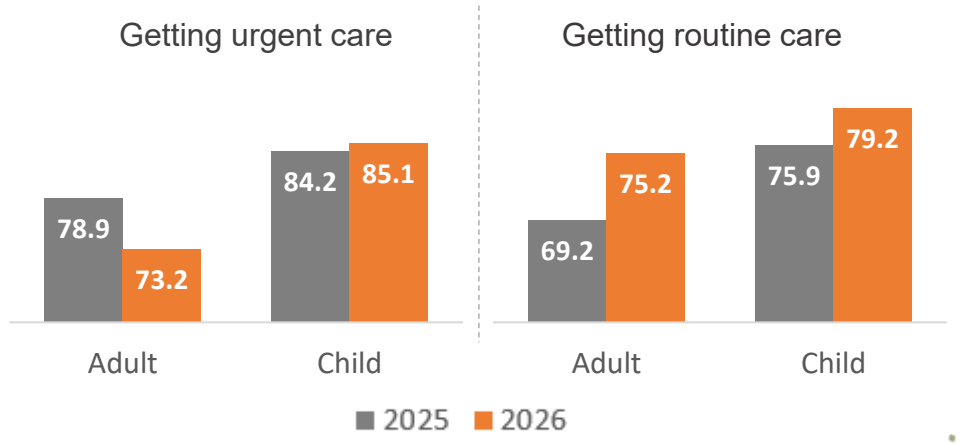
Getting Needed Care

	MY25	%tile[1]	Δ 90th %tile	MY25 Star Rating
Adult	78.4 ▲ 3.9	10th	9.5	★★
Child	84.4 ▲ 6.5	33rd	6.8	★★★



Getting Care Quickly

	MY25	%tile[1]	Δ 90th %tile	MY25 Star Rating
Adult	74.2 ▲ 0.2	<5th	12.5	★
Child	82.1 ▲ 2.1	10th	11.0	★★



Access improved overall, but adult urgent-care experience fell, and timely access remains a challenge.

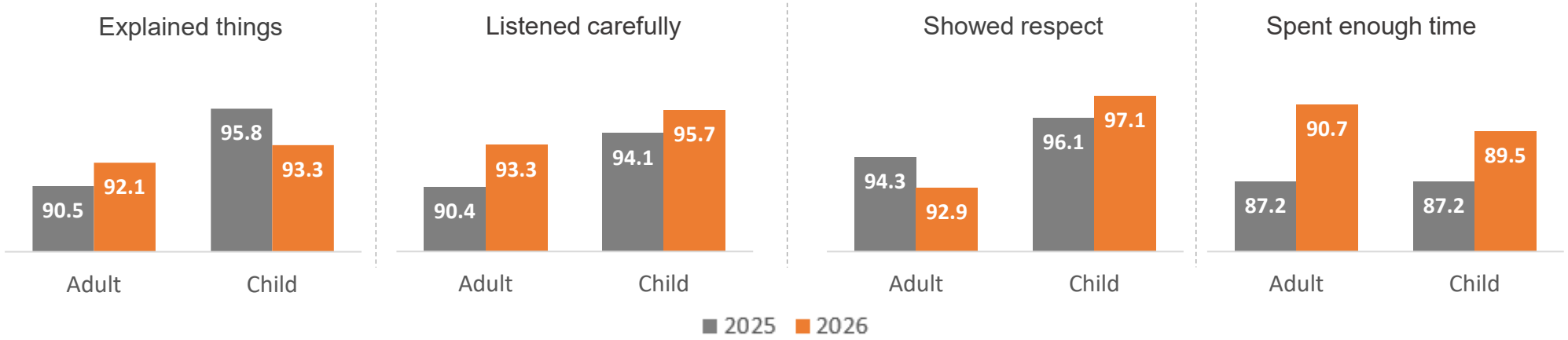
★ *NCQA Star Rating results; [1]Quality Compass Percentile ranking amongst Medicaid Health Plans nationally*

How did members rate how well doctors communicate?

%Usually & Always

Doctor Communication

	MY25	%tile[1]	Δ 90th %tile
Adult	92.3 ▲1.7	10th	4.9
Child	93.9 ▲0.6	33rd	3.4



Doctor communication remains strong, with adult composite performance improving 1.7 points and child performance holding steady overall.

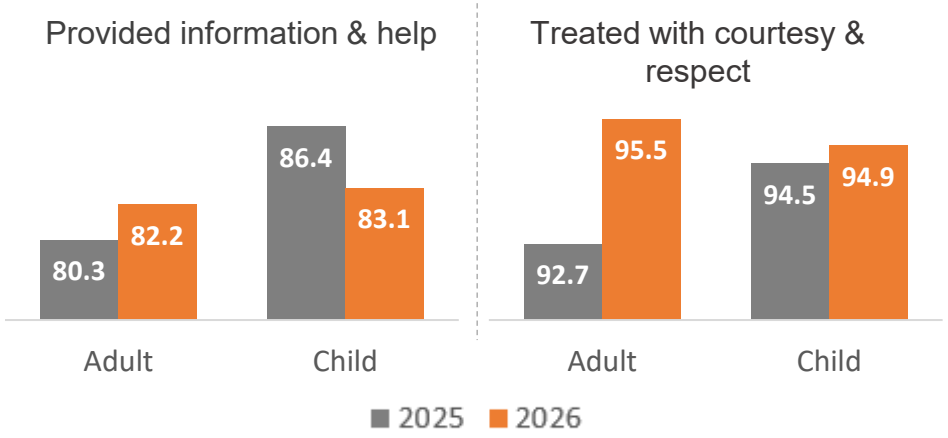
[1]*Quality Compass Percentile ranking amongst Medicaid Health Plans nationally*

How did members rate their interactions with us?

%Usually & Always

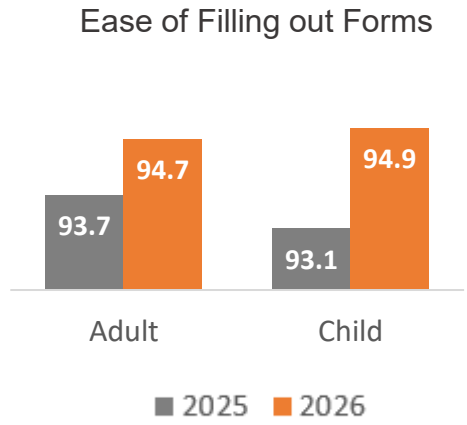
Customer Service

	MY25	%tile[1]	Δ 90th %tile
Adult	88.8 ▲ 2.3	33rd	4.9
Child	89.0 ▼ 1.5	66th	2.3



Ease of Filling out Forms

	MY25	%tile[1]	Δ 90th %tile
Adult	94.7 ▲ 1.0	33rd	2.2
Child	94.9 ▲ 1.8	33rd	2.7



Customer service measures improved among adult respondents, while for child respondent's information and help measure declined 3.3 points.

[1]*Quality Compass Percentile ranking amongst Medicaid Health Plans nationally*

How did we perform in comparison with other Health Plans?

Adult CAHPS Measures	MY24	MY25	Δ (25-24)	MY25 Ranking	#1 Ranked Health Plan in CA (MY25)
Care Coordination	81.3	83.9	▲ 2.6	6th of 11	Kaiser/ Southern California
Customer Service	86.5	88.8	▲ 2.3	6th of 16	Blue Shield/ Promise
Dr Communication	90.6	92.3	▲ 1.7	8th of 17	Blue Shield/ Promise
Getting Needed Care	74.5	78.4	▲ 3.9	11th of 17	Kaiser/ Southern California
Getting Care Quickly	74.0	74.2	▲ 0.2	14th of 17	Inland Empire
Rating of Health Plan	55.8	64.2	▲ 8.4	12th of 23	Inland Empire
Rating of Healthcare	55.4	54.7	▼ -0.7	20th of 19	Kaiser/ Southern California
Rating of Personal Dr	65.7	64.5	▼ -1.2	20th of 21	Community Health Group
Rating of Specialist	70.3	65.2	▼ -5.1	11th of 15	Kaiser/ Northern California

Adult CAHPS performance improved on 6 of 9 measures, but specialist and personal-doctor ratings lost ground.

How did we perform in comparison with other Health Plans?

Child CAHPS Measures	MY24	MY25	Δ (25-24)	MY25 Ranking	#1 Ranked Health Plan in CA (MY25)
Care Coordination	84.7	85.8	▲ 1.1	4th of 6	CenCal Health/Southern California
Customer Service	90.5	89.0	▼ -1.5	3rd of 10	Community Health Group
Dr Communication	93.3	93.9	▲ 0.6	6th of 17	Gold Coast Health Plan
Getting Needed Care	77.9	84.4	▲ 6.5	3rd of 13	Health Plan of San Mateo
Getting Care Quickly	80.0	82.1	▲ 2.1	3rd of 13	Community Health Group
Rating of Health Plan	72.9	69.9	▼ -3.0	17th of 21	Community Health Group
Rating of Healthcare	66.4	68.0	▲ 1.6	6th of 18	Community Health Group
Rating of Personal Dr	78.6	76.8	▼ -1.8	13th of 20	Community Health Group
Rating of Specialist	73.8	75.5	▲ 3.7	3rd of 5	Santa Clara Family Health Plan

Child CAHPS performance improved on 5 of 9 measures, but the health-plan rating fell from 8th to 17th.

Where are we focusing our efforts in FY27?

CAHPS Composites	Adult		Child	
	MY25	YoY	MY25	YoY
Getting urgent care	73.2	▼ -5.7	85.1	▲ 0.9
Getting specialist appointment	75.4	▲ 4.9	80.2	▲ 7.1
Getting care, tests, or treatment	81.3	▲ 2.7	88.6	▲ 5.9
Rating of Health Care	54.7	▼ -0.7	68.0	▲ 1.6
Getting routine care	75.2	▲ 6.0	79.2	▲ 3.3
Dr. explained things	92.1	▲ 1.6	93.3	▼ -2.5
Dr. listened carefully	93.3	▲ 2.9	95.7	▲ 1.6
Dr. showed respect	92.9	▼ -1.4	97.1	▲ 1.0
Coordination of Care	83.9	▲ 2.6	85.8	▲ 1.1
Interpreter/language services	70.7	▲ 2.6	76.3	▲ 1.6

Access and care delivery account for 8 of the 10 priority opportunities for FY27.

Member Experience Department Initiatives

What are we doing about it?

Governance

- Enhancing MX/CAHPS framework
- Building Experience Dashboard & Risk Scores

Action

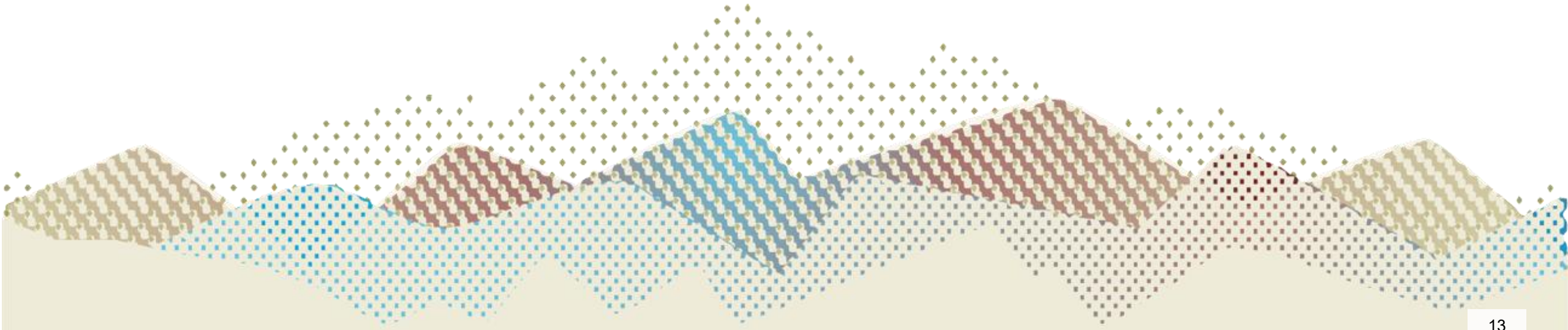
- FY 26-27 Org. Goals
- Service Recovery Program
- Build the Experience Culture

Strategy

- Roadmap to driving MX excellence
- Improve Continuous Listening

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Questions?

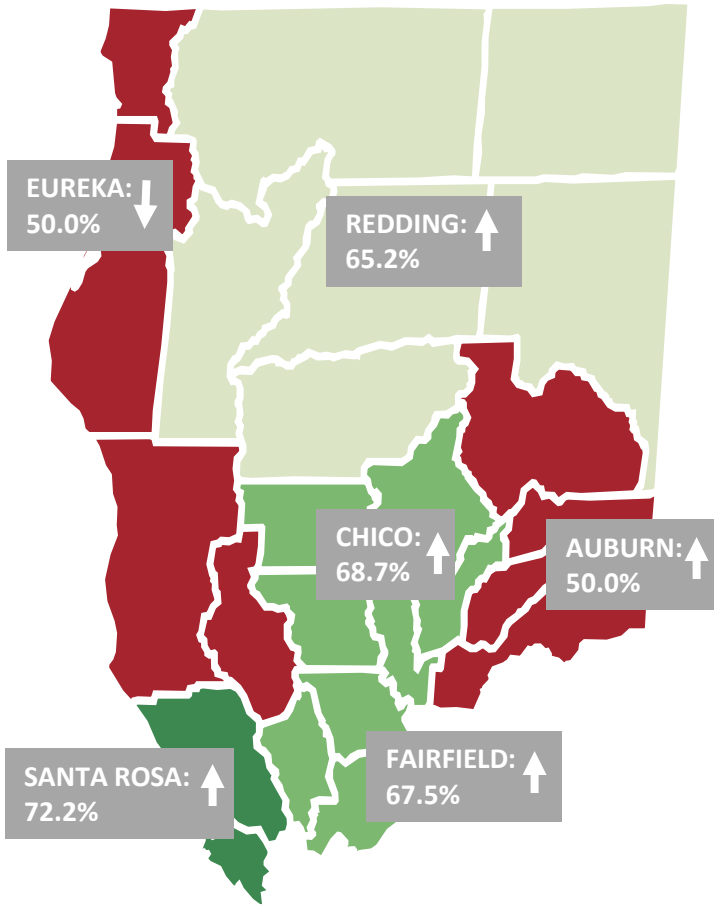




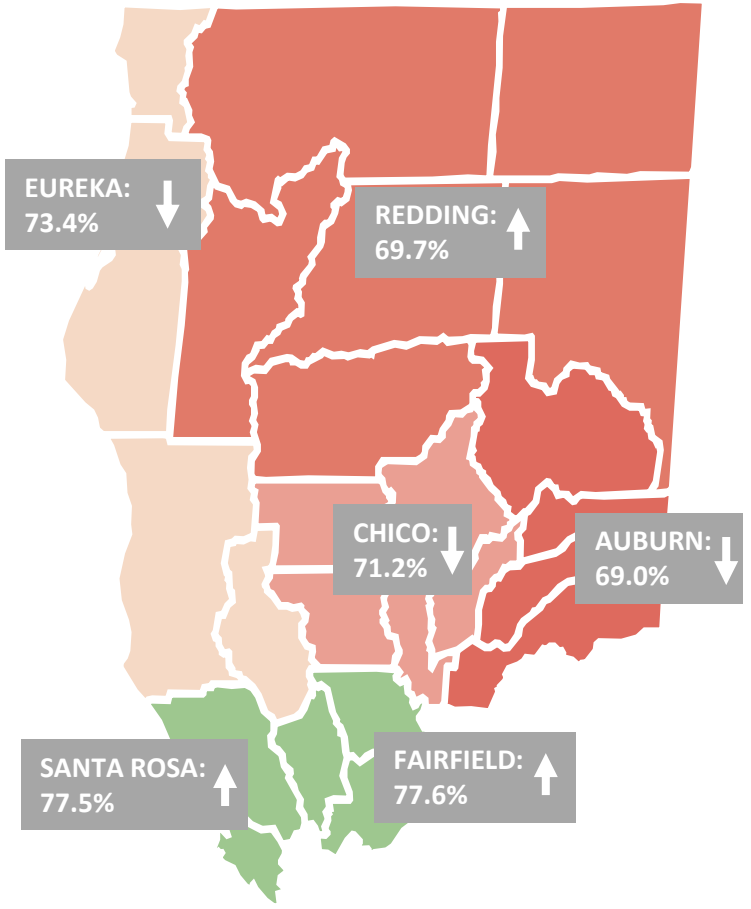
Appendix

Regional Trends – Adult CAHPS

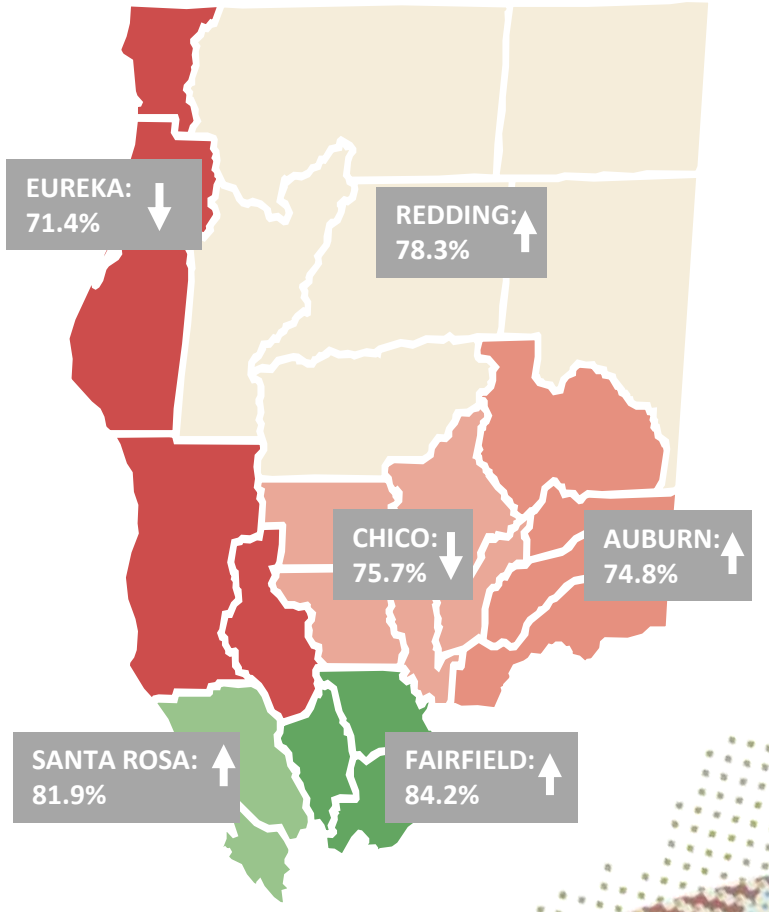
Rating of Health Plan (9+10)
Plan Performance: 64.2%



Getting Care Quickly (Always+ Usually)
Plan Performance: 74.2%



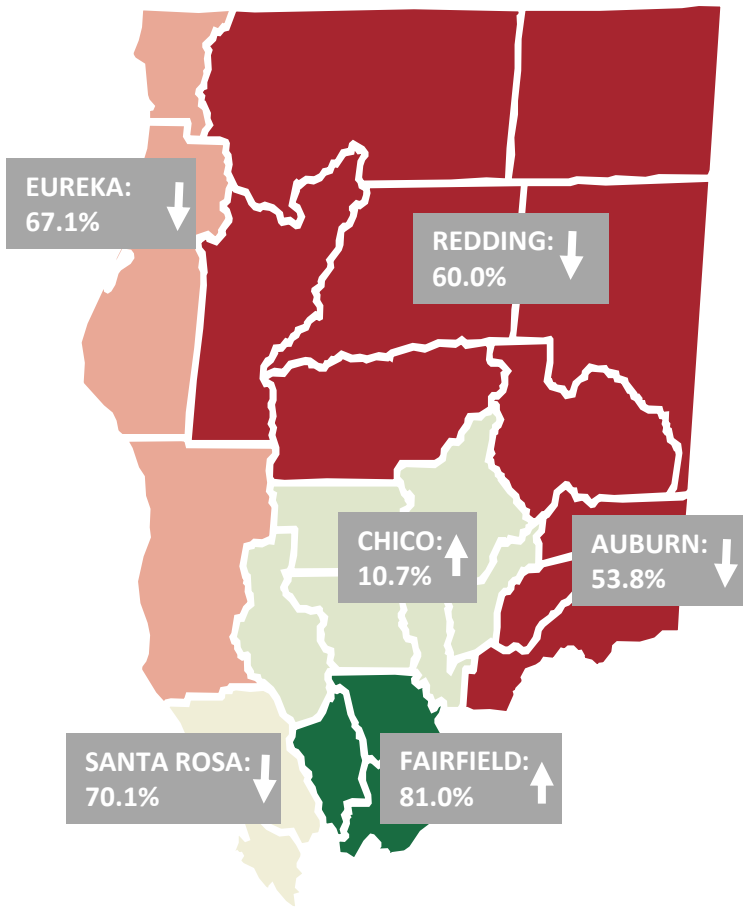
Getting Needed Care (Always+ Usually)
Plan Performance: 78.4%



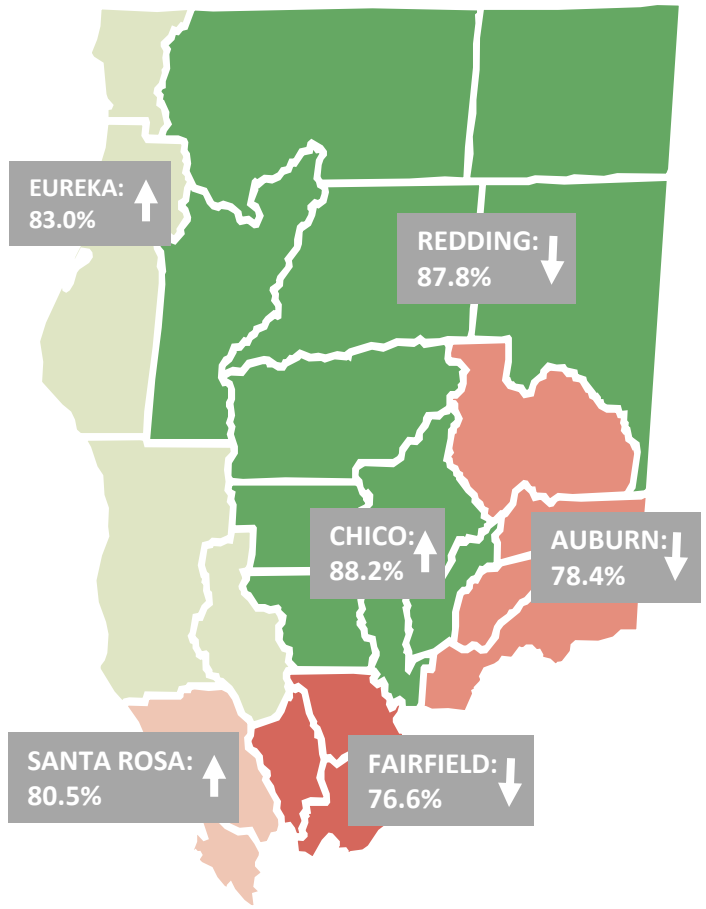


Regional Trends – Child CAHPS

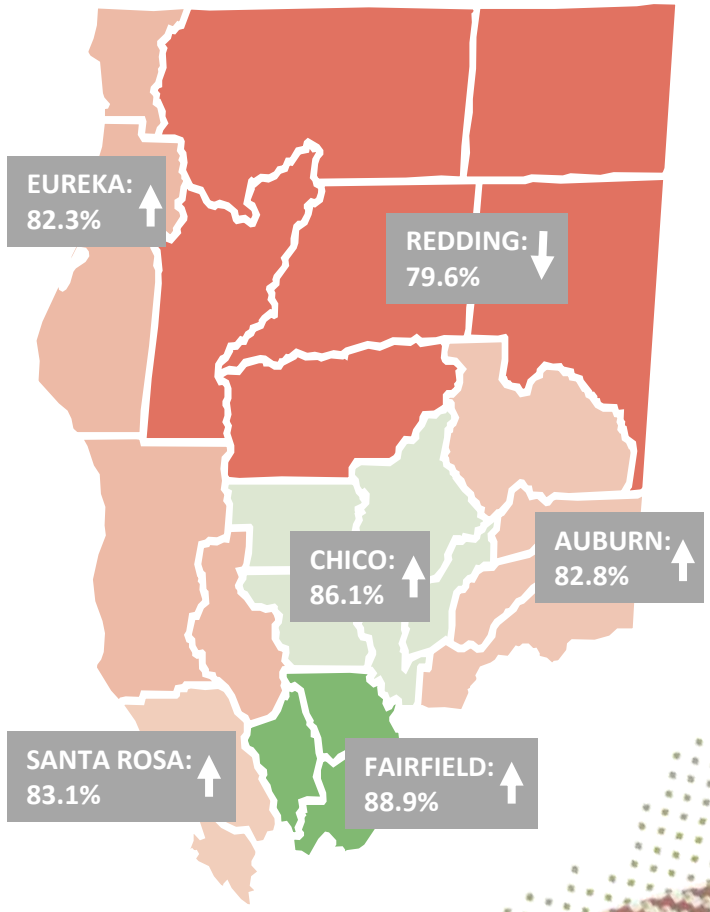
Rating of Health Plan (9+10)
Plan Performance: 69.9%



Getting Care Quickly (Always+ Usually)
Plan Performance: 82.1%

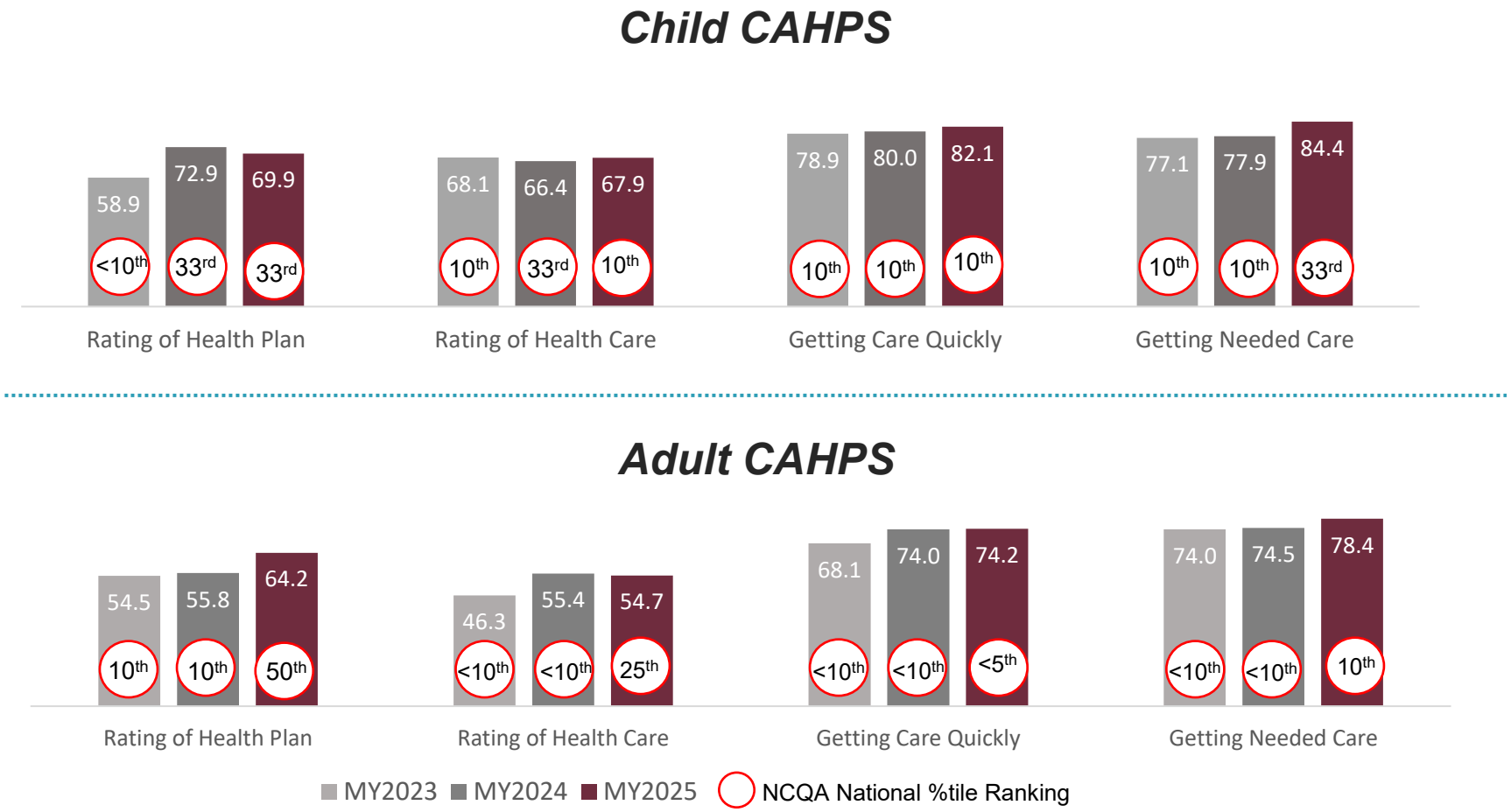


Getting Needed Care (Always+ Usually)
Plan Performance: 84.4%





CAHPS Performance Trends By Population



What Members Are Telling Us

- Experience is improving
- Benchmark gaps remain
- Friction exists across the care journey

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2027 QI Committees Meeting Schedules and Material Deadlines

Policies and Presentations due last Tuesday of preceding month:
Dec. 29, 2026; Jan. 26, 2025; Feb. 23; March 30; April 27; May 25; June 29; July 27; Aug. 24; Sept. 28; Oct. 26

Internal Quality Improvement (IQI) Committee

All meetings are held 2nd Tuesdays January through November. from 1:30 to 3:30 PM;* Note: * Sept. 7 is a first Tuesday *

Jan. 12, 2027 Feb. 9, 2027 March 9, 2027	April 13, 2027 May 11, 2027 June 8, 2027	July 13, 2027 Aug. 10, 2027 *Sept. 7, 2027*	Oct. 12, 2027 Nov. 9, 2027

Per MPQP1004, Standing Committee Members are required to appoint and send a designee if unable to attend:
Administration: CEO; COO; Associate Director of Regulatory Affairs & Compliance;
Appointed Regional Directors; Compliance Manager, Grievance & Appeals
Configuration: Configuration Department Leadership / ***Finance:*** Director, Health Analytics
Health Services *(i.e., BH, CC, EHS, HE, Pharmacy, PHM, QI, and UM):* Appointed Associate Medical Directors
Chief Medical Officer (Committee Chair); Deputy CMO; Medical Director for Quality (Vice Chair);
Medical Director for Medicare Services; Chief Health Services Officer;
Senior Directors of Behavioral Health, Care Management, and Quality & Performance Improvement;
Directors: Care Coordination, Enhanced Health Srvcs, Health Equity, Pharmacy, Pop Health, Quality Improvement;
Associate Directors: Care Coordination, Population Health; Utilization Management;
Manager, Care Coordination Regulatory Performance; Manager, Member Safety Quality Investigations;
Manager, Member Safety Quality Inspections; Senior Health Educator; Policy Analyst, UM
Member Services: Senior Director of Member Services & Grievance
Provider Relations: Director, Provider Relations ***Network Services:*** Director of Network Services

Quality/Utilization Advisory Committee (Q/UAC)

All meetings are held 3rd Wednesdays January through November from 7:30 to 9:00 AM
CONFIDENTIAL Peer Review Committee meets 9 to 10 AM and may need to meet in December, depending on caseload.

Jan. 20, 2027 Feb. 17, 2027 March 17, 2027	April 21, 2027 May 19, 2027 June 16, 2027	July 21, 2027 Aug. 19, 2026 Sept. 15, 2027	Oct. 20, 2027 Nov. 17, 2027

Per MPQP1002, the following Partnership staff, excluding the CMO and Medical Directors, serve as non-voting members:
Administration: Director, Grievance and Appeals; Appointed Regional Directors
Health Services: Chief Medical Officer (Committee Chair); Deputy CMO; Medical Director for Quality (Vice Chair);
Medical Director for Medicare Services; Clinical Director of Behavioral Health; Chief Health Services Officer;
Senior Directors: Care Management, Quality and Performance Improvement;
Directors of Health Equity, Population Health, Enhanced Health Services, and Pharmacy Services;
Director, Care Coordination; Associate Director, Utilization Management;
Manager, Member Safety, Quality Investigations; Manager, Member Safety, Quality Inspections; Senior Health Educator;
Appointed Regional Medical Directors and Associate Medical Directors
Provider Relations: Senior Provider Relations Rep Manager

Health Equity manages the Quality Improvement Health Equity Committee (QIHEC): Jan. 19, March 16, May 18, July 20, Sept. 21, and Nov. 16
The quarterly 2027 Over/Under Utilization Workgroup will meet Jan. 28, April 29, July 29, and Oct. 28.
The quarterly Member Grievance Review Committee (MGRC) will meet Feb. 25, May 27, Aug. 26, and Nov. 18, 2027

2027 QI Committee Presentations Calendar

As of Nov. 12, 2026 (subject to change)

The Internal Quality Improvement (IQI) and Quality/Utilization Advisory Committee (Q/UAC) will not meet in December.

Non-footnoted topics are scheduled for full presentations at both IQI and Q/UAC.

January – *due Tues., Dec. 29, 2026* 2026 Referral Follow-up (Tony Hightower) [1] 2026 CG-CAHPS Analysis (Robert Moore, MD) [1a]	**February** – *due Tues., Jan. 26, 2027* 2026 PQI/PPC Annual Report (Robert Bides) **Care Coordination Grand Analysis** (Angela Guevarra) 2025-2026 HQIP & PQIP 2026 Evaluations (Troy Foster) [1]
March – *due Tues., Feb. 23, 2027* Site Review & PARS Reports (Jackie Krznarich) 2026 C&L/QIHETP Work Plan Final Update (Hannah O'Leary) ***C&L Trilogy*** (Hannah O'Leary): 2026 C&L Program Evaluation, 2027 C&L Program Description, 2027 C&L Work Plan Grievance & Appeals PULSE Quarterly (Latrice Innes) [2] 2026-2027 QI Work Plan Update (Isaac Brown) [2a]	**April** – *due Tues., March 30, 2027* Population Needs Assessment (Hannah O'Leary) **UM/Pharmacy Evaluation/Grand Analysis** (UM/Pharm) UM Program Description (Tony Hightower) Pharmacy Operations Update (Stan Leung) [2a] HQIP & PQIP 2026 6-mo Bridge Evaluations (Troy Foster) [2]
May – *due Tues., April 27, 2027* **Grand Analysis: ME4 E&F Member Experience (BH)** (J. DeVido, MD) Behavioral Health Overview (Mark Bontrager/J. DeVido, MD) [5] IHA – Claims & Encounters Summary (Jackie Krznarich) [1]	**June** – *due Tues., May 25, 2027* InterQual® Annual Review (UM Team) Annual Grievance & Appeals (Kory Watkins) Grievance & Appeals PULSE Quarterly (Latrice Innes) [2] **Population Health Grand Analysis** (DeLorean Ruffin): 2027-2028 Strategy & Program Description, Segmentation Report and Impact Analysis 2026-2027 PHM Work Plan Final Update [2a]
July – *due Tues., June 29, 2027* HEDIS® Annual MCAS Summary (Kristine Gual) **Evaluations of three 2026 Quality Incentive Programs:** ECM & EXT (Deanna Watson) & Palliative (Tony Sengdara)	**August** – *due Tues., July 27, 2027* PQI/PPC 1st & 2nd Qtr 2026 (Robert Bides) [2] 2026-2027 QI Work Plan Final Update (Isaac Brown) ***QI Trilogy*** [3] (Isaac Brown): 2026-2027 QI Evaluation, 2027-2028 QI Work Plan, 2027-2028 QI Program Description **Proposals for seven 2028 QIPs:** ECM[2], EXT[2], Hospital, Palliative[2], Perinatal, Primary Care, and the **new** Dual-eligible Special Needs Plan (D-SNP)
September – *due Tues., due Aug. 24, 2027* 2026 PCP QIP Evaluation (Athena Beltran-Nampraseut) **Grand Analysis: Network Access/Adequacy** (PR Mgmt) 1st/2nd Qtr UM/Pharmacy IRR/Timeliness (UM/Pharm Team) [1] Grievance & Appeals PULSE Quarterly (Latrice Innes) [2]	**October** – *due Tues., Sept. 28, 2027* 5-Star QI Strategic Plan Update / NCQA Health Plan Rating (Kristine Gual) **Health Equity Trilogy & Grand Analysis** (Moe Jalloh): [6] 2027-2028 Strategy & Program Description, Impact Analysis & Program Evaluation, Annual Work Plan Oversight Audit: CY2026 Carelon (Gary Robinson) [2]
November – *due Tues., Oct. 26, 2027* UM Delegated Hospitals Summary (Tony Hightower) [2] Grievance & Appeals PULSE Quarterly (Latrice Innes) [2, 4] **Grand Analysis: Member Experience** (Conery & Sackett) [4] 3NA Survey Results (Vander Harris)	**January 2028** – *due Tues., Dec. 28, 2027* 2027 Referral Follow-up (Tony Hightower) [1] 2027 CG-CAHPS Analysis (Kermit Jones, MD, JD) [1a]

[1] Short presentation at IQI; on Q/UAC consent calendar for acceptance (no presentation)
[1a] Short presentation at IQI; FYI handout at Q/UAC (no vote required)
[2] On both IQI & Q/UAC consent calendars for acceptance (no presentation)
[2a] FYI handouts at both IQI and Q/UAC (no presentation; no vote required)
[3] QI Trilogy documents to be approved at Q/UAC in August, PAC in September, Board in October
[4] includes analysis of annual CAHPS® data
[5] includes Wellness & Recovery Benefit components
[6] to include HEDIS® & PCP/QIP data
[7] Short presentation at IQI. Will be presented at Q/UAC if time allows; otherwise, will be included as FYI in the Q/UAC packet.