PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality & Performance Improvement (QI)
DATE: Oct. 16, 2026
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

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.*
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, Oct. 21, 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
La Clinica, 1450 Fruitvale, Ave., Oakland

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, Regional Medical Director, Northeast
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
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, 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
Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI
Guevarra, Angela, RN, Associate Director of Care Coordination
Hanusiak, Kenze, Assoc. Dir., Regulatory Affairs & Compliance
Isola, Brandy, Mgt of Performance Improvement, QI (Chico/Auburn)
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
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: Oct. 21, 2026 **Time: 7:30 – 8:45 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:
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Partnership Staff only may join by Web-ex:
https://partnershiphp.webex.com/meet/quac Meeting # 809 114 256

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

This Brown Act meeting 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	Mark Netherda, MD	7:30	--
2	*Approval of* Sept. 16, 2026 Quality/Utilization Advisory Committee (Q/UAC) Minutes			5 – 11
3	*Acknowledgment and acceptance of draft minutes of the* • Sept. 8 Internal Quality Improvement (IQI) Committee • Sept. 15 & July 21 Quality Improvement Health Equity Committee (QIHEC) • Sept. 24, June 18, & Feb. 5 Substance Use Internal Quality Improvement (SUIQI) Committee • Aug. 27 Member Grievance Review Committee (MGRC)			13 – 85
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isaac Brown, MHA/MBA	7:40	87 – 98
2	HealthPlan Update	Robert Moore, MD, MPH, MBA	7:45	--
III.	**Old Business – None.**			
IV.	**New Business - Consent Calendar**			
Reports	Consent Calendar	All	7:50	99
	Primary Care providers Quality Incentive Program (PCP QIP) CY 2025 Evaluation – *direct questions to Athena Beltran – Nampraseut, CPhT*			101 – 126
	Q1/Q2 2026 Prior Authorization Metrics Report by Partnership County			127 – 128
	2026 Annual Oversight Audit: Carelon – Notice of Final Audit Results CY 2025			129 – 133
HS Policies	**Behavioral Health**			
	MCBP8015 – Coordination of Care for Child Welfare-Involved Members			135 – 139
	MPBP8007 – Screening and Treatment for Substance Use Disorders			141 – 156
	MPBP8013 – Eating Disorder Management Policy			157 – 165

	Item	Lead	Time	Page #
	Quality Improvement			
	MCQP1021 – Initial Health Appointment			167 – 177
	Utilization Management			
	MCUG3032 – Orthotic and Prosthetic Appliances Guidelines			179 – 182
	MCUP3020 – Hospice Services			183 – 198
	MCUP3114 – Physical, Occupational and Speech Therapies			199 – 205
	MCUP3128 – Cardiac Rehabilitation			207 – 212
	MCUP3130 – Osteopathic Manipulation Treatment			213 – 215
	MPUP3116 – Positron Emission Tomography Scans (PET Scans)			217 – 219
Non-HS	**Member Services**	All	--	
	MP316 – Provider Request to **Reassign** Member & Assistance with Inappropriate Member Behavior – **NEW TITLE –** *CLEAN copy of the policy begins on p. 235*			221 – 239
V.	**New Business – Health Services Discussion Policies**			
	Synopsis of Changes		--	241 – 245
	Quality Improvement			
	MPQG1005 – Adult Preventive Health Guidelines **–** *CLEAN copy of the policy begins on p. 261*	Mark Netherda, MD	7:55	247 – 264
	Utilization Management			
	MCUP3013 – Durable Medical Equipment (DME) Authorization	Tony Hightower, CPhT	8:01	265 – 280
	MCUG3118 – Prenatal & Perinatal Care	Colleen Townsend, MD	8:07	281 – 299
	MCUP3133 – Wheelchair Mobility, Seating and Positional Components	Tony Hightower, CPhT	8:13	301 – 312
VI.	**Presentations**			
1	MY 2025 NCQA Health Plan Rating – *PowerPoint begins on p. 313* • 5 Star Strategic Plan for Quality Improvement – 2026 – 2029 – *PowerPoint begins on p. 315; FYI report begins on p. 361* • The MY2025 / RY 2026 Healthcare Effectiveness Data and Information Set (HEDIS®) Health Plan Accreditation (HPA) Summary of Performance was not finalized when Q/UAC reviewed the Managed Care Accountability Set (MCAS) Summary of Performance in July; *the HPA white paper is included in today's packet under FYI and may also be found here:* https://edge.sitecorecloud.io/partnershipae75-partnership4b61-production30f9-46fc/media/Project/partnership-sites/partnershiphp/files/PDF/HEDIS-MY2025-Summary-of-Performance_HPA_COMSFINAL.pdf	Kristine Gual, PMP, CPHQ	8:19	313 – 321
2	Health Equity Disparities Grand Analysis: MY 2025 / RY 2026 - *PowerPoint begins on p. 323* • MCED6001 Health Equity and Community Reinvestment Strategy and Program Description was presented in August committee meetings and approved at the Sept. 9 Physician Advisory Committee (PAC). *A clean copy is included for context under FYI* • FY 2026-2027 Work Plan – *begins on p. 355* • Health Equity Strategic Plan (2027 - 2030) – *begins on p. 359*	Mohamed Jalloh, Pharm.D	8:30	323 – 360
VII. FYI	5-Star Strategic Plan for Quality Improvement 2026-2029 Report			361 – 379
	HEDIS® HPA white paper			381 – 444
	MCED6001 – CLEAN			445 – 479
	Adjournment scheduled by 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Nov. 18, 2026			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Quality and Utilization Advisory Committee (Q/UAC) Meeting Minutes
Wednesday, Sept. 16, 2026 / 7:31 a.m. – 8:25 a.m.
Fairfield: Napa/Solano Room, Redding: Airpark, Chico: Stony Creek, Santa Rosa Huddle

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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Approval/ Acceptance of Minutes Announcements	Committee Chair and Chief Medical Officer Robert Moore, MD, MPH, MBA, sitting in Fairfield called the meeting to order at 7:31 a.m. • The Aug. 19 Q/UAC Minutes were approved without any corrections. • *Acknowledgment and acceptance of draft meeting minutes of the* ○ Aug. 11 Internal Quality Improvement (IQI) Committee as amended at Sept. 8 IQI ○ July 29 Over/Under Utilization Workgroup • Announcements: ○ Medical Director for Quality Mark Netherda, MD, welcomed Jackie Krznarich, RN, and Jennifer Durst in their new respective roles as manager of Member Safety-Clinical Inspections and senior manager of Quality Improvement Programs.	Motion to **approve the Q/UAC minutes:** John Murphy, MD Second: Meagan Mulligan, FNP *Approved unanimously* Motion to **accept other minutes:** John Murphy, MD Second: Meagan Mulligan, FNP *Accepted unanimously*

II. Standing Updates

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

- The DataLink pilot has scaled up, and our vendor is helping us pull in data that we wouldn't normally be able to pull in from the various electronic health records (EHRs) at different provider organizations (POs). We have 26 POs on board; another 31 are in the process of getting DataLink at their sites. We hope this will result in acknowledgment of the great work that our network has already done and that we see this materially improve our Healthcare Effectiveness and Data Information Set (HEDIS®) rates.
- We have also had some changes to our Quality Score Measure Improvement (QSMI) groups. Historically, these have been cross functional groups that worked at a plan level. Now these groups are working on regional goals, still using subject matter expertise across the organization, but focused on the priorities we have for each region. So, there are some slight adjustments coming.
- We've also launched a new training program. As budgets have run tighter, we saw a need to provide some additional training to the network around Performance Improvement in Action. The idea here is for organizations, whether community-based organizations (CBOs), skilled nursing facilities (SNFs), primary care providers (PCPs), or counties, etc., would be able to take a problem that they are experiencing and work on it throughout this training program, six sessions over 12 weeks: to make good progress towards identifying a solution that they would like to implement. This is going Sept. 8 through Nov. 17. We encourage organizations to participate, especially if they haven't as many project managers or improvement resources as they have had in the past.

There were no questions for Isaac.

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

- Partnership is hosting a webinar on developmental screening for young children. (See Dr. Moore's monthly Medical Directors newsletter emailed Sept. 17 for registration information.) The Sept. 24 event will be hosted primarily by the University of California, Davis and Chape de Tribal Health. They developed a partnership where Chape de has moved the diagnostic part of the workup for kids who screen positive for developmental problems to their health center with individuals with specialized training, not relying on the regional centers, which were having a huge backlog. It's a strong model and has been put together well. I recommend that pediatric providers and health center leaders attend.
- You will recall last month that Kristine Gual presented the HEDIS® results. In October, we will be going through the Health Plan Accreditation (HPA) measures, which include additional measures above and beyond the Managed Care Accountability Set (MCAS). One notable group of those measures is the use of statins in individuals with diabetes, coronary artery disease, etc. Although clearly best practice and recommended by all specialist societies, the rates within our network were not as high as we would hope. (We do not have a pay-for-performance program.) This has impacted our overall National Committee on Quality Assurance (NCQA)

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Stars score, so the Pharmacy team is willing to do an analysis on prescribing data within your organization and give individual-level information so that individual can be reminded to appropriately prescribe the statins. Please remind your providers to follow the national guidelines on the use of statins and to request academic detailing from Partnership. • The Partnership Leadership Academy to assist up and coming leaders in our primary care network (complete with) a heavy dose of quality improvement methodology and learning) has just had its second session. There are 35 participants very dedicated to the community they serve. It's very inspiring to be working with them. This is a one-year pilot, and depending upon the finances, we will see if we can continue it in the future. • As you are aware, persons with unsatsfactory immigration status (UIS) are going to be carved out of Partnership, effective Jan. 1. This will include populations we have had all along, including kids with complex care needs (CCS) and pregnant women. This is a big transition. The State is not prepared to take on all the roles. They specifically had a strategy to move all the care they were responsible for to the Managed Care Plan (MCPs) a couple of years ago, and now they seem to have a strategy to bring it back in. It will be sort of a two-tiered system. More to come on that. • The State had worked with the federally qualified health centers (FQHCs) for several years to try and bring up an alternative payment methodology (APM) for FQHC care in the Medi-Cal system. Version 1 was not ultimately approved by the Centers for Medicare & Medicaid Services (CMS), and it was never implemented. The State proceeded with a Version 2 without CMS approval: CMS just formally disapproved the entire APM pilot a couple of weeks ago. The lesson there is just because you like a project do not assume it will be approved. It will be work to go backwards: we will have to repay based on the old system for all the care provided on the APM. • The H.R. 1 work requirements now have several tiers. (CMS squashed DHCS initial approach to make anything slightly plausible to be disabling a suitable condition for exemption.) Now, the work requirements from CMS have several tiers. Tier 1 is really people in the hospital. Tier 2 is some other diagnoses where other data sources can be involved. Tier 3 requires a clinician to sign off. There is much detail. The State now has to take the CMS framework and then create their regulations. • Our Board met last month and honored the high performers in the PCP QIP. It was a nice recognition. There were so many high performers, we had a separate Board session just for the recognitions. • Partnership's Board of Commission has approved a budget that involves a shortfall. Partnership will be spending down reserves this year with something like a $50M loss. It is a considerable shortfall, but compared to the size of the business, it is not gigantic. Partnership has been doing well with that balance sheet for some time; other plans are not doing so well and are doing layoffs, among other things. The financial strength of our organization allows us to weather tough times, which is a critical message to get out. *Q/UAC voter and pediatrician Randy Thomas, MD, asked about the Sept. 24 webinar. Dr. Moore reiterated the high points and added it is covering bringing in or training an in-house specialist – but not at the same level as someone who has completed a neuro-psych fellowship program – sufficient to do the initial screening to figure out autism and other developmental issues. Based on that, children would be triaged to the right location.*	
III. Old Business – None.		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Extended Care Quality Incentive Program (EXT QIP) CY 2027 Proposed Measure Set- *direct questions to Tony Sengdara* Pharmacy/Utilization Management Treatment Authorization Request (TAR) Timeliness, Inter-Rater Reliability (IRR) and UM Rates Reports – Quarters 1 & 2 2026 – *direct questions to Stan Leung, Pharm.D or Tony Hightower, CPhT* – **Dr. Moore pulls** Grievance & Appeals' PULSE Report, Issue 22, September 2026 – *direct questions to Latrice Innes* **Health Services Policies** Quality Improvement MPQP1002 – Quality/Utilization Advisory Committee		*Q/UAC voters posed no questions.* Motion to **approve the remaining slate as presented:** Randy Thomas, MD Second: Meagan Mulligan, FNP

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPQP1008 – Conflict of Interest Policy for QI Activities MPQP1022 – Site Review Requirements & Guidelines (with three revised attachments and one **archived** attachment) MPQP1053 – Peer Review Committee Utilization Management MCUG3022 – Incontinence Guidelines MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/D-H, ICF/DD-N Facilities MCUP3115 – Community Based Adult Services – **Anna Campbell pulls** MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump MPUP3078 – Second Medical Opinions	MCUP3115: Anna Campbell said UM has confirmed with Regulatory Affairs & Compliance (RAC) that paragraph VI.K can be deleted. Darling v. Douglas Settlement mention dating from 2012 is no longer necessary. Dr. Moore called Q/UAC's attention to the semi-annual Pharmacy/UM report. Pharmacy is hitting timeliness and has a low and "acceptable" overturned appeal rate. UM is also hitting timeliness goals. Q/UAC voter John Murphy, MD, asked what medications Partnership is responsible for and what goes through Medi-Cal Rx? Director of Pharmacy Stan Leung, Pharm.D, replied "our department is responsible for all the physician administered drugs (PADs). Medi-Cal Rx is responsible for all the pharmacy dispensed drugs and also certain home infusion drugs that go through the pharmacy."	*Approved unanimously* Motion to **approve MCUP3115 as amended:** Randy Thomas, MD Second: Meagan Mulligan, FNP *Approved unanimously* Motion to **approve the Pharmacy/UM Report as presented:** Randy Thomas, MD Second: John Murphy, MD *Approved unanimously* Next Steps: Oct. 14 Physician Advisory Committee (PAC)
V. New Business – Discussion Policies		
Policy Owner: Provider Relations – *Presenter: Aaron Brincko, MPH, Director of Provider Relations*		
MPPRGR210 – Provider Grievance	**This policy was pulled from July 7 IQI consideration for more edits. During this subsequent review, edits were made to incorporate Provider Relations' standing up of an internal mechanism to track provider grievances outside of Claims, Provider Dispute Resolutions (PDRs), and Treatment Authorization Requests (TARs).** **I. Related Policies** – updated to include CLPM-41 Claims Provider Dispute Resolution Mechanism and CMP38 Escalation and Corrective Action **II. Impacted Departments** – updated to "All Departments" as multiple departments may be impacted by a provider issue **III. Definitions** – updated Network Provider, PDR, and Provider Grievance definitions. **V. Purpose** – This policy establishes the process by which Network Providers may submit, and Partnership HealthPlan of California (Partnership) may review and resolve provider grievances. This policy applies to provider grievances that are not member grievances or member appeals and does not replace or supersede the Utilization Management/Pharmacy appeals or Medi-Cal Member Grievance processes. This policy is also separate from the Provider Dispute Resolution (PDR) process. Claims payment disputes, overpayment disputes, and other claim- related matters must first be addressed through the PDR process and are not eligible for review through the Provider Grievance process unless all applicable PDR processes have been exhausted. Providers not contracted with Partnership are not eligible to submit provider grievances. **VI. B. Intake** – To describe the Provider Relations' process for accepting and reviewing submitted	*Q/UAC voters posed no questions.* Motion to **approve as presented:** Randy Thomas, MD Second: Meagan Mulligan, FNP *Approved unanimously* Next Steps: Oct. 14 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	provider complaints. Informal complaints will be resolved by the PR team, with help from impacted departments For formal grievances, upon review, PR ensures that all Partnership appeal processes have been exhausted. Providers must submit their complaint within 180 days of the initial incident date. **VI.C Review/Resolution** – provides the grievance resolution cycle, including steps and timeline **IX. Position Responsible for Implementing Procedure –** updated to the Director of Provider Relations to reflect the new departmental organization. Aaron noted that one of the main components PR looks at for grievances is the timeline. That timeline now includes an 180-day submission deadline or any contracted provider who would like to grieve something within Partnership, usually a process. A formal provider grievance must be written. We will acknowledge that within a five-day time period and respond within 60 days. Within that 60-day time period, there is an opportunity for Provider Relations' PPO (Provider Performance Oversight) team to investigate. If there is additional review needed by the Executive team, we allow 15 days for that review and an additional 15 days to draft a letter, get all the necessary approvals, and respond. Each provider grievance is tracked in PR's customer resource management (CRM) tool. One other main highpoint is that this policy now differentiates the provider grievance process from a Claims PDR or a UM appeal, Aaron added. That's important because we want to preserve the integrity of those processes. Therefore, a provider cannot grieve an individual decision that has been an outcome of one of those processes; however, they can appeal the process. Dr. Moore called VI.E.1 to attention, noting that the informal process is where most issues come up where people are inquiring, if nothing else. It's different than for members where any expression of dissatisfaction bumps another grievance process, he said, and Aaron agreed, adding that the Health & Safety Code has more built into the requirements for member grievances versus provider grievances. Most of our questions or inquiries from providers do not have to be handled as a formal grievance. Most things can be resolved through conversation and minimal research. Finally, this policy is consistent with a couple of other sister plans.	
V. Presentations		
Grand Analysis: Network Access Assessment of Network Adequacy – CY 2025 *Presented by Renee Trosky, BSRRT, MOL, Manager, Network Services Compliance, Network Services*		
Dr. Moore prefaced Renee's high-level report by noting it meets an NCQA standard. NCQA standards for network management guide the creation of the NET reports, Renee began. This NET 3 report covers three categories: availability of practitioners, accessibility of services and a final assessment of network adequacy. Availability is the geographic distribution of practitioners, along with the appropriate type and number of practitioners to meet the needs of our members. Accessibility is the extent to which a member can obtain available services when they are needed. The overall assessment of network adequacy looks at availability, accessibility, and "member experience" via member grievances, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores and out-of-network referrals.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Plan-wide, Partnership met the provider to member ratio standard for all PCP practitioners. We also met the provider ratio standards for all our chosen high-volume specialty providers. We met the performance goal plan-wide for geographic distribution of primary care and the individual performance standard for each type of PCP; however, when we look at a breakdown of the data at a county level, we see that Lassen County did not meet the performance goal for any of the three types of primary care despite the family practice to member ratio being 1:1,300. Renee said this is indicative of a rural county where the population is widely dispersed, and the providers are in or near towns and cities. Plan-wide, Partnership met the performance goal for the geographic distribution of high volume and high impact specialties.

Four sparsely populated counties (i.e., Modoc, Siskiyou, Lassen and Del Norte) are too small to sustain a practice for many specialties and thus did not meet the time or distance standard for specialty care access. Our 3NA survey results show that plan-wide we did not meet our 2025 performance goal for non-urgent adult, pediatric, or newborn primary care appointments. For specialty care, we met the 2025 goal for non-urgent specialty care appointments but did not meet the goal for urgent specialty care appointments. In a closer look at non-urgent specialty care by region, Cardiology and Dermatology fell below the standard. Ob-Gyn fell short in the Eureka region, Ophthalmology in the Fairfield and Santa Rosa regions, and Orthopedic Surgery in the Santa Rosa region.

When we look at member grievances regarding access, we see that we met the threshold of 3.12 grievances per 1,000 in 2025 despite small increases from 2024. Breaking down the access grievances between primary and specialty care, the majority of grievances are related to primary care in all three areas: appointment availability, office availability, and telephone availability.

Looking at CAHPS®, the adult composite score for getting needed care and getting care quickly both increased slightly, however, both failed to meet the ≥33rd Partnership benchmark. We see the same scenario for the child composite scores. This indicates we continue to have dissatisfaction with member access, which influences health plan ratings.

Partnership did meet the out-of-network request (≤20 per 1,000 members) and utilization performance (≤10 per 1,000 members) standards for 2025: both OON requests and claims decreased from 2024 totals.

When we put all the data together, an opportunity for improvement was identified in appointment access to non-urgent primary care. Partnership has fallen short of the goal for a second year in a row. To address this, the provider recruitment program was refined and extended to incentivize providers to join and remain in the network. The PRP offers sign-on bonuses for providers new to the Partnership network, including providers practicing outside our 24-county service area, as well as graduates completing training programs within our service area. We have seen success with this approach: in 2025, Partnership approved 185 awards. Family Medicine remained the most frequently awarded specialty, accounting for approximately 51% of the awards compared to 57% in 2024.

There are other opportunities that can be identified and several other initiatives are going on, but for the purposes of this report and NCQA, we select one opportunity to highlight.

Dr. Moore commented that Partnership has sponsored feasibility studies and other ways for the formation of primary care residencies in our area. About 15 years ago, there were two primary care residencies in our service area. Now, there is about 13 to 15. There's a new one starting up in Del Norte.

He added that, for the OON requests, we probably had a spike in 2024 with the new counties because we hadn't finalized all our contracts: specialty referrals in the new region were going to specialists who had not yet been contracted and thus were captured as OON referrals. It's not that 2025 was down but that 2024 was an anomaly on the high side, he clarified. One note on specialty access, Fairfield and Santa Rosa are not rural but urban, and those are the areas where we struggle with access. Dr. Moore asked Director of Provider Relations Aaron Brincko if he had any reflections on the specialty access in our suburban southern part of the region. Aaron responded that a perhaps more informative way to look at the data would be to differentiate time and distance standards by whether a county is either rural or suburban.

Dr. Moore recalled that CMS froze new federally funded residency slots back in 1998, commenting "It takes a while to have a ripple, but it has now as retirements

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

happen and the number of residencies coming into the system is stable (but) not growing with the population. The shortage is a nationwide phenomenon. One of the things that saved us a little bit is that nurse practitioners and PAs came into the system to save us from the fact that we were undertraining primary care clinicians. We are seeing many more PAs and NPs joining specialty practices. It comes at a cost of less training and experience but at the same time it allows access."

Dr. Moore added that "many specialists don't like the fee-for-service Medi-Cal reimbursement rate," and that an acute shortage of specialists will continue even as the UIS population is carved out from Partnership's membership rolls. "One solution on the specialty side, because of the economic forces, is to have the health centers do what they have been doing and hire their own specialists, at least on the outpatient side."

Associate Medical Director Marshall Kubota, MD, asked if the specialty distance measures are irrespective of county borders and also account for telehealth. Dr. Moore responded that our computer systems account for both.

Q/UAC voter John Murphy, MD, asked if the thresholds in this report were set by DHCS, internally, or some of both. Dr. Moore replied that these are NCQA thresholds and offered to further discuss this offline.

Q/UAC voter Randy Thomas, MD, said about 30% of the persons he refers to Dermatology do not need to go but they wanted to before even trying an adequate trial of therapy. "I wonder if webinars to try to make primary doctors more comfortable with their skills could be helpful with reducing that?" he asked. Dr. Moore suggested primary care providers talk "we'll try this, and if it doesn't work, we'll try that, and if that doesn't work, we'll send you to Dermatology."

Medical Director for Quality Mark Netherda, MD, suggested that PCPs do know how to have these conversations but "are just burned out and tired of patients coming in and demanding things and being angry at them when they say no. The grievances I get are 'I went in and asked to see a cardiologist just so I could get checked out, and they said no. I went in for genetic testing, and they said no.'" Dr. Moore acknowledged this is a problem, adding it is particularly hard when a patient the doctor doesn't know comes in and asks for such.

Motion to approve the Grand Analysis: Jennifer Wilson, MD/Randy Thomas, MD. Unanimously approved.

VI. Adjournment to 7:30 – 9:00 a.m. Oct. 21 2026

Dr. Moore adjourned the meeting at 8:25 a.m.

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

Signature of Approval: _____ Date: _____

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

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Sengdara,

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

Tuesday, Sept. 8, 2026 / 1:33 – 2:44 PM

Members Present:	Hanusiak, Kenzie, Assoc. Dir., Regulatory Affairs & Compliance
Ayala, Priscila, Director of Network Services	Innes, Latrice, Compliance Manager, Grievance & Appeals
Barresi, Katherine, RN, BSN, PHN, Chief Health Services Officer	Jalloh, Mohamed, Pharm.D, Dir. of Health Equity (Health Equity Officer)
Beard, Alyssa, RN, Manager of CC Regulatory Performance	Jensen, Annika, RN, Assoc. Dir. of Clinical Integration, Care Coordination
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations	Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Services
Bontrager, Mark, Senior Director of Behavioral Health, Health Services	Krznarich, Jackie, RN, Manager, Member Safety – Quality Inspections
Brincko, Aaron, Director of Provider Relations	Leung, Stan, Pharm.D, Director of Pharmacy Services
Brown, Isaac, MHA/MBA, Senior Director, Q & PI	O'Connell, Lisa Brundage, MHA, Director, Enhanced Health Services
Brunkal, Monika, RPh, Associate Director of Population Health	Randhawa, Manleen, Senior Health Educator, Population Health
Campbell, Anna, MPH, Policy Analyst, Utilization Management	Villasenor, Edna, Senior Director, Member Services and Grievance
Devan, James, Director of Quality Improvement, QI	Vaisenberg, Liat, Director of Health Analytics
DeVido, Jeffrey, MD, Behavioral Health Clinical Director	Ward, Lisa, MD, Regional Medical Director (SW-Santa Rosa)
Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI	
Members Absent:	Klakken, Vicky, Regional Director (NW-Eureka)
Andrews, Leigha, Regional Director (SW)	Matthews, R. Douglas, "Doug," MD, Regional Medical Director (Chico)
Bjork, Sonja, JD, Chief Executive Officer	Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Davis, Wendi, Chief Operating Officer	Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Newman, Rachel, RN, BSN, Associate Director, Credentialing
Guevarra, Angela, RN, Director of Care Coordination	Ruffin, DeLorean, DrPH, Director of Population Health
Hightower, Tony, CPhT, Associate Director, UM Regulations	Townsend, Colleen, MD, Regional Medical Director (SE-Fairfield)
Guests:	Leung, Paul, Sr. Health Data Analyst I, Finance
Aarons, Rose, Quality Training Specialist & Dental Liaison, QI	Mednick, Christy, Sr. Health Data Analyst I, Finance
Akintan, Folo, MBBS/MD, MPH, MBA, Epidemiologist, Pop Health	Moraghebi, Roudabeh, Manager of Health Analysts, Finance
Allen, Angier, Senior Data Scientist I, Finance	Newell, Amber, CPhT, Program Manager I, QI
Beltran-Nampraseut, Athena, Program Manager II, QI (PCP QIP)	Nguyen, Tom, Manager of Health Analytics, Finance
Bikila, Dejene, Manager of Data Science, Finance	O'Leary, Hannah, MPH, CHES, Manager of Population Health
Brackett, Jacquelyn, Administrative Assistant I, Pharmacy	Quichocho, Sue, Manager of Quality Measurement, QI
Clark, Kristen, Manager of Quality & Training, Member Services	Rathnayake, Rasitha, Sr. Health Data Analyst I, Finance
Cunningham, Aryana, Policy Analyst, Care Coordination	Rednic, Hanny, Program Manager I, UM
Durst, Jennifer, Senior Manager of Performance Improvement, QI	Roach, Erika, Program Manager II, Network Services
Elder, Alaina, Manager of Provider Network Teams, Provider Relations	Salehi, Tiphanie, Senior Health Data Analyst II, Finance
Harris, Vander, Senior Health Data Analyst I, Finance	Sengdara, Tony, Program Manager I, QI
Hendrix, Hillary, Executive Assistant, Behavioral Health	Smith, Christine, Community Health Needs Liaison, Population Health
Isola, Brandy, Manager of Performance Improvement, QI (Chico)	Spiller, Bettina, MD, Associate Medical Director
Kubota, Marshall, Associate Medical Director	Thomas, Penny, Senior Health Data Analyst I, Finance
Kulkarni, Shreya, JD, Policy Analyst, Regulatory Affairs & Compliance	Trosky, Renee, Manager of Provider Relations Compliance, Network Services
Lee, Donna, Manager of Claims, Claims	Vance, Brooke, Program Manager I, Network Services
Legere, James, Project Coordinator I, Regional Admin, Chico	Watson, Deanna, Program Manager I, QI (ECM QIP)
Ling, Samuel, Sr. Health Data Analyst I, Finance	Yu, Fei, Sr. Data Scientist I, Finance
	Zhao, Li Sr. Health Data Analyst I, Finance

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order • Announcements • Approval of Minutes	Senior Director of Quality & Performance Improvement Isaac Brown called the meeting to order at 1:33 p.m. from the Fairfield-West office. He announced that the IQI chair will rotate between him, Senior Director of Care Management Brigid Gast, RN, and physician leadership during the next several months as Partnership prepares for Chief Medical Officer Robert Moore's retirement. Likewise, the Quality/Utilization Advisory Committee (Q/UAC) chair will rotate between Deputy Chief Medical Officer Kermit Jones, MD, JD, and Medical Director for Quality Mark Netherda, MD. • **The Aug. 11 IQI Minutes were approved with one amendment proposed by Anna Campbell:** o **Add the following meeting postscript** to the discussion of MCUP3052 – Medical Nutrition Therapy (MNT) Services: Further offline discussion on whether members utilizing the MTM benefit through Community Supports can simultaneously utilize the MNT benefit has determined that Department of Health Care Services' (DHCS) guidance would technically allow that. • **The July 29 Over/Under Utilization Workgroup minutes were accepted after some discussion**. o Anna Campbell pointed out that the Treatment Authorization Request (TAR) volume captured seemed high as UM only had 162,000 for the same reporting period. Dr. Jones speculated the O/U reported number included Transportation, and Associate Medical Director Marshall Kubota, MD, agreed. Isaac added that the reported number does jibe with dashboard figures. *After IQI*, Anna conferred with UM Program Manager Kandice Dixon, who seemed certain the O/U capture was really "prior authorizations," which included both TARs and Referral Authorization Forms (RAFs).	Motion to approve IQI minutes with the one change: Lisa O'Connell, MHA Second: Aaron Brincko, MHA *Motion passes* Motion to accept the O/U minutes as presented: Stan Leung, Pharm. D Second: Kristine Gual *Motion passes*
II. Old Business – None.		
III. New Business Consent Calendar (Committee Members as applicable)		
Grievance & Appeals' PULSE Report, Issue 22, September 2026 – *direct any questions to Latrice Innes* **Health Services Policies** <u>Pharmacy</u> MCRP4066 – AB1114 Benefit Implementation and Oversight <u>Quality Improvement</u> MPQP1002 – Quality/Utilization Advisory Committee MPQP1008 – Conflict of Interest Policy for QI Activities MPQP1022 – Site Review Requirements & Guidelines (with only revised attachments E, L, & M; ARCHIVING old L) MPQP1053 – Peer Review Committee <u>Utilization Management</u> MCUG3022 – Incontinence Guidelines MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/D-H, ICF/DD-N Facilities MCUP3115 – Community Based Adult Services MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump MPUP3078 – Second Medical Opinions **Non-Health Services Policies** <u>Network Services - Credentialing</u> MPCR12 – Credentialing of Individual and Private Duty Nurses Under EPSDT – ***pulled for discussion*** MPCR200 – Credentials Committee and CMO Credentialing Program Responsibilities – ***pulled for discussion***	Motion to **approve the slate without the 2 Credentialing policies:** Lisa O'Connell Second: Edna Villasenor *Motion passes* <u>Next Steps MCRP4066</u>: • Oct. 8 Pharmacy & Therapeutics Committee (P&T) • Nov. 4 Physician Advisory Committee (PAC) <u>Next Steps rest of Health Services' Slate:</u> • Sept. 16 Q/UAC • Oct. 14 PAC Motion to **approve MPCR12 as amended:** Kristine Gual Second: Lisa O'Connell

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Anna Campbell pulled both Credentialing policies to ask questions. Re MPCR12, she suggested that the private duty nursing services definition should be identical to Care Coordination's MCCP2031, which mentions licensed practical nurses (LPNs). Anna also suggested that if Attachment A – Individual Nurse Agreement is our form that it be placed on Partnership letterhead or otherwise branded as our document. Lastly, Anna suggested that "nurse practice act B" be better described in the first paragraph of Attachment A. **Anna will send her notes to Renee Trosky, who will work with Rachel Newman, RN, to update the policy for the Credentials Committee's consideration Sept. 9.** Re MPCR200, Anna said that if PAC is to be an approver, some policy language may need to change. Also, as the Board of Commission By-laws delegates policy approval only to Finance, PAC, and the Credentials Committee, there is no need to add PAC as an additional approver after the Credentials Committee has already approved a policy. Anna suggested Kenzie Hanusiak, Rachel Newman and Board Clerk Ashlyn Scott look at the By-laws, as compliance with that language is part of our DHCS Contract. **Dr. Jones said this meeting should happen soon so that the policy can come back to Oct. 13 IQI, and Chief Medical Services Officer Katherine Barressi, RN, then tabled further IQI consideration until that time.**	*Motion passes* MPCR200: Priscila Ayala said a meeting to answer expressed concerns would occur within the next five business days.
IV.	**New Business – Discussion Policies**	
Policy Owner: Provider Relations – *Presenter: Aaron Brincko, MPH, Director of Provider Relations*		

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

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

MPPRGR210 – Provider Grievance	**This policy was pulled from July 7 IQI consideration for more edits. During this subsequent review, policy edits were made to incorporate Provider Relations' standing up of an internal mechanism to track provider grievances outside of Claims, Provider Dispute Resolutions (PDRs), and Treatment Authorization Requests (TARs).** **I. Related Policies** – updated to include CLPM-41 Claims Provider Dispute Resolution Mechanism and CMP38 Escalation and Corrective Action **II. Impacted Departments** – updated to "All Departments" as multiple departments may be impacted by a provider issue **III. Definitions** – updated Network Provider, PDR, and Provider Grievance definitions. **V. Purpose** – updated to reflect the updated Provider Grievance process by which provider grievances are submitted, reviewed, and resolved. **VI. B. Intake** – To describe the Provider Relations' process for accepting and reviewing submitted provider complaints. 1. Informal complaints will be resolved by the PR team, with help from impacted departments	Motion to **approve as amended:** Anna Campbell Second: Kermit Jones, MD, JD *Motion passes* Next Steps: Sept. 16 Q/UAC Oct. 14 PAC ***Meeting postscript***: Alaina emailed Sarah Browning on Sept. 21 that PR would like to verbally change the title of its intake form mentioned at VI.B.3 from Provider

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	2. For formal grievances, upon review, PR ensures that all Partnership appeal processes have been exhausted. 3. Providers must submit their complaint within 180 days of the initial incident date. **VI.C Review/Resolution** – provides the grievance resolution cycle, including steps and timeline **IX. Position Responsible for Implementing Procedure** – updated to the Director of Provider Relations to reflect the new departmental organization Aaron noted that this policy had not been updated for some time and that it is now refreshed with some observations from Regulatory Affairs and Compliance (RAC). Instead of 45 days, providers now have 180 calendar days from the incident date to formally or informally report any concerns to Provider Relations. If the PR team is unable to adjudicate the grievance within 30 business days, the matter may be referred to the Executive Committee, which has a further 15 days to determine a final decision. Anna Campbell wondered if it would be more correct to check the follow-up box for "Provider Education" instead of "IPN" as claims may not be grieved. Aaron acknowledged this, clarifying that providers may grieve how the PDR *process* worked. **This policy's Purpose statement is amended to read, in part,** "This policy applies to provider grievances that are not member grievances or member appeals and does not replace or supersede the Utilization Management/ Pharmacy ***appeals process*** or Medi-Cal Member Grievance processes."	*Grievance* Intake Form to Provider *Concern* Intake Form at the Oct. 14 PAC.
MPPR210 – Long-Term Services and Supports Liaison	**This policy was reviewed in accordance with All Plan Letters (APLs) 26-010, 26-011, and 26-012. It had been an internal policy but is coming to IQI now as an external policy. This policy outlines the role of our Long-Term Services and Supports (LTSS) Liaison, including their contact information, training received, and responsibilities.** **Related Polices**: Several EHS, UM, and PR policies are added. **Definitions:** Long-Term Care, (LTC) Long-Term Services and Support (LTSS) and Network Provider as defined. **VI.A.** – The LTSS Liaison serves as the Health Plan's point of contact for LTSS providers. **VI.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 **VI.C.7** – The LTSS Liaison will facilitate quarterly "office hours" webinars for all eligible Network Providers furnishing LTC services. **References**: Updated to include the three APLs listed above. Aaron noted the intent is to make this policy sound less like a job description. The policy deliberately uses DHCS's long term care definition, and Aaron asked if this runs contrary to how Partnership defines its like term. Anna Campbell said Partnership UM further defines the variations of long term care in MCUG3038 -	After discussion, IQI agreed to defer action on this policy until Aaron Brincko and Kenzie Hanusiak could do further work together. ***Meeting postscript***: PR will further discuss this policy on Sept. 22. This policy may come back to IQI on Oct. 13.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Review Guidelines for Member Placement in Extended Care (Custodial/Long-Term Care, Skilled or Subacute) Facilities to make it clear where extended care takes place vs. other levels of inpatient care that may occur in, for example, acute rehab facilities as defined in MCUG3024 – Inpatient Utilization Management. Partnership usually thinks of long term care as custodial care, Anna said. Anna and Janet Rudd, RN, (UM's Manager of Long Term Support Services) have sent to Alaina Elder a draft of MPPR210 that aligns with MCUG3038. The draft includes UM's definition of extended care facilities. RAC Associate Director Kenzie Hanusiak noted this liaison position is contractually defined by DHCS, and she wondered if updating the policy definitions may affect how the liaison interacts with any one site. Kenzie recommended that PR again review this policy to make sure that our liaison is not over committed. Our current liaison, she said, does not provide coaching and oversight for LTAC (long term acute care).	

V. Presentations

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

- Early in 2026, the Performance Improvement leadership team, in coordination with our Healthcare Effectiveness Data Information Set (HEDIS®) team, evaluated accountable measure performance across our 24-county footprint and identified priority measures by geography that needed to be prioritized according to several factors, including financial risk. At that time, leadership decided performance varied enough by geography that a regionally focused strategy was needed. Today, additional geographic stratification is required.
- 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.
- Partnership's next National Committee for Quality Assurance (NCQA) Health Plan Accreditation (HPA) Renewal Survey is scheduled for Sept. 15. We are projecting a 3.0 Star rating utilizing the Consumer Assessment of Healthcare Providers and Systems' (CAHPS®) Child Survey.
- We are looking at expanding medical record review of W30.

There were no questions for Isaac.

Extended Care Quality Incentive Program (EXT QIP) CY 2027 Proposed Measure Set – *Tony Sengdara, Program Manager I, QI*

There are no changes proposed for the Gateway measures. Measures 1 through 9 are changing in available point targets. An additional expectation of "successful entry into the California Immunization Registry (CAIR)" s being added to Measures 3 and 4: Percentage of long-stay residents who needed and got a flu shot, and percentage of long-stay residents who received a vaccine to prevent pneumonia, respectively.

Measure 10 – Health Equity Impact Analysis and Plan – is being added. Facilities are required to submit by Aug. 31, 2027 for Partnership review/approval/rejection an updated Health Equity Impact Analysis and Plan that addresses health disparity in at least one of the following measures:

- Percent of high-risk residents with pressure ulcers
- Percent of residents who lose too much weight
- Long-stay residents who receive a vaccine to prevent pneumonia
- Percent of residents experiencing one or more falls with major injury
- Percent of residents who have/had a catheter inserted and left in the bladder

There were no questions for Tony.

Isaac noted that Partnership is endeavoring to wrap each of its 2027 measure sets by the end of September 2026 so to proceed to contracting.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

Pharmacy/Utilization Management TAR Timeliness, IRR and UM Rates Reports – Quarters 1 & 2 2026 – *Stan Leung, Pharm.D, Director of Pharmacy Services, and Hanny Rednic, Program Manager I, UM*

Stan reported that in both Q1 and Q2 2026, Pharmacy was 100% compliant in overall timeliness of denials notification in Adverse Benefit Decision (ABDs) determinations resulting from medical necessity review and benefit coverage reviews. Pharmacy also exceeded the 95 percent threshold with 100% compliance in each quarter for urgent/concurrent (within 72 hours), urgent pre-service, non-urgent pre-service, and post-service (within 30 calendar days) requests. Between Jan. 1 and June 30, 2026, 3,907 or 86.15% of 4,535 TARs were approved, and 897 or 19.78% were denied. (The numbers do not add to 100% because they include modified approvals, Stan noted.) The Pharmacy Inter-Rater Reliability (IRR) 90% concurrence threshold was also exceeded across both pharmacy technicians (99%) and pharmacists (99%). Only one Pharmacy appeal decision was overturned during this time period.

UM enjoyed a similar compliance record but fell a bit short of the 95% timeliness threshold in two categories in Q2 with 94.9% in urgent preservice and 94.2% in non-urgent preservice TARs. Hanny noted that one reason why is that UM changed its pediatric rates, allowing for staff training. Overall, UM approved 73.53% of 159,225 (117,078) non-Behavioral Health TARs while denying 27.64% (44,017). All UM teams scored well above the 90% IRR concurrence threshold: inpatient nurse coordinators (96.6%), outpatient nurse coordinators (99.67%), long-term services and supports (LTSS) nurse coordinators (96.3%), and physicians (98.8%). Month-over-month across all regions during the first half of 2026, inpatient UM nurse coordinators averaged 9.7 non-Behavioral Health TARs each day; outpatient nurse coordinators averaged 20.86 TARs each day, and LTSS nurse coordinators averaged 6.9 TARs each day.

There were no ABD determinations resulting from medical necessity and benefit coverage reviews for Behavioral Health during Q1 and Q2. (No TARs are required for low to moderate behavioral health, Hanny noted.) Month-over-month, however, two UM nurse coordinators each averaged 4.4 Wellness & Recovery TARs per day.

Hanny concluded that, based on Q3 and 4 2025, UM is on track to similarly finish 2026.

There were no questions for either Stan or Hanny.

Grand Analysis: Network Access Assessment of Network Adequacy – CY 2025 – *Renee Trosky, BSRRT, MOL, Manager of Provider Relations Compliance, Network Services*

NCQA standards for network management guide the creation of the NET reports, Renee began. This NET 3 report covers three categories: availability of practitioners, accessibility of services and a final assessment of network adequacy. Availability is the geographic distribution of practitioners, along with the appropriate type and number of practitioners to meet the needs of our members. Accessibility is the extent to which a member can obtain available services when they are needed. The overall assessment of network adequacy looks at availability, accessibility, and "member experience" via member grievances, Consumer Assessment of Healthcare Providers and Systems (CAHPS®) scores and out-of-network referrals.

Plan-wide, Partnership met the provider to member ratio standard for all PCP practitioners. We also met the provider ratio standards for all our chosen high-volume specialty providers. We met the performance goal plan-wide for geographic distribution of primary care and the individual performance standard for each type of PCP; however, when we look at a breakdown of the data at a county level, we see that Lassen County did not meet the performance goal for any of the three types of primary care despite the family practice to member ratio being 1:1,300. Renee said this is indicative of a rural county where the population is widely dispersed, and the providers are in or near towns and cities. Plan-wide, Partnership met the performance goal for the geographic distribution of high volume and high impact specialties. Partnership Epidemiolgist Folo Akintan, MBBS/MD, asked if Lassen's shortcomings are more than geographical and if telehealth couldn't fill some gaps? Renee replied that while telehealth can indeed fill some care gaps, it cannot be utilized to meet geographic standards.

Four sparsely populated counties (i.e., Modoc, Siskiyou, Lassen and Del Norte) are too small to sustain a practice for many specialties and thus did not meet the time or distance standard for specialty care access. Our 3NA survey results show that plan-wide we did not meet our 2025 performance goal for non-urgent adult, pediatric, or newborn primary care appointments. For specialty care, we met the 2025 goal for non-urgent specialty care appointments but did not meet the goal for urgent specialty care appointments. In a closer look at non-urgent specialty care by region, Cardiology and Dermatology fell below the established median 15-day appointment standard. Ob-Gyn fell short in the Eureka region, Ophthalmology in the Fairfield and Santa Rosa regions, and Orthopedic Surgery in the Santa Rosa region.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

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When we put all the data together, an opportunity for improvement was identified in appointment access to non-urgent primary care. Partnership has fallen short of the goal for a second year in a row. To address this, the provider recruitment program was refined and extended to incentivize providers to join and remain in the network. The PRP offers sign-on bonuses for providers new to the Partnership network, including providers practicing outside our 24-county service area, as well as graduates completing training programs within our service area. We have seen success with this approach: in 2025, Partnership approved 185 awards. Family Medicine remained the most frequently awarded specialty, accounting for approximately 51% of the awards compared to 57% in 2024.

There are other opportunities that can be identified and several other initiatives are going on, but for the purposes of this report and NCQA, we select one opportunity to highlight. Renee concluded her presentation, reiterating that this is the NET3 report. Persons interested in the NET1 and NET2 reports may contact her for more information.

VI. Adjournment

Isaac Brown adjourned the meeting at 2:44 p.m. IQI next will meet Tuesday, Oct. 13, 2026.

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

Approval Signature: *Date:*

Issac Brown, MHA/MBA
Senior Director, Quality & Performance Improvement

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4665 Business Center Drive
Fairfield, California 94534

MEETING Minutes

Meeting & Project Name: Quality Improvement Health Equity Committee (QIHEC)

Date: 9/15/2026 **Time**: 7:30 a.m. – 9:00 a.m.

Facilitator: Mohamed Jalloh, Pharm D

Coordinator: Bethany Hannah

Meeting Locations:

- Webex

Attendees: Aaron Brincko; Adrianne Prado, Amanda Harrison; Amanda Kim, Anna Cambell; Anthony Sackett; Brittany English; Brandon Yadi; Candy Stockton; Chelsea Lingao; Bethany Hannah; Christine Smith; Dawn Cook; DeLorean Ruffin; Denise Rivera; Folo Akintan; Hannah O'Leary; Irem Conery; Isaac Brown; Jesus Hermosillo; Jeffrey DeVido; Jim Huckin; Kermit Jones; John Lemoine; Jose Purga; Katherine Barresi; Katheryn Power; Kory Watkins; Kristine Gual; Lilly Merino; Lisa Ward; Lisa O'Connell; Liz Romero; Liat Vaisenberg; Manleen Randhawa; Matthew Morris; Mark Bontrager; Mark Netherda; Marshall Kubota; Michele Grupe; Melissa Schumann; Mohamed Jalloh, PharmD; Monika Brunkal; Naz Sattari; Nicole Curreri, MPH CHES; Rebecca Stark; Rod Grace; Roni Schultz; Saskia Garcia; Shahrukh Chishty; Shantal Shamoiel; Sydni Aguirre; Valerie Padilla; Stan Leung, Sue Lee; Robert Moore, MD; Sue Quichocho; Tiffany Tryan; Tony Hightower; Wendy Starr;

Guests: Saskia Garcia; Brittany English; Chelsea Lingao

Absent: Sonja Bjork; Whitney Haggerson; Amanda Smith; Hendry Ton, MD; Ian Kim; Kimberly Robertello; Noemi Doohan; Rachel Newman; Rocio Rodriguez; Rebecca Stark; Shannon Boyle; Latrice Innes; Nisha Guppta;; Robert Bides; Shahrukh Chishty; Nicole Escobar; Heather Eset; Greg Allen Freedman; Jaymee James; Sue Quichocho; Dorian Roberts; Tim Sharp; Amy Turnipseed; Edna Villasenor; Bridget Gast; Dana Codron; Monica Ferguson; Priscila Ayala; Wendi Davis; Chloe Ungaro; Kristina Coester; Ledra Guillory; Lisa Wada; Tiffani Thomas; Chloe Ungaro; Kristina Coester; Ledra Guillory; Dana Constantino; Sydni Aguirre; Eugene Durrah; Kelly YoungsStone; Liz Romero; Amanda Kim; Cathryn Couch, DrPH, MPH; Leila Romero; Ben Spencer; Denise Whitsett; Emily Wellander; James Devan; Juan Godinez; Kimberly Robertello; Sunshine Jackson; Vicky Klakken

External Advisory Members

Name	Affiliation	Org Type	3/17/26	5/19/26	7/21/26	9/15/26	11/17/26
Jason Cunningham, MD Chief Executive Officer	West County Health Centers	FQHC	X	X	X	X	
Eugene Durrah Equity Services Manager	Solano County	County	X				
Ian Kim, MD Family Physician	Communicare + Ole	FQHC				X	
Hendry Ton, MD Associate Vice Chancellor	UC Davis	Health System					
Shandi Fuller, MD Maternal Child and Adolescent Health	Solano County	Public Health Department					
Eva Julien Senior Manager, Quality Improvement	Providence	Health System				X	
Valerie Padilla Director of Quality and Patient Safety	Open Door Community Health	Health System	X	X	X	X	
Arlene Pena Senior Program of Quality Improvement	Aliados Health	Community Based Org	X	X		X	
Jeremy Plumb Systems Director, Quality	Northbay Medical Center	Hospital					

Division							
Lelia Romero Health Program Specialist - Health Equity	Lake County	Public Health Department	X	X	X	X	
Robin Schurig, MPH, CPH Executive Director	Health Alliance of Northern California	Community Based Org					
Candi Stockton, MD Health Officer of Humboldt County	Humboldt County	Public Health Department	X	X	X		
Tiffani Thomas Case Manager	Solano County Superior Court	Local Government					
Brandon Thornock Chief Executive Officer	Shasta Community Health Center	Health System					
Denise Whitsett Quality Improvement Coordinator	Community Medical Centers	Health System	X	X	X		
Cathryn Couch Chief Executive Officer	CERES Community Project	Community Based Org	X	X			

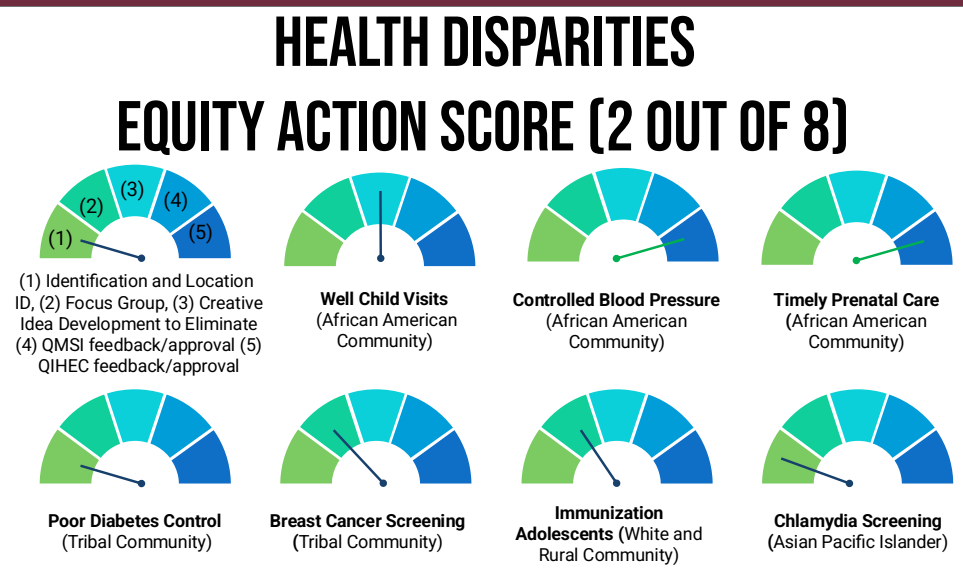
Agenda Topic	Notes	Action Item
Agenda Item 1 **Welcome/ Introductions/Roll Call/ Minutes Review** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh welcomed everyone to the meeting as well as took a roll-call for external members. New members we are considering are Saskia Garcia and Brittany English. Saskia is the Director of Strategy and Integration Health Equity Rising. Brittany English is the Director of the Intellectual and Developmental Disability Program at Santa Rosa Community Health Centers out of our Dutton Campus. B. Bethany confirmed that quorum had been met, as 6 external members attended.	Motion to approve meeting minutes from July 2026. 1st: Valerie Padilla 2nd Jason Cunningham

Agenda Topic	Notes	Action Item
	C. Motion to approve meeting minutes from July 2026. 1st: Valerie Padilla 2nd Jason Cunningham	
Agenda Item 2 **CMO Health Plan Updates** *Speaker: Kermit Jones MD, JD on behalf of Robert Moore, MD, MPH, MBA*	A. The first deputy CMO update focuses on the 84,000 current Partnership members that will be transitioned from managed care Medi-Cal to fee for service Medi-Cal. They'll still get their pharmacy through Medi-Cal RX, but they will lose anything Cal Aim affiliated, specifically the enhanced care management community supports, non-medical transportation and a plan coordinating their care. B. Approvals and referrals running through December 31st will not carry over to January, they will have to be resubmitted through whichever fee for service provider that member lands with. C. Another issue is the paid enrollment prerequisite, the DHCS provider application and validation for enrollment system. Every rendering clinician at every service location as part of a practice must be active and paved, not just the group. (This is where some of the speed bumps are coming up) D. Rolling checks every month to try and close that gap. Dr. Leong from pharmacy and other leaders have been meeting with DHCS to clarify how they are implementing this. E. One common question that comes up is "Will fee for service cover an e-consult or telemedicine?" The answer is yes, it will. Our contracted specialists obligated to keep seeing transitioned members. F. For measure year 2025 HEDIS a number of practices feeding clinical data through data link the NCQA data aggregator went from 6 to more than 30. This is important because NCQA is reporting only through CDS electronic clinical data systems by 2029.	

Agenda Topic	Notes	Action Item
	G. Ian Kim asks specifically about his patients who need specialist access and are going to move to a fee for service model. H. Patients who are already seeing a specialist, that is not going to end December 31st. They must make sure that they're enrolled in Pave in order to submit a claim to medical and for that claim to get paid. Finally, they must decide if they are willing to accept fee for service rates at Medi-Cal. I. Saskia Garcia asked a question about data link, to which Dr. Jones didn't have the answer, he asks Saskia to send him an email with her question and he will get back to her with the answer. J. Kristine Gual offers some information on data link, data link is a data aggregator, and it works with EHRs and health information systems to extract data in a structured way. The data will be used for a number of things like quality measure rate generation, at the long term it will be used for things like CMS interoperability framework.	
Agenda Item 3 **HEO Health Plan Health Equity Updates** *Speaker: Mohamed Jalloh, Pharm.D*	A. There is approximately over 80,000 UIS members who will be losing coverage from the Health plan and will be transitioned to fee for service. B. DHCA is changing how their quality withhold function is working. Previously they had funds where instead of paying the Health Plan the full amount for their quality achievement, they would withhold a certain amount and make it that you have to earn it back by addressing specific health disparities. C. We are submitting our community reinvestment final submissions in the next 30 days. The state provided us updated amounts for each County. Partnership will be reaching out to our County contacts to let them know what their updated Community reinvestment amounts. D. Old Business Update a. Dr. Jalloh shared the program description with the group. He shared that the name of the document was changed from QIHETP program description to "Health Equity and Community Reinvestment Strategy and Program	Motion to approve changes made to the program description. 1st Ian Kim 2nd Dr. Romski

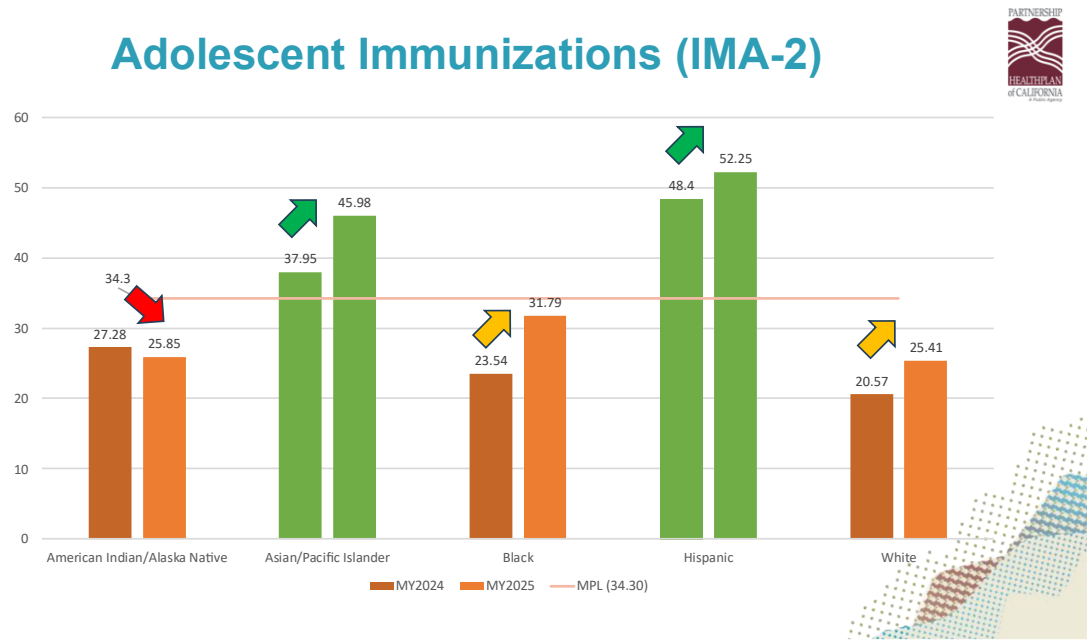
Agenda Topic	Notes	Action Item
	description." Updates included: (1) how Partnership calculated health disparities and metrics that we will be measuring on a year-to-year basis per department. Finally, we updated how we are managing the community reinvestment.	
Agenda Item 4 **Grand Analysis** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh shared the 18 MCAS accountable measures in MY2025. B. The core measures of focus are child and adolescent well care visits, controlling high blood pressure, glycemic status assessment for people with diabetes, adolescent immunizations, and timely prenatal care. C. In MY2024 we see improvements in lead screening, controlled blood pressure, and well child visits in 0 to 30months. Well-care visits and childhood immunizations remained below minimum performance level for the majority of race groups. Lead screening in children is lower in black members and immunizations for adolescents are significantly lower for white members. D. Dr. Jalloh shared the health disparities equity action score:	*Partnership team members will engage with the Tribal Liaison to conduct a preliminary root-cause-analysis (RCA) to identify if low quality scores are due to* claim lag issues, data submission delays, system limitations or other operational factors that could have contributed to the decline in performance.

Agenda Topic	Notes	Action Item



E. Dr. Jalloh shared a graph showing improvement from MY2024 to MY2025 for controlled blood pressure for all race groups.
F. A preliminary impact analysis and review of interventions were done.
    - Four disparities eliminated, four disparities improved and zero disparities worsened.
    - CHW – barber program charter development was launched in 2026.
    - Health equity pay for performance QIP bonus was launched.
G. Dr. Jalloh shared a graph showing improvement in all race groups for poor A1c control.
    - Two disparities were eliminated, three disparities improved and zero disparities worsened.
H. Measures that do need more support: Adolescent Immunizations.

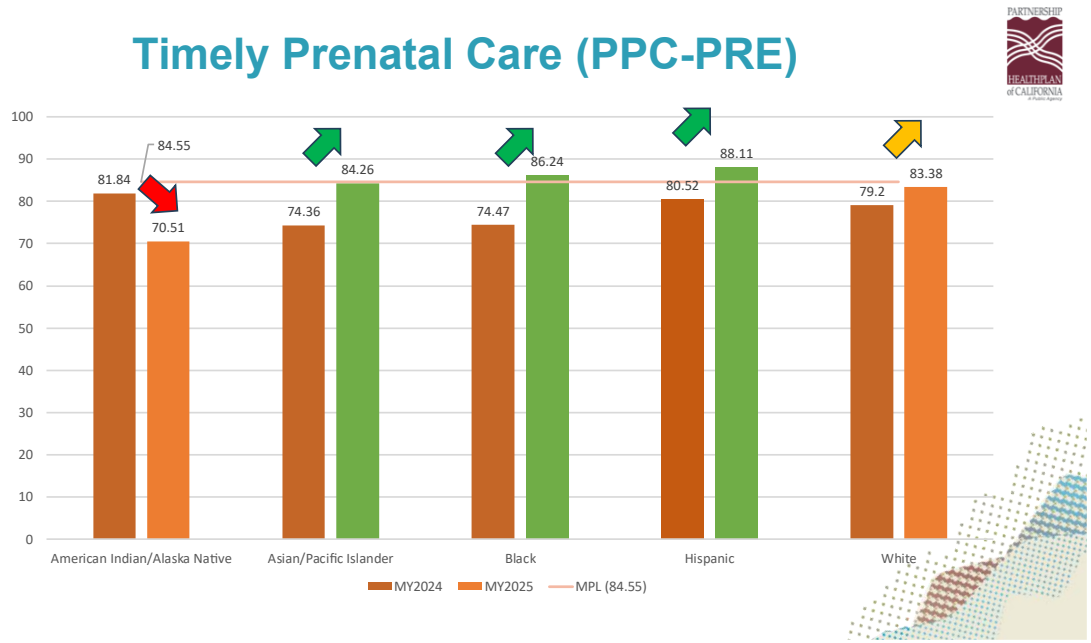
Agenda Topic	Notes	Action Item



I. Preliminary Impact Analysis and review of interventions:
   - Zero disparities eliminated, two disparities improved, and one disparity worsened.
   - Focus groups planned but not executed.

J. Dr. Jalloh shared a graph on Timely Prenatal Care

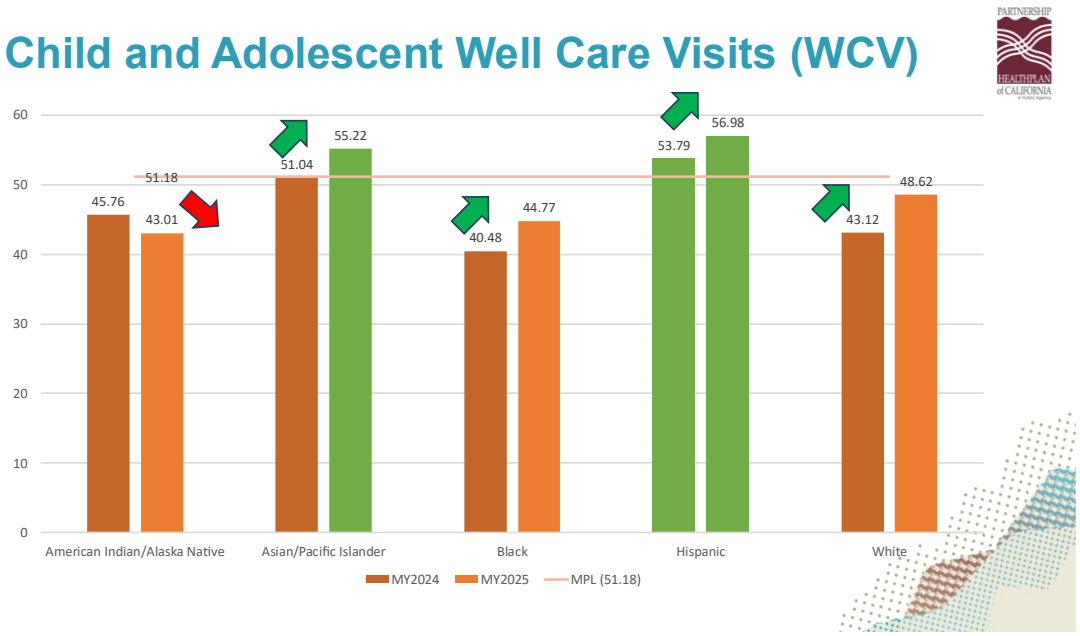
Agenda Topic	Notes	Action Item



K. Preliminary Impact Analysis and review of interventions:
- Two disparities eliminated, two disparities improved and one disparity worsened.
- Tribal Perinatal Program recruitment
- Maternal photoshoots pilot; perinatal growing together program

L. Dr. Jalloh shared a graph on child and adolescent well-care visits.

Agenda Topic	Notes	Action Item



M. Preliminary Impact Analysis and review of key interventions:
- One disparity eliminated, two disparities improved, and one disparity worsened
- Healthy babies growing together program, member incentive continuation
- Health equity pay-for-performance QIP bonus launch

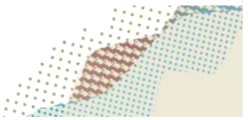
N. Secondary MCAS measures of focus for disparities:
- Childhood immunizations
- Lead screening
- Post-partum care
- Breast cancer screening
- Cervical cancer screening

Agenda Topic	Notes	Action Item
	O. A question was raised as to how we are defining a disparity. Dr. Jalloh explains that we are looking at it in two ways. 1. Not meeting the MPL. 2. Comparing the measures for each race group to the white community. Ian Kim comments that he will be curious to see how the data changes next year as we are losing a significant amount of UIS members. Dr. Jalloh agrees that we are losing people, and therefore their data would not be included. Anthony Sackett asked if there were any claim lag issues, data submission delays, system limitations or other operational factors that could have contributed to the decline in performance Kristine Gual commented that she thinks about claim timeliness but also whether Tribal Health Centers are using local codes that they use to get their PPS rate, that we need to make sure they are captured. Dr. Jalloh will take the questions back to the Tribal liaison as she would be able to speak more on those topics. Any Tribal Health center that has concerns, it is recommended that they reach out to their regional leader and request practice level rates for some of these HEDIS measures. P. For Childhood Immunization status in MY2025 we see the Tribal community improved but in our Black community it has decreased. Lead screening rates have improved across all race groups. For Prenatal and postpartum care in MY2025, the black community has improved. For Well-child visits in the first 15 months it has decreased by 12% for the American Indian/Alaska Native group. For breast cancer screening, we see a decrease across all race groups. For cervical cancer screening and Chlamydia screening we have increased across all groups. Q. Dr. Jalloh shared the 2025 pay for performance data analysis.	

Agenda Topic	Notes	Action Item

2025 Pay for Performance Data Analysis

Measure Name	ASIAN/ PACIFIC ISL..	BLACK	EAST ASIAN	HISPANIC	NATIVE AMERICAN	OTHER	SOUTH ASIAN	SOUTHEAST ASIAN	UNKNOWN	WHITE
Breast Cancer Screening	54.12	51.41	48.12	69.38	45.53	53.50	58.99	59.26	51.91	49.11
Breast Cancer Screening Monitoring	42.59	37.49	50.32	55.91	35.52	43.58	53.88	48.24	42.67	39.52
Cervical Cancer Screening	52.53	53.44	50.54	67.36	46.86	59.32	59.02	55.81	53.88	50.63
Child and Adolescent Well Care Visits	58.86	50.06	61.71	64.97	50.18	58.56	72.79	55.85	58.76	51.29
Childhood Immunization Status CIS 10	25.23	19.89	27.27	33.56	9.76	20.87	41.41	19.23	20.70	13.50
Chlamydia Screening	16.76	33.00	15.04	28.61	30.63	21.83	14.82	19.01	23.77	26.54
Colorectal Cancer Screening	41.17	35.46	47.39	48.24	29.76	44.76	44.45	47.35	39.12	37.80
Controlling High Blood Pressure	62.72	62.10	68.75	70.52	57.29	68.61	68.28	68.74	64.89	63.18
Diabetes - HbA1C Good Control	71.17	68.73	84.82	75.35	66.35	76.50	80.99	81.14	71.07	71.57
Diabetes - Retinal Eye exam	61.35	53.75	68.75	67.44	49.20	60.48	57.32	63.02	58.07	53.80
Immunization for Adolescents IMA 2	40.74	31.61	38.78	51.87	28.57	31.36	54.95	37.29	28.00	24.19
Lead Screening In Children	84.72	65.12	44.44	82.34	72.41	71.71	84.26	82.05	69.89	67.39
Topical Fluoride in Children Monitoring	6.99	10.18	5.00	14.35	4.08	7.30	9.41	12.24	7.07	5.82
Well Child 15-30 Months	76.14	55.68	66.67	80.68	52.63	67.00	90.00	75.00	70.66	65.30
Well Child First 15 Months	63.24	49.65	66.67	65.93	43.06	48.53	66.13	55.81	54.53	49.35



R. **American Indian/Alaska Native Top Priorities**

- **(Continue)** Improve <u>well-child visits</u> by at least 3% with 3-year goal of at least 9% increase
- **(Continue)** Improve <u>prenatal care</u> visits by at least 5% with 3-year goal of at least 15% increase
- **(Continue)** Improve <u>controlled blood pressure</u> rates among American Indian/Alaska Native members by 2% with a 3-year goal of at least 5% increase
- **(Start)** Improve <u>Breast Cancer Screening</u> by 4% with a 3-year goal of at least 10% increase **OR** Improve Immunization by Adolescents by 2% with a 3-year goal of 12% increase

Agenda Topic	Notes	Action Item
	S. **African American/Black Top Priorities** • **(Continue)** Improve well-child visits by at least 3% with 3-year goal of at least 9% increase • **(Continue)** Improve prenatal care visits by at least 5% with 3-year goal of at least 15% increase • **(Continue)** Improve postpartum care visits by at least 2% with 3-year goal of at least 5% • **(Continue)** Improve controlled blood pressure rates by 3% with a 3-year goal of at least 5% T. **White/Rural Location** • **(Continue)** Improve well-child visits by at least 1.5% with 3-year goal of at least 4% increase U. Total number of MCAS disparities (MY2024): 26 Total number of disparities eliminated (MY2025): 10	
Agenda Item 5 **Grand Analysis discussion and vote** **Speaker: All**	A. Dr. Jalloh asked the group if there are any additional stratifications they would want done. Eva Julien asked what the purpose of stratification is. Dr. Jalloh responded that the purpose of the stratification is to identify if there are health inequities. Arlene Pena suggests stratifying by language. Ian Kim would like the data broken down by County. Dr. Jalloh explains that we do have our data which is a larger data set that we could explore breaking it down by County. Saskia suggested to stratify by race and also by people who receive ECM or community support services. Dr. Jalloh will take that info back to our ECM team to see what we can provide at the next meeting.	*Motion to add language stratification for future meeting.* *1st Arlene Pena* *2nd Ian Kim* *Motion to approve the grand analysis.* 1st Arlene Pena 2nd Eva Julien

Agenda Topic	Notes	Action Item
		Partnership will investigate with the ECM and Health Analytics teams our ability to stratify MCAS measures by specific ECM or CS access
Agenda Item 6 **Health Equity Policy Review** *Speaker: Naz Sattari*	• Community – Access – Respect – Engagement Services (CARES) and Transgender, gender diverse, or intersex training program requirements for internal employees and external practitioners (where applicable) (MCEP6004) • Naz shared the updates to policy MCEP6004. With the following core changes: a. CARES acronym change b. TGI training information addition c. Inclusion of Staff members d. Updated Measures and Annual Reporting	Motion to approve policy changes. 1st Valerie Padilla 2nd Jason Cunningham
Agenda Item 7 **Health Disparities Action Review** *Speaker: Mohamed Jalloh, Pharm.D*	A. Health Equity Strategic Plan draft discussion. • Member engagement: Increase members (experiencing disparities)motivation to access, understand and apply accurate health information to make informed judgments regarding disease prevention. • Community engagement: Equip key local communities experiencing disparities with resources to provide timely basic Medi-Cal navigation, community benefit resource navigation, health education, and care	

Agenda Topic	Notes	Action Item
	coordination. Also, equip such communities with resources to co-design community-based solutions to address health disparities. • Provider engagement: Increase access to excellent affordable health services in multiple modalities (in-person, digital, peer-led, etc.) without barriers related to race, language, immigration status, gender identity, rural location or justice involvement. (such as incarceration) B. Dr. Jalloh asks the external advisory committee which of these do they feel we should invest the most in to address health disparities. • Ian Kim feels community engagement is important because people are at risk of losing their coverage. • Saskia feels we should prioritize community engagement. She feels it starts with listening to the community, starting with solutions that are driven by community members. C. Dr. Jalloh asks the group what success stories they have with doing these types of activities. • Eva Julian comments that something that has been a key part of their success is for those patients who they have already established relationship with, beginning to work in the offices with Community Health Workers. D. Dr. Jalloh asks the group, if you had a magic want for the next 3-5 years, what would success look like? • Chelsea Lingao states that one measure of success would be if specific community organizations can refer members to resources, which would build rapport with community members.	

Agenda Topic	Notes	Action Item
Agenda Item 8 **New Committee Member discussion/vote** *Speaker: Bethany Hannah*	A. Saskia Garcia Endorsement: Eva Julien 2nd : Valerie Padilla B. Britanny English Endorsement: Valerie Padilla 2nd: Arlene Pena C. Committee attendance: How many meetings could be missed before being removed from the group? Valerie states 4 meetings missed in a year. Eva states that they should attend at least 3 of the meetings throughout the year. Anna Campbell brings up the idea that on other committees a member could take a sabbatical from the committee for a period of time and then return to the committee.	Saskia Garcia Endorsement: Eva Julien 2nd: Valerie Padilla Britanny English Endorsement: Valerie Padilla 2nd: Arlene Pena
Agenda Item 9 **Adjournment** *Speaker: Mohamed Jalloh, Pharm.D*	A. Next meeting: November **17, 2026 7:30 a.m. - 9:00 a.m. PST**	

4665 Business Center Drive
Fairfield, California 94534

MEETING Minutes

Meeting & Project Name: Quality Improvement Health Equity Committee (QIHEC)

Date: 7/21/2026 **Time**: 7:30 a.m. – 9:00 a.m.

Facilitator: Mohamed Jalloh, Pharm D

Coordinator: Bethany Hannah

Meeting Locations:

- Webex

Attendees: Aaron Brincko; Amanda Harrison; Anna Cambell; Anthony Sackett; Ben Spencer; Brandon Yadi; Candy Stockton; Bethany Hannah; Christine Smith; Dawn Cook; Denise Whitsett; Denise Rivera; Emily Wellander; Folo Akintan; Hannah O'Leary; Jesus Hermosillo; Kermit Jones; James Devan; Juan Godinez; Katherine Barresi; Kimberly Robertello; Kory Watkins; Kristine Gual; Lisa Wada; Liz Romero; Liat Vaisenberg; Manleen Randhawa; Mark Bontrager; Mark Netherda; Marshall Kubota; Michele Grupe; Melissa Schumann; Mohamed Jalloh, PharmD; Monika Brunkal; Naz Sattari; Nicole Curreri, MPH CHES; Rod Grace; Roni Schultz; Shahrukh Chishty; Shantal Shamoiel; Sunshine Jackson; Sydni Aguirre; Valerie Padilla; Stan Leung, Sue Lee; Robert Moore, MD; Sue Quichocho; Tiffany Tryan; Tony Hightower; Vicky Klakken; Wendy Starr;

Absent: Sonja Bjork; Whitney Haggerson; Amanda Smith; Hendry Ton, MD; Ian Kim; Kimberly Robertello; Noemi Doohan; Rachel Newman; Rocio Rodriguez; Rebecca Stark; Shannon Boyle; Latrice Innes; Nisha Guppta;; Robert Bides; Shahrukh Chishty; Nicole Escobar; Heather Eset; Greg Allen Freedman; Jaymee James; John Lemoine; Sue Quichocho; Dorian Roberts; Tim Sharp; Amy Turnipseed; Edna Villasenor; Bridget Gast; Dana Codron; Monica Ferguson; Priscila Ayala; Katheryn Power, Wendi Davis; Monica Ferguson; Chloe Ungaro; Kristina Coester; Ledra Guillory; Lisa Wada; Tiffani Thomas; Chloe Ungaro; Kristina Coester; Ledra Guillory; Dana Constantino; Sydni Aguirre; Eugene Durrah; Eva Julian; Jeffrey DeVido; Kelly YoungsStone; Liz Romero; Amanda Kim; Arlene Pena; Cathryn Couch; DeLorean Ruffin, DrPH, MPH; Isaac Brown; Jason Cunningham; Leila Romero; Lilly Merino

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External Advisory Members

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Jason Cunningham, MD Chief Executive Officer	West County Health Centers	FQHC	X	X	X		
Eugene Durrah Equity Services Manager	Solano County	County	X				
Ian Kim Family Physician	Communicare + Ole	FQHC					
Hendry Ton, MD Associate Vice Chancellor	UC Davis	Health System					
Shandi Fuller, MD Maternal Child and Adolescent Health	Solano County	Public Health Department					
Eva Julien Senior Manager, Quality Improvement	Providence	Health System					
Valerie Padilla Director of Quality and Patient Safety	Open Door Community Health	Health System	X	X	X		
Arlene Pena Senior Program of Quality Improvement	Aliados Health	Community Based Org	X	X			
Jeremy Plumb Systems Director, Quality Division	Northbay Medical Center	Hospital					
Lelia Romero Health Program Specialist -	Lake County	Public Health Department	X	X	X		

Health Equity							
Robin Schurig, MPH, CPH Executive Director	Health Alliance of Northern California	Community Based Org					
Candi Stockton, MD Health Officer of Humboldt County	Humboldt County	Public Health Department	X	X	X		
Tiffani Thomas Case Manager	Solano County Superior Court	Local Government					
Brandon Thornock Chief Executive Officer	Shasta Community Health Center	Health System					
Denise Whitsett Quality Improvement Coordinator	Community Medical Centers	Health System	X	X	X		
Cathryn Couch Chief Executive Officer	CERES Community Project	Community Based Org	X	X			

Agenda Topic	Notes	Action Item
Agenda Item 1 **Welcome/ Introductions/Roll Call/ Minutes Review** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh welcomed everyone to the meeting as well as took a roll-call for external members. B. Bethany confirmed that quorum had been met, as 5 external members attended. C. Motion to approve meeting minutes from May 2026. 1st: Candy Stockton 2nd Valerie Padilla	Motion to approve meeting minutes from May 2026. 1st: Candy Stockton 2nd Valerie Padilla

4665 Business Center Drive
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Agenda Topic	Notes	Action Item
Agenda Item 2 **CMO Health Plan Updates** *Speaker: Kermit Jones MD, JD on behalf of Robert Moore, MD, MPH, MBA*	A. Organization updates are divided into 3 main areas; external factors and responses, internal strategies to improve quality, and compliance modernization initiatives that we are undergoing. B. On June 11th CMS released new guidance on its 1115 Medicaid demonstration budget neutrality policy that came into effect with HR1 last year. HR1 established the first statutory requirement for Medicaid 115 budget neutrality. The CMS guidance is designed to give states early notice of budget neutrality changes. This means that with this statute for the first time budget neutrality is codified in federal law. It is a requirement that the CMS Chief Actuary needs to certify that a section of 1115 demonstration is budget neutral before approval. The secretary may not approve new demonstrations or renew existing ones on or after January 1st, 2027, absent that certification. C. California has multiple years long section 1115 demonstrations. One example of this is the CalAim 1115 waiver demonstration which was approved December 2021 and is effective until December 31st of this year. Falling under CalAim are the community supports in lieu of services, housing navigation, incubative care, ECM, and justice involved reentry initiatives among others. D. The BH connect, approved in 2024 which is the behavioral health community-based organization networks of equitable care and treatment, which was DHCS's effort to build out community based behavioral health continuum for MediCal members with serious mental health illnesses and serious emotional disturbances. E. The practical effect of these certification requirements is that at the state level it is going to result in increased documentation. States will have to invest in much more time and resources, there will be less financial flexibility, fewer activities will be accepted.	

Agenda Topic	Notes	Action Item
	F. Internally, Partnership Health Plan is nearing completion of its organization wide plan for quality, 2026-2029. In broad strokes, the purpose of this plan is to improve outcomes with our members, strengthen relationships with providers, align across departments within QI, and focus on greater quality impact in the communities we serve. G. With the modernization aspects of the organizational updates, a new claims processing system, HRP will be implemented.	
Agenda Item 3 **HEO Health Plan Health Equity Updates** *Speaker: Mohamed Jalloh, Pharm.D*	A. New guidance from CMS regarding HR1 for work requirements. Many of these requirements have been published regarding what are going to the requirements for these upcoming years. B. Community reinvestment: The health plans are obligated to reinvest a certain amount of their net income back into the community. $10 million that Partnership will be giving to its 14 counties. This is based on Partnership's 2024 net income. As of now, we have reviewed the information that the state has provided and met with respective counties, guiding them as well as encouraging them to work with their county leaders, specifically behavioral health and public health directors, they are ultimately the ones who have to sign off for each county's respective amount for community reinvestment. C. We have provided the funding amounts to the county leaders, as well as providing guidance on what they should consider. Counties had autonomy over choosing what they would decide, they have submitted that to Partnership and Partnership is in the process of getting ready to package it and submit it to DHCS. D. Dr. Jalloh directs the group to review the Committee Charter. Candy Stockton asks to clarify whether new members joining the committee would be subject to a majority vote. Dr. Jalloh clarifies that we would at least have a motion to vote someone in, and that they were likely	Motion to approve the Charter contingent on policy notating Simple Majority Vote for including new committee members and clarification of which types of analyses QIHEC will review. 1st: Candy Stockton 2nd Denise Whitsett

Agenda Topic	Notes	Action Item
	endorsed by a current QIHEC member. Candy suggests a simple majority vote or an endorsement from someone on the committee and she wants to clarify what is required in the vote. Dawn Cook asks to clarify who is responsible for analyzing and evaluating the results, to which Dr. Jalloh clarified that QIHEC is responsible for analyzing and evaluating the results of QI and Health Equity activities. Dawn feels there is a word or two missing that make it unclear. Dr. Jalloh suggests to separate those statements into two sentences.	
Agenda Item 4 **Tribal Engagement workgroup updates** *Speaker: Sunshine Jackson*	A. The Tribal Perinatal Program's goal is to support Tribal communities to achieve the best possible outcomes for Native Americans in Northern California. There are now 8 Tribal Health Programs fully contracted and 2 contracts in process. This upcoming year TPP will focus on PPC 1st visit within 21 days and two postpartum visits. B. Sunshine is working on a Partnership Prenatal and Postpartum Passport. She is also in the process of planning a Tribal Maternal Photoshoot. Sunshine is also working with Dr. Townsend to develop a detailed PP presentation that uses real-life PHPS case scenario to help TPP's better understand the services available through the program. Additionally, Sunshine is setting up a Tribal Perinatal Program Collaborative. C. This year we are holding a 4th Annual Partnership HealthPlan Tribal Convening. The convening will focus on vaping prevention and smoking cessation. Tribal singers from Butte County will provide the opening blessing and welcome. Dr. Cutcha Risling-Baldy, Daniel Calac and Roland Moore have confirmed as keynote speakers. Virgina Hedrick(California Rural Indian Health Board CEO) and Andrea Zubitate(Chief of the Office of Tribal Affairs) are presenting as well. There will be breakout sessions with Tribal Health programs. There will also be a Elder/Youth Panel. D. Medi-Cal & Partnership updates affecting Tribal Health:	

Agenda Topic	Notes	Action Item
	• Legislative update • TPP & other OB/GYN updates • QI/PI initiatives and presentation on Colorectal Project • HEDIS/Health Equity • CalAIM updates E. CMO updates: • BH: Traditional healing • Patient Experience • Partnership Leadership Academy F. Awards: • Most Improved & Highest Score QIP • Small but Mighty QIP • Maternal & Child Health Champion • Traditional Healing Integration • Excellence in Patient Care • Tribal Advocacy G. Sunshine states that they are being very intentional this at this years convening and will hire indigenous caterers and will have indigenous artwork on the SWAG.	
Agenda Item 5 **Grand Analysis** *Speaker: Hannah O'Leary*	A. Hannah reviews findings from the Population Health 2025 Impact Analysis. . • This grand analysis does not include the Population Program Description, Strategy, or the Annual Plan as in the previous year and was notated to be included in a future meeting. B. The Growing Together Program has 3 pillars: • Healthy Babies (0-30 months) • Healthy Kids (ages 3-6)	

Agenda Topic	Notes	Action Item
	• Perinatal program (covers prenatal and postpartum period) C. Engaged members - members who qualified for the program, reached by phone and opted in to program participation • Declined – members who qualified for the program, reached by phone, and opted against program participation • Left message – members who qualified for the program, did not answer the phone, and were left a voice message encouraging a behavior • Unable to reach – members who qualified for the program but were not able to be reached via phone • Not referred - members who qualified for the program retrospectively but were not identified prospectively for campaign inclusion D. Partnership offers the Growing Together Prenatal outreach campaign, enrolling members identified as pregnant to receive targeted program outreach and support. PHM staff contacts these members and offers engagement in a campaign that supports prenatal care, reinforces the importance of Tdap vaccinations during pregnancy, and reminds them of the importance of post-partum care, as well as well-child visits and vaccinations in the first months following delivery. E. In addition to Partnership's Growing Together Prenatal outreach campaign, Population Health offers a campaign for members after delivery to encourage them to attend post-partum care visits as well as encourages early entrance to care by bringing their child to well-baby visits. F. The goal was for 75% of engaged members to attend a postpartum visit within 60 days of delivery. Postpartum visit attendance exceeded	

Agenda Topic	Notes	Action Item
	the goal at 79% among engaged members. Engagement clearly drives better outcomes, as all other groups performed significantly lower. G. Goal 2 is to attend a well child visit within the first 60 days of life. The target was met with a 76% completion rate among engaged members. Engagement again showed a strong positive impact, with higher rates than other groups. Unlike other measures, we didn't see significant differences across racial groups here, suggesting a more uniform effect. Overall, this is another strong indicator that the program is working. H. Population Health enrolls infants under 24 months of age in the Healthy Babies Growing Together Program the month they become Partnership members. The program provides health education and promotion of well-child visits and the importance of timely vaccinations to support the child's lifetime of immunity. Incentives are also offered for completing well-care visits with immunizations throughout the duration of the program. I. Healthy Babies goal outcome: 80% of engaged members will complete 50% or more of their vaccinations during the program period. This goal was met at 83% of engaged members. Goal 2: 65% of engaged members would be compliant with well-child visits. The goal was met at a rate of 89% compliance. Goal 3 J. This was the most ambitious Healthy Babies goal, completing *all* well-child visits, and engaged members exceeded the target by a wide margin, achieving a 60% completion rate. The 26-point gap between	

Agenda Topic	Notes	Action Item
	engaged and unreachable families reinforces that engagement is the key lever. While overall performance is strong, recurring equity differences point to opportunities for more tailored outreach. K. The biggest gap is around contact and not program effectiveness . L. For Healthy Babies vaccinations, engaged members achieved an 83% completion rate, the highest of any group. All other categories performed significantly worse, including members who were not referred. Even voicemail contact improved outcomes, but live engagement clearly drives the strongest results. M. 60% of families who engaged with the outreach team completed all recommended visits, the highest rate by far. N. The Healthy Kids program aims to reach all children between the ages 3 through 6 that have not had a well-child visit in the last 11 months or longer. Once identified, these members are offered an incentive to encourage the completion of their annual well-child visits prior to their next birthday. O. Healthy Kids goals outcomes: The first goal for this intervention is for 50% of members engaged in the program to have a well-child visit within 120 days of the phone call outcome referred to as “Agreed to Participation.”	

Agenda Topic	Notes	Action Item
	P. Goal 1: 70% of engaged members will have a well-child visit between July 2024 – June 2025. This goal was met at a rate of 80%. Engaged members had a statistically significantly higher rate of completing well child visits than any of our other campaign categories. Q. Transitional Care Services (TCS) focuses on members who are transitioning across settings or benefit structures with a high-risk of poor outcomes. R. The criteria for members identified (Adults) are > 20 and are discharging home from an inpatient admission with any length of stay and meet the criteria for high-risk transitioning members. (Pediatric) criteria are under age 21 and discharging home from an inpatient stay with an admission date > 60 days from their date of birth and having any length of stay. S. The program is performing well from a member experience standpoint, demonstrating effective care transitions and strong care team impact. T. Transitional Care Services Goals: Goal 1 is that 75% of members surveyed agree with each statement of the Adult TOC or TCS satisfaction Survey. This goal was met. Goal 2 is that 75% of members surveyed agree with each statement of the Pediatric TCS satisfaction survey. This goal was also met.	

Agenda Topic	Notes	Action Item
	U. Complex Case Management is support for members who have multiple chronic conditions, social determinants of health barriers and/or have difficulty navigating the healthcare system without the intensive support of a care coordinator and an individualized care plan. The criteria for members is that they have multiple chronic conditions, social determinants of health barriers and/or difficulty navigating the healthcare system, and/or CCS condition. Member satisfaction with the complex case management program is ascertained via telephonic survey by a Partnership designee either annually (for multi-year interventions) or upon case closure, if the case is active for less than one year. V. Complex case management goals: Goal 1 is that 75% of members surveyed agree with each statement of the Adult CCM satisfaction survey. This goal was met. Goal 2 is that 75% of members surveyed agree with each statement of the Pediatric CCM satisfaction survey. This goal was met. W. Lessons learned have shown that the most effective programs utilize multiple modalities of reaching members, such as combining mailings with phone calls and with incentives to maximize engagement. A significant finding that has carried on through 2025 is feedback from members about the ongoing challenges around scheduling well child visits due to the lack of provider availability to serve the member population in a timely manner.	

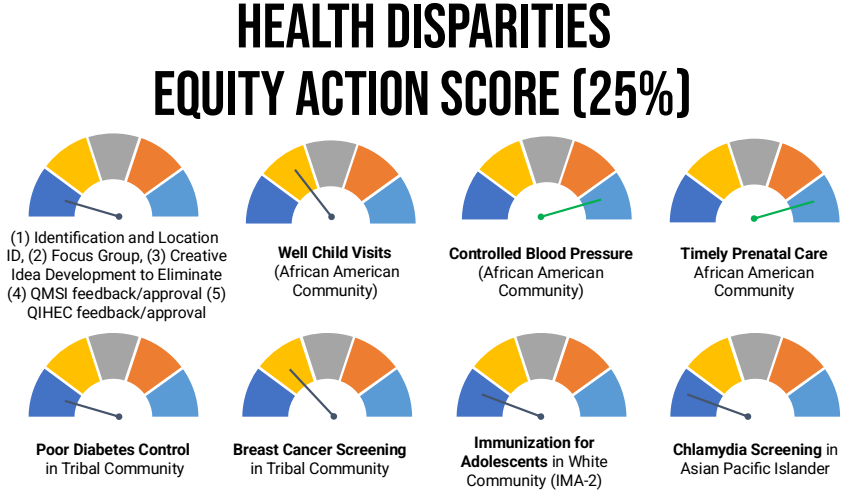
Agenda Topic	Notes	Action Item
Agenda Item 6 **Grand Analysis discussion and vote** **Speaker: All**	A. Marshall Kubota shares feedback that you can't stratify a historic group retrospectively, but you can take the total group data after the intervention and compare it to no intervention. Candy Stockton comments that if we are focusing on cost effective interventions, we need to be careful not to confirm our own biases.	Motion to approve the inclusion of an additional analysis of a total group historical data comparison 1st Candy Stockton 2nd Valerie Padilla Motion to approve the 2025 Grand analysis. (Population Health) 1st Candy Stockton 2nd Valarie Padilla
Agenda Item 7 **Behavioral Health Presentation** *Speaker: Brandon Yadi*	A. Starting with the Access Line, Back in 2025, Partnership made a decision to bring some member-facing responsibilities in-house instead of leaving them fully with Carelon Behavioral Network — that included access, care coordination, G&A, and UM. B. The goal was to directly improve the experience our members were having while at the same time making sure the referrals going into the network were actually good ones – because that increases chances of closing the loop on a referral.	*Motion to approve the Grand Analysis.(Behavioral Health)* *1st Candy Stockton* *2nd Denise Whitsett*

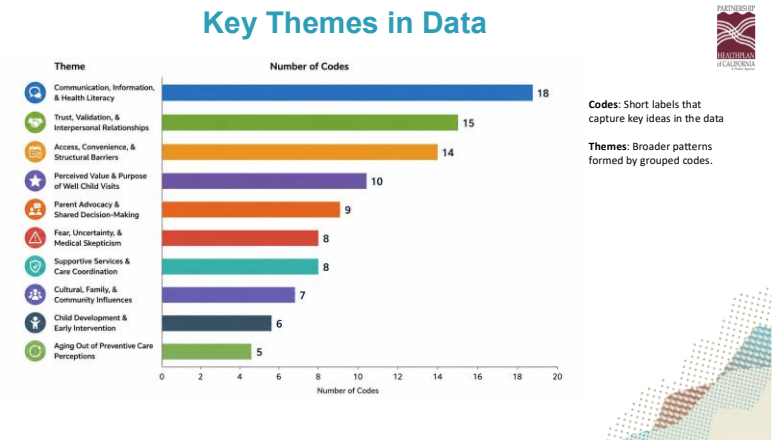
Agenda Topic	Notes	Action Item
	C. Outreach and Education: The goal is to engage staff and providers in promoting service delivery, and most importantly, making sure our members actually understand their mental health benefits. A lot of underutilization isn't about access; it's that people just don't know what's available to them. D. Each year will start with a utilization review to spot disparities and service gaps. The review tells where to focus for the upcoming year. Then the review and action plan are put together in an annual report, which goes to DHCS every year . E. Member Experience is more formally addressed through NCQA measure ME7 E&F, where the health plan is reviewed against 2 areas: grievance & appeals and member survey. F. The cycle looks like: distributing questions through an annual member experience survey, review G&A data for behavioral health, and bring both data sources together to write a Grand Analysis Report. G. DHCS requires us to do an annual utilization assessment for non-specialty mental health, identify where utilization is low, and build a outreach plan to close those gaps. H. For 2026, input was received from several different groups; the Consumer Advisory Committee, the Quality Improvement Health	

Agenda Topic	Notes	Action Item
	Equity Committee, PCPs through an engagement survey, and our Tribal partners. I. PCP engagement around a new BH Access Line, perinatal mental health outreach, community events, and specific work in Modoc County around school-based referral coordination for youth. Sierra County is also exploring MH telehealth through their County Office of Education. And social media and text campaigns are running throughout the year. J. Data capture: dividing utilization by race and ethnicity, collect SDoH and demographic data, and separating survey results by population. K. Targeting strategy: looking at underutilization by demographic and by county, Tribal outreach and hold an annual convening, and building language and cultural responsiveness directly into our messaging . L. Interventions: the text messaging pilot in Solano and Modoc, follow-up outreach for members after an ED discharge, quarterly social media and in-person MH fair presence, and monthly COE meetings along with Tribal outreach. M. Utilization trends : non-specialty mental health utilization rose to 8.6% in 2024, up from 7% in 2023. With adding specialty mental health, utilization climbs past 12%, compared to 9% in 2023. And when primary care data is added in too, there is an even bigger jump —	

Agenda Topic	Notes	Action Item
	which likely reflects the safety-net role our medical system is supporting our members who aren't otherwise directly engaging BH services. N. Breakdown by race and ethnicity: White members have the highest utilization at 12%. Asian members have the lowest, at 1.7%. Hispanic members sit at 6.4%. Black members increased slightly to 7.6% in 2024, up from 5% the year before. Native American members — utilization jumped to 10.2% in 2024, up from 5.5% in 2023 O. Geographically: Shasta County has the highest utilization at 15%. That's likely driven by strong FQHC-integrated behavioral health there, plus North American Mental Health Services has a large clinic in-county. Modoc County is one of our lowest utilizers at 3.5%, P. Candy Stockton asked if we had more mental health support services which look like the communities that we served. Brandon didn't have that data but will circle back and see if that is something they have implemented in the last year or so. Q. Dr. Kubota would like some data about Spanish speaking behavioral health practitioners and PHC panels.	

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Fairfield, California 94534

Agenda Topic	Notes	Action Item
Agenda Item 8 **Health Equity Tracker** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh shared the Health Disparities Equity Action Score.  	
Agenda Item 9 **Health Equity Policy Review** *Speaker: Mohamed Jalloh, Pharm.D*	A. Dr. Jalloh shares the QIHETP program description. B. The Program Description Name was changed from the "Quality Improvement and Health Equity Transformation Program Description" to the "Health Equity and Community Reinvestment Strategy and Program Description" to increase ease of communication to internal team members C. Health Equity Accreditation Name Change on Page 10: The Program Description changed the NCQA HEA name to HOA to reflect NCQA's changes. D. Quality Improvement Priorities on Page 11, 13: The Program Description was updated to include the top Quality Improvement Priorities and how Partnership clarified it's health disparity priorities. E. Health Disparity Measures on Page 14: The Program Description was updated to reflect which annual QIHETP administrative measures will	*Policy will be sent out, and will be discussed as old business in the next meeting due to low amount of time to review.*

Agenda Topic	Notes	Action Item
	be measured per department (e.g. Quality Improvement, Population Health, Human Resources, etc) F. Community Reinvestment Updates on Page 17: The Program Description was updated to reflect the updated change of the community reinvestment management. Specifically, it was changed to reflect that Public Health Directors and Behavioral Health Directors per county will lead county selection efforts versus Partnership providing a specified list for the counties to pick. G.	
Agenda Item 10 **Focus Group Updates** **Health Disparities Action Review (Focus group and Project Updates** *Speaker: Jesus Hermosillo, MPH*	A. Jesus conducted two focus groups in the Fairfield region on the topic of Well Child Visits on 5/22/26 and 6/16/26.  B. Top themes that came out of the focus groups were: communication, information, and health literacy. C. Findings were that members don't connect with the term Well Child Visits, and don't understand the purpose of the visit. There is a lack of understanding of the purpose of these WCVs. Families that participate in WCVs don't really know that they are engaging in a WCV.	

Agenda Topic	Notes	Action Item
	D. Parents see these visits as not urgent. They don't know what to expect at these visits. Families are asking for some type of flyer that explains the WCV and a checklist that they could use during the WCV.	
Agenda Item 11 **Adjournment** *Speaker: Mohamed Jalloh, Pharm.D*	Next meeting: **September 15, 20267:30 a.m. - 9:00 a.m. PST**	

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MEETING AGENDA / MINUTES

Meeting/Project Name:	**Substance Use Internal Quality Improvement Committee Meeting (SUIQI)**		
Date of Meeting:	**09/24/2026**	**Time:**	**10:00 AM**
Meeting Facilitator:	**Stephanie Wilson**	**Location:**	**Webex**

Meeting Objective/s

A committee comprised of County and Partnership staff who track DMC-ODS initiatives, compliance and oversight, and auditing.

Meeting Agenda

Topic	Person(s) Responsible	Time Allotted
1. Welcome, Introductions, Review & Approve Minutes from June 18, 2026	Stephanie Wilson	5 Minutes
2. Wellness and Recovery Program Updates, Enhancements, and Highlights a. Transition b. Treatment Perception Surveys c. Deliverables	Nicole Escobar Stephanie Wilson	20 Minutes
3. Monitoring and Oversight a. Grievances & Appeals	Latrice Innes	10 Minutes
4. Monitoring and Oversight a. Quality Improvement Program Activities i. W&R Provider Site Reviews ii. W&R Site Review CAP Tracker	Alicia Kay	5 Minutes
5. Monitoring and Oversight a. Member Services i. Beneficiary Access Line/Call Center Statistics ii. Member Correspondence – None this Quarter	Hayley Garnick	5 Minutes
6. Monitoring and Oversight a. New Providers for Quarter b. Credentialed Network Providers c. Provider Compliance Summary i. Open Admissions CalOMS Reporting ii. Provider CAP Compliance iii. DATAR Reporting	Becky Miller	10 Minutes

7. Monitoring and Oversight a. Utilization Management i. TARs and TAR Denials ii. Member Utilization by Level and County iii. Timely Access iv. Transitions of Care	Stephanie Wilson	10 Minutes
8. Monitoring and Oversight a. Claims Processing i. Timeliness, Payment & Denial Rates – Claims Processing for Quarter	Nicole Escobar	5 Minutes
9. Monitoring and Oversight **a. Compliance** i. BHINs & Policy Updates **1. 26-022 NTP Counseling Unit Threshold and Manual Review** 2. **26-023 2026 Behavioral Health Network Adequacy** Certification Requirements 3. 26-024 Updated MHSA Regulations through BHSA County Policy Manual 4. 26-025 MAT Requirements for MHRCs and PHFs 5. 26-026 BH-Connect Option to Receive FFP for SMHS in IMDs 6. 26-027 Administrative Day Rate 7. 26-028 Final Allocation of Funding for SUBG **8. 26-029 Member Handbook** 9. 26-030 Authorization of Outpatient Services for SMHS	Nicole Escobar	5 Minutes
10. County Discussion	Counties	45 Minutes
11. Wrap up and Closing	Stephanie Wilson	5 Minutes

Attendees		
Name	**Department/Division**	**Attended**
Amy Cone	Humboldt County	X
Deanna Bay	Humboldt County	X
Nancy Starck	Humboldt County	X
Kevin Barnetche	Lassen County	X
Lori Griffith	Lassen County	X
Tiffany Armstrong	Lassen County	X
Jenine Miller	Mendocino County	X
Navin Bhandari	Mendocino County	X
Terry Toste	Mendocino County	X
Dolores Navarro-Turner	Modoc County	X
Nancy McCoy	Modoc County	X
Amber Kovalchuk	Partnership	X
Becky Miller	Partnership	X
Brandi Lockhart	Partnership	X
Carina Glover	Partnership	X
Hayley Garnick	Partnership	X
Jeffrey DeVido	Partnership	X
Jessica Null	Partnership	X
Latrice Innes	Partnership	X
Matt Ramsey	Partnership	X
Nicole Escobar	Partnership	X
Stephanie Wilson	Partnership	X
Joanna Chorpenning	Shasta County	X
Sarah Collard	Siskiyou County	X
Christine Lam	Solano County	X
Cutina Maddox	Solano County	X
Diana Tolentino	Solano County	X
Layla Gray	Solano County	X
Mary Kate Whall	Solano County	X
Rob George	Solano County	X

Notes, Decisions, Issues

1. Welcome, Introductions, Review & Approve Minutes from June 18, 2026
    a. Stephanie started meeting by reviewing housekeeping items:
        i. Add name in chat if you joined by phone or in a group setting for attendance keeping
        ii. Please stay muted if not speaking
    b. Nancy Starck and Deanna Humboldt approved 6/18/2026 meeting minutes
2. Wellness & Recovery Program Updates, Enhancements, and Highlights
    a. Transition
        i. Each transition group is working at a different speed
        ii. Various meetings and discussions being held with counties and CalMHSA
    b. Treatment Perception Surveys
        i. Preparing for next round of TSPs – scheduled for 10/19/2026 – 10/23/2026
        ii. Participating providers were notified on 9/19/2026 that Partnership would send individualized materials by 10/2/2026
        iii. Earlier this week, UCLA posted the final documentation on their website and since then, Partnership has finished preparing all the provider materials and will be sending those out next week
        iv. After survey week is complete, providers should mail all paper surveys to Partnership. Partnership will forward to UCLA – this is UCLAs requirement.
        v. To meet UCLAs deadline of 11/20/2026, surveys are due to Partnership no later than 11/13/2026.
    c. Deliverables
        i. Timelines coming up in the next few weeks – three specific deliverables being tracked
            1. Partnership's vendor will be finalizing and printing the 60-day letter for drop prior to 11/1/2026. The list of members will be shared.
            2. Provider contract terminations will be released, meeting the 90-day notice requirements. Partnership has a parallel communication planned to ensure the communication coming from the contracting team does not land in a way that providers may react to, fully recognizing the legalese that is necessary.
            3. Contract notice of termination notices will be sent to counties to meet the formality requirements of our mutual contract language
        ii. FY 26-27 Q1 1915(b) Appeal and Grievance and TGI Grievance Reports
            1. DHCS distributes the template each quarter, but Partnership does not receive it directly. Asked counties to please forward the template to Partnership once they receive it, it is greatly appreciated.
        iii. Latest deliverables spreadsheet is available in ShareFile.
3. Monitoring and Oversight
    a. Grievances & Appeals
        i. Received and closed 6 cases – all closed in regulatory timeframe.
            1. Slide deck shows reporting period, 2Q 2026 numbers, trending issues, DHCS reporting, and 2Q 26 DHCS Grievances Categories.
        ii. Slide deck shows grievances by county, but it is incorrect. Partnership will update slides.
            1. Mendocino had three cases instead of four
            2. Shasta had two cases instead of one
            3. Humboldt had one case
4. Monitoring and Oversight
    a. Quality Improvement Program Activities

i. Reviewed by Amber Kovalchuk
    1. W&R Provider Site Reviews
        a. Site Review Overview shared on screen, will be in SUIQI packet and added to ShareFile
    2. W&R Site Review CAP Tracker
        a. 0 CAPs issued – all closed

5. Monitoring and Oversight
    a. Member Services
        i. Beneficiary Access Line/Call Center Statistics
            1. Call Volume – Total
                a. Outbound calls have increased compared to Q1
                b. 2000 more calls monthly due to FUA/FUM
            2. Service Level Agreements
                a. Performance Metrics
                    i. 92% of inbound calls answered under 30 seconds – averaging 10 second answers
                    ii. 2% call abandonment rates
                    iii. SUD Spanish: IT issues caused abandonment, and the smaller number of calls caused the spike in percentage. Issue has been resolved.
            3. W&R Referrals
                a. Numbers remain consistent
            4. FUM/FUA Outreach
                a. Numbers through all 24 counties
                b. Solano and Shasta shared interest in collaborating to avoid duplicate efforts. If other counties are interested, reach out to Hayley.
                c. Deanna asked for county specific data – Hayley to share
        ii. Member Correspondence
            1. None this quarter

6. Monitoring and Oversight
    a. New Providers for Quarter
        i. One new provider – Elev8 in Butte County providing 3.1 res services for men. Contracting and credentialing have been completed, can now accept new members.
        ii. 2 Providers will round out the year
            1. Aegis – Siskiyou County NTP
            2. Community Outreach Recovery & Rehabilitation (CORR) – Placer County 3.1 Res
                a. Still working on completing contracting and credentialing. Anticipated date to start providing services 10/1/2026
    b. Credentialed Network Providers
        i. 49 Substance Use providers credentialed in FY 25/26 Q4
        ii. List attached to SUIQI packet
    c. Provider Compliance Summary
        i. Open Admissions CalOMS Reporting
            1. 0 records over 14 months old and therefore not considered out of compliance, but old records continue to be entered by NTP providers causing compliance to come down significantly.

2. Partnership continues to work closely with providers and their CalOMS records to ensure records are maintained 12 months and below. Continuous TA being provided to providers

ii. Provider CAP Compliance
1. None issued Q4 FY 25/26

iii. DATAR Reporting
1. Q4 FY 25/26 DATAR maintained a compliance rate of 100% by submitting DATAR by regulation timeframe of the 10th of each month.
2. Providers who experienced a challenge in submitting their DATAR reached out to Partnership to ensure timely submission.

7. Monitoring and Oversight
a. Utilization Management
i. TARs and TAR Denials
1. Authorizations
a. FY Q4 25/26, 469 authorization requests were received.
b. Two requests not approved but because they represented less than 1% of the total, the approval rate rounded to 100% and denial rate rounded to 0%
c. No expediated requests received during the quarter
2. Denials
a. Approved/Denied TARs broken down by county
b. One denial involved Shasta County member who was no longer eligible for services because the member had lost eligibility
c. Authorization was submitted for Solano County that was not processed. Authorization submitted was for services not requiring an authorization. Member entered residential services but only remained for three hours. Therefore, it was determined an authorization was not required.
3. Monitoring and Oversight – OOC Authorizations
a. Breakdown of authorizations by provider, where the provider is located, and the county of members per county they served during the quarter

ii. Member Utilization by Level and County
1. FY 25/26 Q4 had a little over 3,500 members and about 162k visits
2. NTP services continue to be the top services received, followed by residential, group counseling, and then individual counseling
3. Attached are same views broken down by county – also shared via email to each county on 9/19/2026

iii. Timely Access
1. # SUD Treatment Episodes Q4 FY 25/26: 2,067
2. 97% (1,997) episodes met timely access and 80% (1,649) were walk-in episodes
3. Continuing to meet regulation target date of 10 days for non-urgent services with average days to SUD treatment at 1.9 and urgent episodes at 1.4 days with regulation target dates being 3 days.
4. Distribution of days between level of care screening to SUD treatment for non-urgent 92% are being seen between 1-3 days and urgent 97% seen between the same amount of time.
5. Attached are same views broken down by county

iv. Transitions of Care
1. 649 stepped down to lower LOC while 427 required a step-up

2. Average days to transition down: 2.15
3. Average days to step-up: 4.11
4. Numbers stayed consistent with last quarter
5. Attached are same views broken down by county

8. Monitoring and Oversight
    a. Claims Processing
        i. Timeliness, Payment, & Denial Rates – Claims Processing for Quarter
            1. Adjudication for Q4 FY 25/26 shared
            2. BH team has taken over remediation of claiming and improvements are being seen.
            3. Lassen County had an eligibility issue and it is more apparent in data due to low denominator
            4. Data is distributed at invoicing level, it is included as a level of oversight. Partnership reimbursed providers a total of $17.3M in Q4 FY 25/26
            5. Nearly $70M annual cost of care for beneficiaries receiving SUD treatment, while Tribal claiming equating to approx. half
9. Monitoring and Oversight
    a. Compliance – Reviewed BOLD.
        i. BHINs & Policy Updates
            1. 26-022 NTP Counseling Unit Threshold and Manual Review
            2. 26-023 2026 Behavioral Health Network Adequacy Certification Requirements
            3. 26-024 Updated MHSA Regulations through BHSA County Policy Manual
            4. 26-025 MAT Requirements for MHRC's and PHF's
            5. 26-026 BH-Connect Option to Receive FFP for SMHS in IMDs
            6. 26-027 Administrative Day Rate
            7. 26-028 Final Allocation of Funding for SUBG
            8. 26-029 Member Handbook
            9. 26-030 Authorization of Outpatient Services for SMHS
10. County Discussion
11. Wrap Up and Closing
    a. Dr. DeVido shared a webinar happening on 10/26 at 12pm for Kratom – surge seen in US.
        i. Shasta is interested.
    b. Next meeting 11/2026
    c. Meeting concluded at 11:00am

Action Items

Action	Owner	Due Date
1. Meeting minutes to group	Carina Glover	10/1/2026
2. County specific date for FUA/FUM	Hayley Garnick	10/1/2026
3. Kratom Webinar link/information	Dr. DeVido Stephanie Wilson	10/1/2026

MEETING AGENDA / MINUTES

Meeting/Project Name:	**Substance Use Internal Quality Improvement Committee Meeting (SUIQI)**		
Date of Meeting:	**6/18/2026**	**Time:**	**10:00 AM**
Meeting Facilitator:	**Stephanie Wilson**	**Location:**	**WebEx**

Meeting Objective/s

A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services* oversight. Activities and progress are reported to the IQIC.

Meeting Agenda

Topic	Person(s) Responsible	Time Allotted
1. Welcome and Introductions, review and approve minutes	Stephanie Wilson	5 Minutes
2. Population Health Needs Assessment a. Presentation	Hannah O'Leary	15 Minutes
3. Wellness and Recovery Program Updates, Enhancements and Highlights a. Transition b. Reviews i. HSAG ii. DMC-ODS and SUBG c. Deliverables d. TPS Survey Results	Nicole Escobar Stephanie Wilson	20 Minutes
4. Monitoring and Oversight a. Grievances & Appeals	Latrice Innes	10 Minutes
5. Monitoring and Oversight a. Quality Improvement Program Activities *i.* W&R Provider Site Reviews	Cori Gray	5 Minutes
6. Monitoring and Oversight a. Member Services i. Beneficiary Access Line/Call Center Statistics ii. Member Correspondence – None this quarter b. DATAR Reporting	Becky Miller Stephanie Wilson	10 Minutes
7. Monitoring and Oversight a. New Providers for Quarter	Becky Miller Stephanie Wilson	10 Minutes

i. No New Providers – Several Providers in Contracting and Credentialing Process ii. Provider Recruitment b. Credentialed Network Providers c. Provider Compliance Summary i. Open Admissions CalOMS Reporting ii. DATAR Reporting d. Provider CAP Compliance – No CAPs		
8. Monitoring and Oversight a. Utilization Management i. TARs and TAR Denials ii. Member Utilization by level and county iii. Timely Access iv. Transitions of Care	Becky Miller Stephanie Wilson	10 Minutes
9. Claims Processing i. Timeliness, Payment & Denial rates - Claims Processing for Quarter	Nicole Escobar	5 Minutes
10. Monitoring and Oversight a. Compliance i. BHINs & Policy Updates 1. 26-004 2. 26-005 3. 26-006 4. 26-007 5. 26-008 6. 26-009 7. 26-010 8. 26-011 9. 26-012 10. 26-013 11. 26-014 12. 26-015 13. 26-016 14. 26-017 15. 26-018 16. 26-019 17. 26-020 18. 26-021	Nicole Escobar	5 Minutes
11. County Discussion	Counties	20 Minutes
12. Wrap-Up and Closing	Nicole Escobar	5 Minutes

Attendees		
Name	**Department/Division**	**Attended**
Cori Gray	Partnership	X
Stephanie Wilson	Partnership	X
Nicole Escobar	Partnership	X
Vivian Agudelo	Partnership	X
Jeffrey DeVido	Partnership	X
Becky Miller	Partnership	X
Armondo Romo	Partnership	X
Jackie Krznarich	Partnership	X
Joshua Bradley	Lassen County	X
Kevin Barnetche	Lassen County	X
Latrice Innes	Partnership	X
Lori Griffith	Lassen County	X
Matt Ramsey	Partnership	X
Megan Ray	Solano County	X
Dolores Navarro Turner	Modoc County	X
Nicole Bayless	Shasta County	X
Hannah O'Leary	Partnership	X
Vivian Agudelo	Partnership	X
Angie Lewis	Mendocino County	X
Loraine Wisler	Siskiyou County	X
Amber Brock	Shasta County	X
Amy Cone	Humboldt County	X
Bailey Cogger	Shasta County	X
Christine Lam	Solano County	X
Jenine Miller	Mendocino County	X
Joanna Chorpening	Shasta County	X
Maria Machado	Mendocino	X
Megan Ray	Solano County	X
Navin Bhandari	Mendocino County	X
Nicole Bayless	Shasta County	X
Silvia	Modoc County	X
Sitara Cavanagh	Partnership	X
Tiffany Armstrong	Lassen County	X

Notes, Decisions, Issues

1. Welcome and Introductions

a. Stephanie Wilson opened the meeting acknowledging all for the attendance and went over housekeeping items. She followed by requesting approval of February SUIQI meeting minutes in which Nichole Bond moved to approve, and Tiffany Armstrong offered a second.

2. Population Health Needs Assessment

a. Presentations began with Hannah O'Leary providing an overview of Partnership's Population Needs Assessment. Participants were provided with a copy of the slides as an addendum to the meeting packet.

3. Wellness and Recovery Program Updates, Enhancements and Highlights

a. Program updates included the transition of the Wellness & Recovery benefit at the end of the year. Nicole Escobar offered updated including an upcoming meeting with CalMHSA and providers, where Solano and Mendocino are encouraged to also attend. Counties shared activity has yet to gear up with DHCS with impending transition plans to be released soon.

b. Nicole went on to discuss DHCS reviews including HSAG, DMC-ODS and SUBG. Inquiries are coming in sporadically from reviewers and are being addressed with data and responses as needed. It was requested that any feedback from either entity be forwarded to Partnership as soon as possible to allow for sufficient time to pull necessary data or documentation.

c. Stephanie provided an overview of the deliverables coming up, highlighting the clinical and non-clinical PIP for HSAG due in July and API authorization in August.

d. Stephanie continues with a presentation on the treatment perception survey, highlighting areas where improvements were evident. Responses came from 464 adults and 31 youth with more than 60 programs participating. The respondent rate increased by more than 250% from 2024 and more than doubled in program participation. While some areas decreased marginally such as working with physical health providers and mental health providers, members reported an increase in being treated with respect. Slides were provided on all outcomes.

4. Grievance and Appeals

a. Additional presentations were provided by Latrice Innes from Grievance & Appeals, offering details to the cases opened in the quarter with no specific trends other than one member filed against multiple providers.

5. W&R Provider Site Reviews

a. The meeting moved along to the Site Review overview provided by Cori Gray, highlighting the reviews completed in the quarter and recognizing corrective action plans have been resolved within the same measurement period.

6. Beneficiary Access Line

a. Hayley Garnick joined the conversation from the Behavioral Health Access team, providing an overview of call volume and outcomes. Hayley highlighted the service level requirements were met this quarter, and overall referral count. Hayley also included outcomes of FUA interventions in the data.

7. New Providers, Credentialed Network Providers, Provider Compliance Summary

a. Stephanie continued the monitoring and oversight review with the inclusion of new providers, highlighting 3 which will wrap up the year and include Aegis in Siskiyou, Elev8 a residential in Butte, and CORR a residential in Placer. Also, 2 new traditional healthcare service providers, Desert Sage Wellness Center and Sacred Oaks, both of which will not be contracted, will be available for our Tribal population. Credentialed providers were included in the packet.
b. CalOMS was presented on by Becky Miller, recognizing no providers are out of compliance. NTP programs continue to place risk to the compliance as they enter records exceeding 14 months. As this indicates immediate non-compliance by the provider, Partnership is addressing as instances occur.
c. DATAR continues to remain compliance and rounds out the operational reporting with no CAPs on providers during the measurement period.

8. Utilization

a. Stephanie continued with residential authorizations, highlighting 2 denials for the period, both due to a lack of eligibility; one in Shasta and one in Solano. Out of county placements were included to recognize potential contracting needs in 2027 due to utilization. Transitioning from residential to overall utilization, service modalities were discussed by county. NTP and outpatient services remain the top 2 utilized, followed by residential.
b. Overall timely access for services remains well represented across the region with 99% of regular episodes in the measurement period meeting regulations, and 100% of urgent. This was consistent with all counties near at that same percentage. To complement timely access, transitions of care metrics were shared, with an average of 1.43 days to transition, and 4.5 for step up and 1.94 for step down.

9. Claims Processing

a. Nicole provided an overview of Short Doyle claims processing, emphasizing the work is continuing to resolve outstanding claims. Resolutions are highlighted in the arrears due to delays in DHCS processing, with January 2026 being a good reflection of the work being done and representing a 96.26% approval rate. Denials trends continue with outpatient services provided the same day a residential occurrence does, which given the step-up needs, aligns with the utilization and needs within the community. Taxonomy codes continue to be addressed with Partnership's technical team. Further, Partnership claims processing included unique utilizers served, and total cost of claiming. Tribal claims were shared with Mendocino averaging 77 members on average actively receiving NTP services, and others only averaging one.

10. Compliance

a. Stephanie provided an overview of all behavioral health information notices released in the quarter, specifically to 8 which have some impact on operations. No assistance is needed currently as Partnership is moving forward with implementations as necessary.

11. County Discussion

a. Stephanie offered the floor to County partners for open discussion in which additional sharing regarding the transition occurred. The topic will be discussed further in upcoming meetings.

12. Wrap-Up and Closing

a. The meeting was adjourned with all agenda topics discussed and the next meeting scheduled for September 24, 2026 at 11:13am.

Action Items

Action	Owner	Due Date
1. Send out meeting minutes and SUIQI package for review: Sept 2026 and Nov 2026 meeting	Stephanie Wilson	
2. Meeting Minutes	Nicole Escobar	6/25/2026

MEETING AGENDA / MINUTES

Meeting/Project Name:	**Substance Use Internal Quality Improvement Committee Meeting (SUIQI)**		
Date of Meeting:	**2/5/2026**	**Time:**	**10:00 AM**
Meeting Facilitator:	**Stephanie Wilson**	**Location:**	**WebEx**

Meeting Objective/s

A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services* oversight. Activities and progress are reported to the IQIC.

Meeting Agenda

Topic	Person(s) Responsible	Time Allotted
1. Welcome and Introductions, review and approve minutes	Stephanie Wilson	10 Minutes
2. Behavioral Health Director Update	Mark Bontrager	10 Minutes
3. Wellness and Recovery Program Updates, Enhancements, highlights and deliverables.	Stephanie Wilson	20 minutes
4. Monitoring and Oversight a. Grievances & Appeals i. FY 25-26 2nd Quarter Data/4Q25 Pulse Report ii. TGI Grievance FY 25-26 2nd Quarter report	Latrice Innes	5 Minutes
5. Monitoring and Oversight a. New Providers for the Quarter i. Three New Providers ii. Provider Recruitment b. Provider Compliance Summary i. Open Admissions CalOMS Reporting ii. DATAR Reporting iii. Provider CAP Compliance	Kara Kusalich	10 Minutes
6. Monitoring and Oversight a. Utilization Management i. TARS and TAR Denials ii. Member utilization by level and county iii. Demographics iv. Timely Access	Stephanie Wilson	10 Minutes

v. Transitions of Care		
7. Monitoring and Oversight a. Claims Processing i. Timeliness of Claims Processing for Quarter ii. Denial Rates iii. DHCS Short Doyle Acceptance Rates	Nicole Escobar	5 Minutes
8. Monitoring and Oversight a. Quality Improvement Program Activities i. W&R Provider Site Reviews ii. W&R CAP Score Tracking	Becky Miller	5 Minutes
9. Monitoring and Oversight a. Member Services i. Beneficiary Access Line/Call Center Statistics ii. Member correspondence	Stephanie Wilson	5 Minutes
10. Monitoring and Oversight a. Compliance i. BHINs & Policy Updates 1. 25-039 2. 25-040 3. 25-041 4. 25-042 5. 25-044 6. 26-001 7. 26-002 8. 26-003	Nicole Escobar	5 Minutes
11. County Discussion	Counties	20 Minutes
12. Wrap-Up and Closing	Nicole Escobar	5 Minutes

Attendees		
Name	**Department/Division**	**Attended**
Mark Bontrager	Partnership	X
Hayley Garnick	Partnership	X
Stephanie Wilson	Partnership	X
Nicole Escobar	Partnership	X
Vivian Agudelo	Partnership	X
Kara Kusalich	Partnership	X
Becky Miller	Partnership	X

Matt Ramsay	Partnership	X
Jackie Krznarich	Partnership	X
Vicki Klakken	Partnership	X
Baylie Allegro	Partnership	X
Latrice Innes	Partnership	X
Jackie Krznarich	Partnership	X
Joshua Bradley	Lassen County	X
Kevin Barnetche	Lassen County	
Lori Griffith	Lassen County	X
Matt Ramsey	Partnership	X
Megan Ray	Solano County	
Dolores Navarro Turner	Modoc County	X
Nicole Bayless	Shasta County	X
Angie Lewis	Mendocino County	X
Loraine Wisler	Siskiyou County	X
Amber Brock	Shasta County	X
Amy Cone	Humboldt County	X
Bailey Cogger	Shasta County	
Christine Lam	Solano County	
Jenine Miller	Mendocino County	
Joanna Chorpening	Shasta County	X
Maria Machado	Mendocino	X
Megan Ray	Solano County	
Navin Bhandari	Mendocino County	
Rob George	Solano County	X
Silvia	Modoc County	X
Alora Sutcliffe	Siskiyou County	X
Tiffany Armstrong	Lassen County	X
Deanna Bay	Humboldt County	X
Mary Kate Wall	Solano County	X
Michelle Thomas	Humboldt County	X
Nancy McCoy	Modoc County	X
Nancy Starck	Humboldt County	X

Notes, Decisions, Issues

1. Welcome and Introductions

a. Stephanie Wilson opened the meeting reminding all of addendum featuring monitoring and evidence which may be found on ShareFile.

b. Stephanie asked for attendees to review and approve the meeting minutes from September and November. September meeting minutes were approved by Nancy Starck first with a second from Deanna Bay. November meeting minutes were approved by Deanna Bay and a second was offered from Nancy Starck.

2. Senior Behavioral Health Director Update

Mark Bontrager offered an update to data sharing. Recognizing that many counties are working with CalMHSA for the purpose of BHAS measures.

Pharmacy, medical and non-specialty mental health will be included in the data package. Data sharing and details related to the layout are being finalized with an expected timeline for sharing falling to late February, early March.

Mark also reminded the MOU outlines a bi-directional data sharing responsibility and suggested counties may already be sharing with CalMHSA and may lean on the vendor to extend the data to Partnership.

3. Program Updates

a. Stephanie offered a spreadsheet indicating the deliverables Partnership is tracking for the purpose of administering the program. The spreadsheet has been provided to counties via ShareFile and is a living document and has been updated as of this morning. The intent of this document is to provide greater transparency to counties related to the oversight and monitoring. Stephanie asked whether counties have any additional information they would like to include. Deanna asked whether this document will be living on ShareFile where counties can review prior to reaching out to Partnership for verification of a met deliverable. Deanna asked Stephanie to walk through the CAP deliverables in the spreadsheet. Stephanie outlined each CAP deliverable with the next being due on 2/10 to address the NTP providers DHCS were unable to acknowledge in the August 2025 274 file. NACT CAPs are on hold while NAOS schedules a statewide webinar. AAS CAPs are due 3/2, separately for rural versus medium. Tiffany Armstrong shared the spreadsheet is helpful in monitoring Partnership's tracking of deliverables.

4. Grievance and Appeals

a. Latrice Innes provided an update on grievances and appeals. In Q2 3 grievances and 0 appeals were received, including 2 program requirements and one interpersonal across Mendocino, Shasta, and Solano. A significant number of closures occurred in the quarter based on a single member filing many grievances across the network.

5. Network and Operational Reporting

a. Kara Kusalich provided a network update including new providers DAAC, New Life Discovery and Family Springs.
• DAAC has 3 programs in Santa Rosa (Sonoma) and included residential (3.1, 3.2 with IMS, and 3.5)
• Outpatient and Intensive Outpatient, including youth services
• Redwood Empire Addiction Program will see youth with restrictions, including up to 2 years of failed SUD treatment. Bilingual services are available.
Deanna asked whether there are additional options for youth residential. Nicole Escobar shared the 2 current options are Muir Woods offering non-DMC-ODS services and Paradise Oaks offering 6 male beds and has little capacity to maintain their existing contracts.

b. CalOMS Open Admissions: Kara provided an update on CalOMS open admissions, sharing one provider who has new staff who has included inappropriate records for submission and out of compliance at date of entry.
c. DATAR: Kara shared quarter 2 Partnership was locked out of the system and was unable to monitor the network in the months of October and November. December brought resolution to the issues and 100% compliance.
d. Kara provided an update on provider corrective actions. Two providers received CAPs for open admissions: Diablo Valley Ranch and MedMark Fairfield.

6. Utilization Management

a. Residential Authorizations (UM): Stephanie provided an overview of the number of authorizations processed in the quarter. Additionally, 3 authorizations were denied due to lack of medical justifications and details were discussed including the timeline and efforts made to assist the provider through the authorization process.
b. Service utilization dashboards were shared highlighting outpatient and NTP services. Timely access has improved, including 96% of episodes meeting regulations. Walk in episodes have decreased slightly and transitions of care data indicate 5.23 days to step up in services, maintain timely access standards. Nicole provided an overview of the timely access data in Tableau. Tiffany asked if we could offer the counties access to the data which is not currently available, however a meeting will be scheduled to take a deeper look at the data.

7. Claims-Processing

a. Claims processing: Nicole reported timeliness of claims processing remains above 90% within one week of loading the claim within Partnership's system. Nearly 150,000 services were processed in the last quarter for payment of $15.5 million. It is important to mention Traditional Healthcare Practices billing window remains at 365 days. We have yet to receive a copy of an approved packet, although we know providers have received them. Outreach has been done to UIHS and a meeting is in the works for Pit River. We are also aware of approvals for New Life and K'ima:w (Kee-maw).CalOMS was presented on by Becky Miller, recognizing no providers are out of compliance. NTP programs continue to place risk to the compliance as they enter records exceeding 14 months. As this indicates immediate non-compliance by the provider, Partnership is addressing as instances occur.
b. Denial Rates: claims outcomes continue with less than 10% requiring a denial outcome to the provider. DHCS Short Doyle Acceptance Rate: Rates were higher in the past quarter as we wrapped up potential resolution of any 2023 FY claiming, expending all opportunities possible for reimbursement (specifically in November and December).
   Denials reasons remain:
   1- Taxonomy code reprocessing
   2- COB Billing and rebilling
   3- NM102 issues with VOTC (awaiting feedback from DHCS)

   Deanna and Tiffany asked whether FFP claiming and payment was monitored differently. Nicole explained the FFP exchange is between the county and DHCS. While Partnership could review 835 files to determine how counties were paid, more details would be needed to understand what the ask is.

8. Site Reviews

a. Becky Miller provided an overview of the site reviews for Quarter 2. Main areas of deficiencies included: missing ROIs or consents, documentation of a physical examination. How confidentiality was maintained, treatment plans, lack of signatures on records.

9. Compliance

a. Nicole provided an overview of the BHINs for the given quarter.
BHIN 25-044: Supersedes BHIN 24-044. Enforcement Actions: Monetary Sanctions for Failure to Meet Minimum Performance Levels (MPLs) for Behavioral Health Quality Measures.
Requirement: Completion of HSAG reporting of MPL for FUA, IET, POD, OUD. Reminder HSAG may indicate a DNA for inability to report with MMEF file.

b. BHIN 25-042: Supersedes BHIN 24-034 effective February 1, 2026. 2026 Integrated Behavioral Health Member Handbook Requirements and Templates.
Requirement: Member Handbook Delivery Method The handbook will be considered provided to the member if the Medi-Cal behavioral health delivery system delivers the handbook as required below: 1. Direct Delivery:
• A printed copy of the member handbook is mailed to the member's mailing address, or
• A printed copy of the member handbook is directly offered during in-person interactions. or
• The Medi-Cal behavioral health delivery system provides the member handbook via an electronic format (e.g., email, or text message that includes a hyperlink or QR code to the handbook from the Medi-Cal behavioral health delivery system's website) after obtaining the member's agreement to receive it electronically.
And
• Made available on the County's Website

c. BHIN 25-040: Mental Health Services Act (MHSA) Allocation and Methodology for Fiscal Year (FY) 2025-26. Communicates the allocation schedule the Department of Health Care Services provided to the State Controller's Office, describes the methodology used to determine those allocation schedules, and provides the amount of money the Governor's budget has estimated will be available in the Mental Health Services Fund.

Requirement: If DMC-ODS utilization data is needed please let us know in advance of March deliverables.

10. County Discussion

a. Tiffany asked if the future state of the SUIQI meetings can take a turn into a deeper dive into operations. Thoughts include deeper dive into FWA cases- more discussion on the how and the why behind the data. Overview is not fulfilling the need of understanding the strain of the administration or the network of which DHCS is looking to counties to be able to explain. Deanna and Joanna Chorpenning mentioned tableau data live versus pdf tables may be helpful. Rob George requested room for discussion related to quality review. Deanna emphasized how beneficial the meeting has been. Partnership will look into ways to further improve the experience for the county.

12. Wrap-Up and Closing

a. Stephanie ended the meeting with no further discussion items. The meeting adjourned at 11:34am.

Action Items

Action	Owner	Due Date
1. Send out meeting minutes and SUIQI package for review: Feb and June 2026	Stephanie Wilson	2/15/2026
2. Meeting Minutes	Nicole Escobar	2/15/2026

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MEETING MINUTES

Meeting Name: Member Grievance Review Committee

Date: August 27, 2026

Time: 2 p.m. to 2:50 p.m.

Location: *WebEx link in meeting invite*
Fairfield West | Board Room
Airpark | Burney Falls Conference Room

Attendees:
Kory Watkins, Director of Grievance & Appeals
Latrice Innes, Compliance Manager, Grievance & Appeals
Mori McLennan, Sr. Manager, Grievance & Appeals
Baylie Allegro, Compliance Analyst, Grievance & Appeals
Edna Villasenor, Sr. Director of MS and G&A
Mark Netherda, MD, Medical Director for Quality, Quality Improvement
Jayne Cappello, Project Coordinator, Grievance & Appeals
Lisa Rowand, Pharm D, Sr. Clinical Pharmacist, Pharmacy
Irem Conery, Director of Member Experience
Anthony Sackett, Program Manager II, Administration
Hannah O'Leary, Manager of Population Health
Brandi Walker, Manager of Transportation
Leigha Andrews, Regional Director, Administration
Marie Medalle, RN, Supervisor of Member Safety Qlty. Inv., Quality Improvement
Charlie Chaleunsy, Program Analyst, RAC
Michela Englehart, Legal Analyst, Legal Affairs
Jill Blake, Regional Director, Administration
Rebecca Stark, Regional Director, Administration
Kathryn Power, Director of Regional Operations, Administration
Isha Bedi, Program Analyst, RAC
Naz Sattari, Supervisor of Health Equity Training, Health Equity
Shreya Kulkarni, Policy Analyst, RAC
Gary Robinson, Program Manager II, RAC
Lonni Hemphill, Program Manager I, RAC
Brigid Gast, RN, Sr Director of Carem Management, Care Coordination
Stan Leung, Pharm.D, Director of Pharmacy
Suzanne Trepoy-Papadopoulos, RN, Manager of Care Coordination
Eric Rushing, Manager of Mental Health Programs, Behavioral Health
Brandi Lockhart, LCSW, Sr, Manager of Behavioral Health Access, Behavioral Health
Andrew Ivey, Manager of Claims
Jayme Bottke, Regional Director, Administration

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Agenda Topic	Minutes	Action Items
Agenda Item #1: Introductions & Objective of Meeting *Speaker: Latrice Innes*	Welcome: Jayme Bottke, Regional Director, Administration Irem Conery, Director of Member Experience Marie Medalle, RN, Supervisor of Member Safety Qlty. Inv., Quality Improvement Brandi Walker, Manager of Transportation The Member Grievance Review Committee (MGRC) represents a multi-disciplinary oversight forum with representatives across multiple Partnership HealthPlan departments to track and trend Grievance, Appeals, Exempts, and State Hearings cases. It serves as a collaborative work group to discuss complex cases or improvement opportunities with the following key focus areas: quality improvements, clinical oversight, operational excellence, member experience, and regulatory compliance. Findings may be presented in the Internal Quality Improvement (IQI) Meeting and/or Quality Utilization Advisory Committees (QUAC).	
Agenda Item #2: Review & approve minutes from last meeting *Speaker: Latrice Innes*	The minutes from the MGRC meeting on May 28, 2026, will be motioned for approval at the November 19, 2026 meeting.	
Agenda Item #3: Old Business *Speaker: Latrice Innes*	**Old Business** **Inter-Rater Reliability (IRR) Findings** IRR assesses the accuracy of clinical decisions made by the Grievance Nurse Specialists (GNS). The assessment is completed by the Chief Medical Officer (CMO), or his designee, and provides clinical oversight on cases that are at higher risk for errors. The cases are also assessed by G&A leadership to	

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	identify learning opportunities. The following issues were identified during the assessment of cases closed in 4Q25: • Grievance Case Analysts have been sending referrals to the incorrect departments and asking inappropriate questions on provider referrals. This was reviewed in June with the individual Grievance Case Analysts impacted. This issue is now closed.	
Agenda Item #4: Department Updates *Speaker: Kory Watkins*	**1. Department Updates** **DHCS** • We are still waiting for the final response from DHCS for potential findings. **NCQA** • We completed the internal Quarterly File Review on 8/13/26 and received 100%. The NCQA Renewal audit will be conducted in 11/2026. • The file Universe, a year's worth of appeal cases, is due 9/9/26. **Jiva** • Currently G&A is separating Acknowledgement and Resolution Letter Assessments • We met with RX and UM to align the appeal processes. The Medical Directors will find this helpful as the appeals from each department will have the same format. The member letters will be more cohesive as well. • There is still more testing needed. • Data has been migrated from Everest to Jiva. Currently there is about a year's worth of data that is being reviewed to ensure the data is coming over correctly. **Internal Audits** • The State Fair Hearing Decision Implementation Audit is a newly established audit initiated by RAC. The review primarily focuses on overturned decisions, with a deeper assessment of the processes followed and how G&A communicates outcomes to impacted departments. Additionally, services must be made available to the member within a	

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	required 72-hour timeframe. This audit is to ensure G&A and the various internal departments are implementing decisions in a timely manner. • The ADA (Americans with Disabilities Act) Claim Response audit is when a member files a complaint related to ADA accommodation. • The ADA Accommodation Request audit is for when members request an ADA accommodation. The purpose of this audit is to establish an enterprise-wide process and tracking mechanism. A CAP has been issued on the ADA internal audits due to the deficiencies. G&A has been working with PMO on projects which include several other departments to ensure the corrections needed are taking place. **2. Staffing Updates** G&A currently has two (2) vacancies for Internal Auditors as a result of findings from the DHCS audit. During the audit, DHCS placed significant emphasis on the quality of G&A's work, including whether resolution letters were reviewed by a second individual prior to being issued. While we do conduct audits of our cases, the current level of review may not meet DHCS's expectations. With only two (2) Internal Auditors currently on staff, it is not feasible to fully accommodate these additional review requirements. As a result, G&A has added two (2) additional Internal Auditor positions and is actively recruiting to fill them.	
Agenda Item #5: Case Statistics *Speaker: Latrice Innes/ Kory Watkins*	**Case Statistics** There were 3,152 cases closed in 2Q26. Twenty-eight cases were closed past 30 days. Acknowledgement letters were sent within five (5) calendar days of receipt for all but 30 cases. G&A met the timeliness goal of 98.3%. The 2Q26 case performance was 98.7% and the acknowledgement letter performance was 98.6%, both exceeding the 98.3% goal. Staffing levels have remained unchanged, with the same number of staff processing cases as in the previous year. Currently, several Grievance Case Analysts (GCAs) are managing caseloads of approximately 70 cases each. Ideally, GCAs would maintain caseloads closer to 40 cases to ensure optimal workload balance and efficiency. As a result, current caseloads remain significantly above the preferred level. In July 2025, we closed 743 cases compared to 1,177 cases closed this July 2026, 52% increase. Year over year looking at the first seven (7) months we saw	

	a 37% increase in cases. Some of the main drivers for the case increases are Community Supports and Transportation. Transportation has completed more rides this year compared to last year. There was one (1) lost State Hearing during 2Q26 regarding Medically Tailored Meals. The member has multiple physical and psychiatric diagnoses that make it difficult for them to prepare their own meals. The hearing was overturned as the Administrative Law Judge (ALJ) determined that there was enough evidence in the member's medical records and documents submitted during the hearing to demonstrate a medical necessity for the Medically Tailored Meals. Hannah O'Leary Q: If the provider had the additional information, why didn't the provider submit the additional information prior to the State Hearing? A: The appeals representative asks for additional information during the appeals process. There are times when no information is received. We ask for the information but do not always receive it. We do not know why providers hold the information until the State Hearing.	
Agenda Item #6: Reporting & Trends *Speaker: Latrice Innes / Mori McLennan/ Baylie Allegro*	**1. Mental Health** **<u>Mental Health Case Trends</u>** In the second quarter, 24 of the 3,152 cases were related to Mental Health, representing 0.8% of the total case volume. The top three (3) trending issues were Treatment Plan Disputes (37.5%), Communication Issues (25%), Poor Attitude (16.7%). With the Mental Health benefit coming in house, our NCQA reporting will increase and include Behavior Health and Non-Behavior Health NET 1&2. **<u>Case Referral Responses</u>** Carelon continues not to respond to G&A's referral questions timely when they deem a case to have a potential quality issue (PQI). G&A has been receiving a generic response indicating that a PQI has been identified and that Carelon has 60 days to respond. G&A has escalated these concerns to Behavioral Health	

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leadership as well as Carelon's leadership. We are in the process of completing a CAP for Carelon.

Mark Netherda, MD
Q: Do we have an idea of when there will be action taken on this concern?
A: Currently we do not have a timeframe, however Mark Bontrager and Alison French are working on this concern together. At our last meeting, Carelon understood what our processes are and what the mandates are from DHCS, however Carelon does not have the adequate staffing to provide the response within the 12-calendar day contracted timeframe.
Dr. Netherda suggested we make RAC aware of the issues we are having. Gary Robinson (RAC) is aware of the issues and Carelon is also aware there is a CAP forthcoming.

Suzanne Trepoy-Papadopoulos
Q: There was a CAP issued in June and now there is another CAP or are they one in the same?
A: The CAP that was issued in June stemmed from Carelon's annual audit which had two (2) issues: a missing report and their policy was missing vital information on what a grievance investigation entails. We are currently still working on that CAP with Carelon. An additional CAP is being issued is for the timely responses.

2. Transportation
Transportation Cases
There were 1,637 transportation-related cases, which accounted for 51.9% of closed cases overall. Transportation completed 390,526 NMT/NEMT trips for 2Q26. Meaning only 0.4% of completed trips had concerns.

Transportation Changes
The Transportation department was recently short staffed. However, 18 new employees started in June and an additional 25 are scheduled to start on August 31, 2026. At the last MGRC meeting we noted we were going to track the trips with concerns for the top five (5) providers with concerns: Lyft had 62,929 trips completed (0.3%), North Bay Transit had 22,313 trips completed (0.4%), Budget

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	Friendly had 7,859 trips completed (0.8%), NorCal Transit LLC had 5,849 trips completed (1.0%) and Easy Day Ride 12,372 trips completed (0.4%). Gary Robinson Q: Are the 390,526 trips completed one-way trips or round trips? Brandi Walker A: One trip is one leg of the trip so the 390,526 is accounting for one leg of the trip. **3. Community Supports** There were 243 Community Supports Services cases. This was an 86.9% increase in cases in 2Q26, representing 7.7% of the total G&A volume for the quarter. While this isn't currently a significant driver of case volume, it is expected to contribute to a continued increase in G&A cases over time. Community Supports remains an evolving program, with ongoing policy clarifications and additional guidance being issued by DHCS. As new guidance is implemented, we anticipate corresponding increases in case volume. This quarter we also saw increased representation across several Community Supports benefits, including Transitional Rent. There were eight (8) cases related to Transitional Rent despite only three (3) members being enrolled in the benefit. Further review indicated that several members were dissatisfied after being denied the benefit, suggesting that many of these cases involved individuals who were not among the enrolled members. Medically Tailored Meals (MTM) continues to be the primary driver Community Supports related cases. Additionally, Notices of Action (NOAs) were briefly issued with appeal rights included in error. This issue has since been identified and corrected. Hannah O'Leary Q: As the new Community Supports changes roll out, is that a reason for the increase in Community Supports Grievances/Appeals? A: Typically, every time Community Supports has a policy clarification, G&A sees an increase in cases.	

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	4. Inter-Rater Reliability (IRR) Findings IRR assesses the accuracy of clinical decisions made by the Grievance Nurse Specialists (GNS). The assessment is completed by the Chief Medical Officer (CMO), or his designee, and provides clinical oversight on cases that are at higher risk for errors. The cases are also assessed by G&A leadership to identify learning opportunities. The following issues were identified during the assessment of cases closed in 1Q26: • Grievance Nurse Specialists scored 100% • In some instances, the GCA did not document the cases correctly by listing incorrect providers or not listing a provider at all. GCAs will receive additional training during the monthly GCA Meeting on September 10, 2026. • The GCAs have used incorrect DHCS categories. GCAs will receive additional training during the monthly GCA Meeting on September 10, 2026. • The GCAs sent referrals past the four (4) calendar days best practice timeframe. GCAs will receive additional training during the monthly GCA Meeting on September 10, 2026. **5. PULSE Report** The 3Q26 PULSE Report will be released in September 7, 2026. If you would like to be added to the email distribution list, please email Latrice. The report will also be available on the Grievance & Appeals page on Partnership4ME. A highlight to look for: • One (1) Overturned State Hearings this Quarter • Increase in Community Supports cases	
Agenda Item #7: Investigation *Speaker: Mori McLennan*	**Case Spotlight** **1. Case 73666** **Issue** Verbiage and Appeal Rights in Notice of Action (NOA) for Medically Tailored Meals (MTM), and Transitional Rent. **Background**	

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	During a recent review, we identified instances where Notice of Action (NOA) language and appeal rights were included for some cases that may not have aligned with the applicable policy. For example, a member was denied MTM services because the member had previously received the requested service under three prior TARs and was considered to have reached a service "cap." G&A was unable to locate this criterion within the policy referenced in the NOA (MCAP7003 CalAIM Community Supports Section). We have also encountered grievances in which appeal rights were provided, and subsequent review indicated that the circumstances may not have met the criteria for appeal rights. **Steps Taken** Several process changes related to MTM and Transitional Rent are being developed. The G&A Leadership Team will review all MTM or Transitional Rent Appeals in which a member was incorrectly provided appeal rights or standard verbiage was not used. These cases will be escalated and reported to EHS Leadership for review.	
Next Meeting	November 19, 2026	

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PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI Department Update
October 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** • CG-CAHPS results from Press Ganey have been received. Survey reports will be shared with providers in early October • The 2025 PCP QIP Evaluation will be presented in October's committee meetings
Palliative Care Quality Incentive Program (Palliative Care QIP)	**Program Overview** Pay for performance program which offers significant financial incentives to support and improve the access to and quality of palliative care provided by our contracted palliative care providers. **Program Update** • Payment processing for 2026 Measure Period I (January 1 – June 30) is being finalized and is on track for payment distribution by September 30, 2026.
Perinatal Quality Incentive Program (PQIP)	**Program Overview** The Perinatal QIP offers financial incentives to participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers providing quality and timely prenatal and postpartum care to Partnership members Program Update **Program Update** • Preliminary Payment Summaries were sent to providers for the 2025-26 Measurement year. Work continues within the DataLink workgroups to validate how to utilize the data received to help score the perinatal providers for timely prenatal visits with depression screenings. The PQIP is inviting several more providers to join the PQIP in 2027, which includes several Tribal Health Providers across our network.
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** • The 2027 ECM QIP measurement set was presented and approved at the Physician's Advisory Committee this month. Because there are upcoming ECM changes by DHCS which may affect the ECM QIP, the 2027 measurement set will remain the same as the 2026 measurement year.

	• Plaques were ordered for five 2025 Top Performers and will be distributed next month. • Measure scoring for 2nd quarter 2026 begins the last week of September with final payment distribution scheduled for end of October.
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** • With all submissions submitted for the 2025-26 measurement year, the hospitals' preliminary scores were calculated throughout the month, and hospitals will receive their Preliminary Payment Summary in the beginning of October. A Hospital Quality Symposium Planning Committee has been created to prepare for the 2027 HQS, which will be held on June 15th and 17th 2026. Part of the HQS will honor Dr. Moore's contributions to hospital quality.
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** • The 2027 EXT QIP measurement set was presented and approved at the Physician's Advisory Committee this month. Changes include adding a California Immunization Registry (CAIR) entry to the CMS influenza and pneumonia vaccination measures and a new Health Equity Impact Analysis and Plan measure. • Performed outreach this month to facilities showing no QAPI Plan and Attestation form submissions.

QUALITY DATA TOOLS

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

	Program Update • No updates
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 MY2026 target of 33% of county membership within the data pulls (approximately the population share represented by the measures listed above). • 7 additional counties are within 5 percentage points of the 33% target. Provider onboarding and data exchange expansion remain key priorities, alongside a significant effort to validate, monitor, and operationalize incoming clinical data to ensure data quality, reporting readiness, and sustainable integration into quality measurement and operational workflows. These activities are particularly focused on underperforming counties where several high-volume PCP organizations remain in discovery, onboarding, or have not yet begun implementation.

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE
STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	**Program Overview** All plans in California are required to conduct PIPs as part of their agreements. DHCS has assigned Partnership two PIPs: a non-clinical PIP for BH and a disparity PIP. DHCS can also require plans to do mandated improvement PDSA projects **Program Update** • No New Update.
QUALITY MEASURE SCORE IMPROVEMENT	**Program Overview** ***Strategic Shift in Approach to Quality Measure Performance Improvement (QMSI)*** QMSI workgroups have historically served as a cross-functional driving force for plan-wide HEDIS measure score improvement. Earlier in 2026, the Performance Improvement (PI) Leadership team, in coordination with our HEDIS Data Team, evaluated accountable measure performance across our 24-county footprint and identified priority measures by geography that needed to be prioritized according to several factors, including financial risk. At that time, leadership decided that performance varied enough by geography that a regionally focused strategy was needed. Additionally, it was recognized that the primary lever for improvement is through Partnership's already established improvement coaching program. To support this shift, QMSI will evolve to support regional improvement work and improvement coaching through 1) Serving as subject matter experts in their family measure domain (e.g. pediatrics, chronic disease, women's health, and behavioral health) and 2) Provide support to regional improvement teams as needed. The cornerstone activity of supporting regional coaching teams is for QMSI workgroups to develop measure-specific improvement toolkits for high-priority improvement measures of focus. These toolkits will serve as resources for the improvement coaches to use when a provider wants to do measure specific improvement. Going forward, this report will be reorganized to better align with shifting strategies and accountability. **Workgroup Updates** • Measure Specific toolkits are drafted and being reviewed by PI Managers
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

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

Program Update: A pilot is currently in progress

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: No new update

Improving Measure Outcomes Webinar Series
This series is designed to help Quality Improvement teams turn knowledge into action. These sessions focus on Partnership's Primary Care and Perinatal Provider Quality Incentive Program (QIP) measures, offering practical strategies to close care gaps, advance health equity, and improve clinical outcomes. Each session highlights proven strategies and best practices from peer clinics that are actively achieving measurable improvements in patient care.

Program Update: No new update

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

	Microlearning **Program Overview** These short, focused modules deliver key concepts in easily digestible formats. **Program Update:** No new update
Joint Leadership Initiative (JLI)	**Program Overview** The Performance Improvement team facilitates Joint Leadership Initiative meetings with seven parent organizations across the Partnership network. Four of the seven organizations are in our expansion counties (Chico and Auburn Regions). This is a quality improvement strategy to collaborate with the largest parent organizations providing primary care who did not earn at least 75% of their PCP QIP scores in the previous year. This number could change once final 2025 PCP QIP scores are finalized. **Update:** No new updates
Regional Improvement Meetings	**Program Overview** Regional Quality Improvement meetings are held quarterly at each of our 6 regional offices (Eureka, Redding, Chico, Auburn, Fairfield, and Santa Rosa) or online with the goal of bringing together regional health center quality leaders to share and discuss strategies to improve measures that are regionally important and learn from Partnership regarding any program changes and/or priorities. **Update:** No new updates

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 final EPT submission cycle is underway (October 1 – November 2). Providers may submit outstanding milestones from prior cycles, along with final performance-based milestones tied to Assigned & Seen KPI's and Population of Focus HEDIS-like measures. • October Learning Community sessions are focused on sharing lessons learned, highlighting practice successes, and preparing providers to sustain improvement efforts after the program concludes. • The EPT program officially concludes for provider practices in November 2026, however, MCPs are 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. **Data Updates** • Two Partnership-sponsored practices achieved milestone-eligible performance at or above the 90th percentile for MY2024 measures: ○ Ampla Health for Depression Screening. ○ West County Health Centers for Well-Child Visits in the First 15 Months of Life. • Several additional Partnership-sponsored practices achieved 90th percentile performance on individual measures but were not eligible for milestone payments due to Population of Focus requirements or minimum denominator thresholds. • Partnership submitted MY2025 data to PHLC in August. Review of submitted MCP data is nearing completion. • Draft guidance for MY2026 data submission has been released, with final MCP feedback expected to inform the reporting requirements and timeline for 2027 data 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.* *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.*

<table>
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Program Updates:

- ***Phase I:*** All 10 counties applied, 9 have received awards, 1 is revising their application.
- ***Phase II:*** 22 providers have been invited to the September 28 informational webinar launching the program. Applications will be accepted through October 30.

</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="3">Event Days
07/01/2026 – 12/31/2026</th></tr>
<tr><th>Region</th><th># of Provider Event Days</th><th># of Community Event Days</th></tr>
<tr><td>Auburn</td><td>4</td><td>0</td></tr>
<tr><td>Chico</td><td>12</td><td>1</td></tr>
<tr><td>Eureka</td><td>17</td><td>0</td></tr>
<tr><td>Fairfield</td><td>8</td><td>0</td></tr>
<tr><td>Redding</td><td>12</td><td>0</td></tr>
<tr><td>Santa Rosa</td><td>4</td><td>0</td></tr>
<tr><td>Plan Wide</td><td>57</td><td>1</td></tr>
</table>

- Planning for November to December 2026 in progress.

</td></tr>
<tr><td>Partnering For Pediatric Lead Prevention Program (PPLP)</td><td>

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

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<tr><td>Abbott Cancer Diagnostics:</td><td>

Program Overview

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</table>

Promoting Colorectal Cancer Screenings	Abbott Cancer Diagnostics, formerly known as Exact Sciences, continues to work directly with providers to support care-gap orders for Cologuard kits. These care-gap orders no longer have a 300 patient minimum. Providers interested in placing a care-gap order should contact their Abbott Cancer Diagnostics representative. Providers who are unsure who their representative is may contact Abbott's support line at 1-844-870-8870 or complete the online contact form at https://www.cologuardhcp.com/contact-us. Partnership's Cologuard Care-Gap Orders page continues to be available as a resource for general information. Since a minimum is no longer required for care-gap orders, Partnerships facilitated orders will be discontinued after our current offering (further details below). If you have any questions, please reach out to the Performance Improvement team at PIT@partnershiphp.org. **Program Updates** • Partnership's last facilitated order launched on 07/20/2026 with a final submission date of 08/17/2026. ○ Three provider organizations participated including Providence, Achieve Community Health Center, and Dignity Health St Elizabeth.in ○ Pre-shipment patient letters were mailed on 09/18/2026 with the kits shipping on 09/28/2026.
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, identifying populations of focus to help improve HEDIS and QIP performance rates, and providing nursing staff to administer vaccines during the event day. **Project Update** • This year's annual Shasta County Drive-Thru Flu Clinic is scheduled for Saturday, October 17, 2026 from 10 a.m. to 2 p.m. at Partnership's building, located at 351 Hartnell Ave, Redding, CA 96002. 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) have been submitted reviewed and approved by the following Committees: and Board approval. Scheduled review and approval dates area as follows: • Internal Quality Improvement (IQI) Committee – 08/11/2026 • Quality Utilization Advisory Committee (Q/UAC) – 08/19/2026 • Physician Advisory Committee (PAC) – 09/09/2026 • The documents are to be submitted to the Board of Directors for review and approval on– 10/28/2026.
SAGE GRANT	**Program Overview** The *Systems Advancement for General EHR* (SAGE) Grant is designed to assist healthcare providers in implementing or upgrading their EHR systems, to help modernize and enhance their ability to deliver high-quality, efficient, and member-centered care. This grant will help providers overcome common barriers to EHR adoption by offering financial support and implementation guidance. The recipient of the SAGE grant, Kimaw Medical Center, signed the agreement on 12/5/2025. The first payment installment of $125,000 was initiated. The SAGE Grant team will continue to conduct regular check-ins and monitor implementation milestones. The SAGE Grant Timeline can be found here. **Program Updates** • Partnership will begin coordination activities for the July – December Progress Check-In with K'ima:w by November 2026.
D-SNP MEDICARE	**D-SNP** **Program Overview** The D-SNP Quality team is responsible for 1) Development and finalization of the Model of Care document, 2) Management of Partnership's CMS Medicare Star quality program, and 3) Developing D-SNP readiness for all Quality Improvement teams. 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 • No new update
ACTIVITY	**UPDATE**
QUALITY ASSURANCE AND PATIENT SAFETY	
ACTIVITY	**UPDATE**
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 08/19/2026 TO 09/25/2026	**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** • 30 referrals were received with 27 coming from Grievance and Appeals, 1 from a Associate Director, 1 from a Regional Medical Director and 1 from Utilization Management • 42 cases were processed and closed • 91 cases are currently open • Three cases were discussed at Peer Review Committee (PRC) on 9/16/2026 and there are four cases awaiting PRC review. • One case was sent to an external Subject Matter Expert for review. • Two nurses provided an overview of the PQI process to the HEDIS team on September 23, 2026.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR)	**Program Overview** Site Review and Medical Record Review performed for monitoring of providers. **Program Update** • No new updates
HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)	
ACTIVITY	**UPDATE**
Annual HEDIS® Projects	**Program Overview** HEDIS is used to evaluate clinical quality in a standardized way. This program shares performance measurement rates with the intent of improving the quality of care delivered to members.

	Program Update • No updates
HEDIS® Program Overall	**Program Updates** • NCQA has published the MY2025 Health Plan Ratings on September 15, 2026. Partnership received 3.0 Stars for its MY2025 performance. • The MY2025 Annual Summaries of Performance for NCQA Health Plan Accreditation and DHCS MCAS Measure Set have been published on the Partnership website.

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's NCQA Health Plan Accreditation renewal survey is scheduled for October – November 2026.
NCQA Health Outcome Accreditation (HOA)	**Program Overview** The State of California requires all Managed Care Plans (MCPs) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years. Partnership's next HOA Renewal Survey is tentatively scheduled for 05/16/2028. **Program Update** • No new updates

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

QUALITY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)

Consent Calendar

Oct. 21, 2026

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

		Pages
Reports	Primary Care providers Quality Incentive Program (PCP QIP) CY 2025 Evaluation – *direct questions to Athena Beltran – Nampraseut*	101 – 126
	Q1/Q2 2026 Prior Authorization Metrics Report by Partnership County	127 – 128
	2026 Annual Oversight Audit: Carelon – Notice of Final Audit Results CY 2025	129 – 133
Health Services Policies	**Behavioral Health**	
	MCBP8015 – Coordination of Care for Child Welfare-Involved Members	135 – 139
	MPBP8007 – Screening and Treatment for Substance Use Disorders	141 – 156
	MPBP8013 – Eating Disorder Management Policy	157 – 165
	Quality Improvement	
	MCQP1021 – Initial Health Appointment [1]	167 – 177
	Utilization Management	
	MCUG3032 – Orthotic and Prosthetic Appliances Guidelines	179 – 182
	MCUP3020 – Hospice Services	183 – 198
	MCUP3114 – Physical, Occupational and Speech Therapies	199 – 205
	MCUP3128 – Cardiac Rehabilitation	207 – 212
	MCUP3130 – Osteopathic Manipulation Treatment	213 – 215
	MPUP3116 – Positron Emission Tomography Scans (PET Scans)	217 – 219
Non- HS Policy	**Member Services**	
	MP316 – Provider Request to **Reassign** Member & Assistance with Inappropriate Member Behavior – **NEW TITLE** - *CLEAN copy of the policy begins on p. 235*	221 – 239

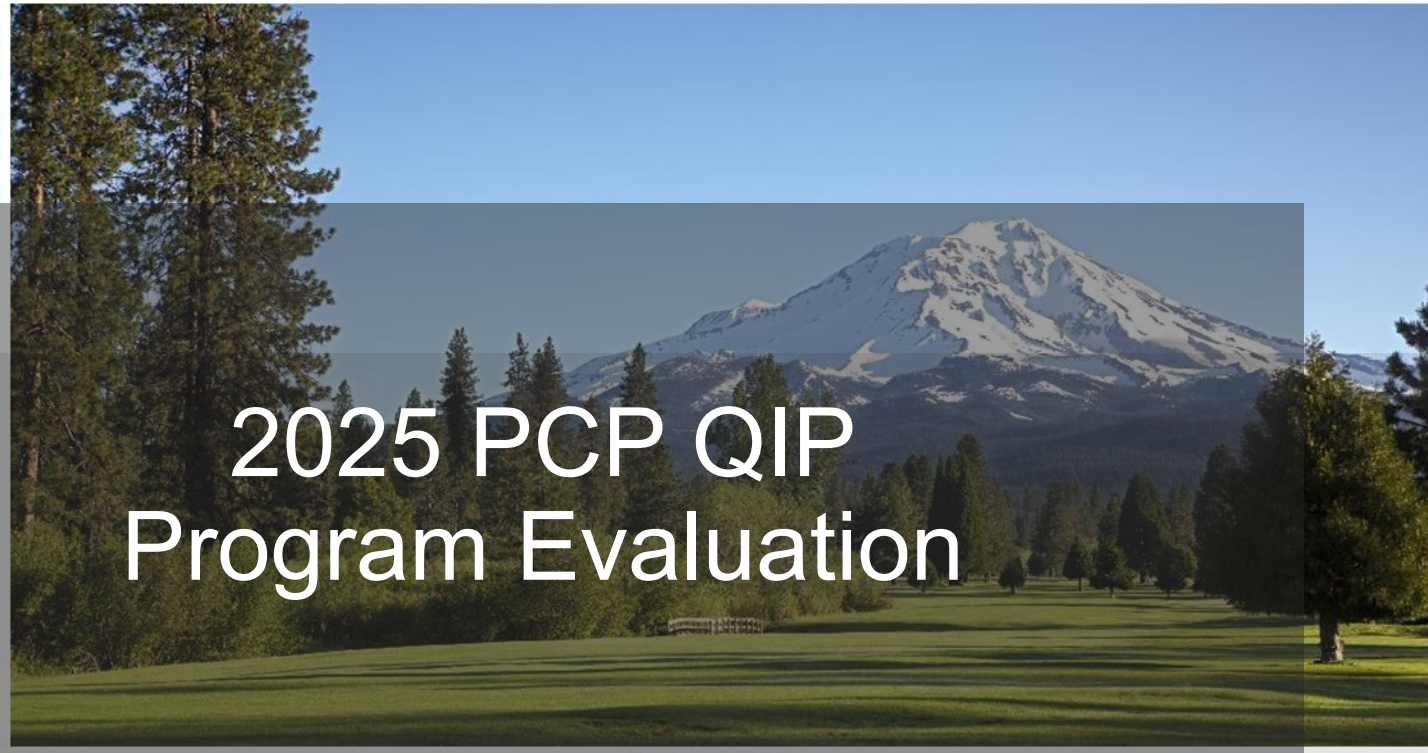
[1] MCQP1021 Attachment A – Provider's Sample Welcome Letter to New Members is ow available in Punjabi

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PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ACCREDITED NCQA HEALTH PLAN



2025 PCP QIP Program Evaluation





Prepared by:
Athena Beltran-Nampraseut
October 2026



Contents


2025 Program Overview


2025 Program Adjustments and Changes


2025 PCP Program Performance


2025 Payout Overview


2025 Summary

2025 PCP QIP Overview



Clinical Core Measurement Set

2025 PCP QIP MEASUREMENT YEAR

(January 1 - December 31)

CLINICAL											
PRACTICE TYPE			MEASURE	MEASURE CATEGORY	AGE RANGE	TARGETS		FULL / PARTIAL POINTS		
FAMILY	INTERNAL	PEDS				FULL 90th	PARTIAL 75th	FAMILY	INTERNAL	PEDS
✓	✓		Comprehensive Diabetes Care - HbA1c Good Control*	CHRONIC DISEASE MANAGEMENT	18 - 75 YRS	70.07%	66.67%	6/4	12/9	-
✓	✓		Comprehensive Diabetes Care - Retinal Eye Exams		18 - 75 YRS	64.06%	59.41%	5/4	6/4	-
✓	✓		Controlling High Blood Pressure		18 - 85 YRS	72.75%	69.37%	6/4	10/7	-
✓		✓	Immunization for Adolescents - Combination 2	PREVENTATIVE SCREENING	13 YRS	48.80%	40.88%	6/4	-	11/9
✓	✓		Childhood Immunization Status - Combination 10		2 YRS	42.34%	34.79%	6/4	-	11/9
✓	✓		Breast Cancer Screening		50 - 74 YRS	63.48%	59.51%	6/4	15/11	-
✓		✓	Cervical Cancer Screening		21 - 64 YRS	67.46%	61.56%	6/4	15/11	-
✓	✓		Colorectal Cancer Screening*		45 - 75 YRS	43.71%**	38.07%**	5/4	12/9	-
✓		✓	Lead Screening in Children		2 YRS	79.51%	71.11%	6/4	-	9/7
		✓	Chlamydia Screening*** *NEW*		16 - 20 YRS	55.95%	-	-	-	5
✓		✓	Child and Adolescent Well Care Visit	PEDIATRIC ACCESS	3 - 17 YRS	64.74%	58.07%	9/7	-	14/12
✓		✓	Well Child Visits in the First 15 Months of Life		15 MONTHS	69.67%	64.99%	9/7	-	11/9
		✓	Well Child Visits in the First 15-30 Months of Life*** *NEW*		30 MONTHS	69.43%	-	-	-	5
✓	✓	✓	Reducing Healthcare Disparity *NEW*	OPTIONAL	--	HPL	MPL or 20% Increase	FP = 7% of QIP Baseline/ PP =3% of QIP Baseline		
✓	✓		Breast Cancer Screening *NEW*	MONITORING ONLY	40 - 49 YRS	--		--		
✓			Chlamydia Screening *NEW*		16 - 24 YRS	--		--		
	✓		Chlamydia Screening *NEW*		21 - 24 YRS	--		--		
✓		✓	Topical Fluoride in Children *NEW*		1 - 4 YRS	--		--		
✓			Well Child Visits in the First 15-30 Months of Life *NEW*		30 MONTHS	--		--		

*Partial Points at 50th%ile and Full Points set at 75th%ile targets
**Internal rates used to set targets

*** Active Measure for Pediatrics with FP target set at 50th%ile, no PT available

Non-Clinical Measurement Set

NON-CLINICAL									
PRACTICE TYPE			MEASURE	MEASURE CATEGORY	TARGETS		FULL / PARTIAL POINTS		
FAMILY	INTERNAL	PEDS					FAMILY	INTERNAL	PEDS
✓	✓		Ambulatory Care Sensitive Admissions	HOSPITAL UTILIZATION	FULL POINT 60TH Percentile (9.17)	PARTIAL POINT 70TH Percentile (11.91)	5 / 4	5 / 4	--
✓	✓		Follow-Up within 7 Days after Hospital Discharge *NEW*		FULL POINT TARGET **SCORE ≥31%**	PARTIAL POINT TARGET **SCORE 25-30%**	5 / 4	5 / 4	--
✓	✓	✓	Avoidable ED Visits	PRIMARY CARE UTILIZATION	FULL POINT 60TH Percentile (13.14)	PARTIAL POINT 70TH Percentil (16.28)	5 / 4	5 / 4	11 / 9
✓	✓	✓	PCP Office Visits		FULL POINT TARGET Greater than 2.0 visits per member per year on average	PARTIAL POINT TARGET Between 1.7 and 2.0 visits per member per year on average	5 / 4	5 / 4	11 / 9
✓	✓	✓	Patient Experience - CG-CAHPS	PATIENT EXPERIENCE	**ACCESS**	**COMMUNICATIONS**	10 / 9	10 / 8	12 / 11
					FULL POINTS 50TH Percentile (44.55%)	FULL POINTS 50TH Percentile (74.70%)			
					PARTIAL POINTS 25TH Percentile (36.39%)	PARTIAL POINTS 25TH Percentile (64.70%)			
			Patient Experience - SURVEY OPTION		**FULL POINTS**	**PARTIAL POINTS**			
					PARTS 1 AND 2	PARTS 1 OR 2			

Unit of Service Measurement Set

PRACTICE TYPE			MEASURE	CRITERIA
FAMILY	INTERNAL	PEDS		
✓	✓	✓	Academic Detailing *NEW*	$2,500 bonus for scheduling & hosting academic detailing meetings with at least one provider for each site, with a minimum of one Medical Director, one Pharmacist (where applicable) & QI team and Partnership Healthplan pharmacist/medical director present. There is a two-part meeting requirement for the incentive: First meeting to review the data ($1500) and Second meeting to follow-up for feedback ($1000). If a pharmacy academic meeting is scheduled with only one medical director at the first initial meeting, only $500 will be given.
✓	✓		Advance Care Planning	Minimum 1/1000th (0.001%) of the sites assigned monthly membership 18 years and older for: • $100 per Attestation, maximum payment $10,000 per site. • $100 per Advance Directive/POLST, maximum payment $10,000 per site
✓	✓	✓	Extended Office Hours	For Capitated PCPs only. Quarterly 10% of capitation for PCP sites must be open for extended office hours the entire quarter an additional 8 hours per week or more beyond the normal business hours (reference measure specification). Non-capitated PCPs will have additional funding added to the Core measure set.
✓	✓	✓	PCMH Certification	$1,000 yearly per site, for achieving or maintaining PCMH accreditation.
✓	✓	✓	Peer-led & Pediatric Group Visits	$1,000 per group, either new or existing. (Maximum of 15 groups per parent organization).
✓	✓	✓	Health Information Exchange	One time $3000 incentive for signing on with a local or regional health information exchange; Annual $1500 incentive for showing continued participation with a local or regional health information exchange. The incentive is available at the parent organization level.
✓	✓	✓	Health Equity	$2000 per parent organization for submission of Health Equity implementation initiative or an annual updated Health Equity report.
✓	✓	✓	Tobacco Use Screening	$5.00 per tobacco use screening or counseling of members 11- 21 years of age after 3% threshold of assigned members screened.
✓	✓	✓	Electronic Clinical Data Systems (ECDS)	Maximum of $5,000 per parent organization. Allowance of data exchange from Provider Electronic Health Records to Datalink to capture clinical screenings, follow-up care and outcomes. Participation to include data collection of specific clinical components for all Partnership members within your organization. 1. $2,000 per Parent Organization who signs an agreement with DataLink to allow the extraction of HEDIS data by September 30, 2024. Agreements signed after September 30, 2024 will be eligible for half payment ($1,000) through December 31, 2024 2. An additional $3,000 per Parent Organization when DataLink receives HEDIS data abstraction successfully from EMR by October 31, 2024 and the Parent Organization responds timely to request for verification.
✓		✓	Early Administration of 1st HPV Dose	Administer the first HPV dose by the age of 12 in order to have the required 6-month pause between the first and 2nd dose and another 6 months to administer the 2nd HPV dose before the 13th birthday $50 per HPV dose given before age 12.
✓		✓	Early Administration of Initial Flu Vaccine Series (Two Doses)	Early administration of influenza and to complete administration of the 2nd dose within 60 calendar days of the 1st dose. $50 per two dose series completed by 15 months of age, with the 2 doses up to 60 days apart.

2025 PCP Program Adjustments/Changes



Core Measurement Sets Adjustment 2024 ➡ 2025

2024 Core Measurement Set
Clinical Measures
Breast Cancer Screening
Cervical Cancer Screening
Child & Adolescent Well Care Visits
Childhood Immunization Statue: Combo 10
Colorectal Cancer Screening
Comprehensive Diabetes Care: HbA1c Good Control
Comprehensive Diabetes Care: Retinal Eye Exams
Controlling High Blood Pressure
Lead Screening in Children
Immunization of Adolescents - Combo 2
Well-Child Visits in the First 15 Months of Life
Non-Clinical Measures
Ambulatory Care Sensitive Admissions
Risk Adjusted Readmissions
Aviodable ED Visits/1000 member per year
Patient Experience
PCP Office Visits
Monitoring Measures

2025 Core Measurement Set
Clinical Measures
Breast Cancer Screening (50-74yo)
Cervical Cancer Screening
Child & Adolescent Well Care Visits
Childhood Immunization Statue: Combo 10
Colorectal Cancer Screening
Comprehensive Diabetes Care: HbA1c Good Control
Comprehensive Diabetes Care: Retinal Eye Exams
Controlling High Blood Pressure
Lead Screening in Children
Immunization of Adolescents - Combo 2
Well-Child Visits in the First 15 Months of Life
Well-Child Visits in the First 15-30 Months of Life, Pediatrics Only
Chlamydia Screening (16-18yo), Pediatrics Only
Non-Clinical Measures
Ambulatory Care Sensitive Admissions
~~Risk Adjusted Readmissions~~
Avoidable ED Visits/1000 member per year
Patient Experience
PCP Office Visits
Follow-Up within 7 Days after Hospital Discharge
Monitoring Measures
Well-Child Visits in the First 15-30 Months of Life, Family Medicine
Chlamydia Screening (16-24yo), Family Medicine
Chlamydia Screening (18-24yo), Internal Medicine
Breast Cancer Screening (40-49yo), Family and Internal Medine Only
Topical Flouride in Children, Family Medicine and Pediatrics Only

Key
~~RED~~ = Retirement
Blue = New Measure

UOS Measurement Sets Adjustment 2024 ➡2025

2024 Unit of Service Measures
Advance Care Planning
Extended Office Hours
PCMH Certification
Peer-led & Pediatric Support Groups
Health Information Exchange
Health Equity
Dental Fluoride Varnish
Tobacco Use Screening
Electronic Clinical Data Systems (ECDS)
Early Administration of 1st HPV Dose
Early Administration of Initial Flu Vaccine Series (Two Doses)

2025 Unit of Service Measures
Advance Care Planning
Extended Office Hours
PCMH Certification
Peer-led & Pediatric Support Groups
Health Information Exchange
Health Equity
~~Dental Fluoride Varnish~~
Tobacco Use Screening
Electronic Clinical Data Systems (ECDS)
Early Administration of 1st HPV Dose
Early Administration of Initial Flu Vaccine Series (Two Doses)
Academic Detailing

Key
~~RED~~ = Retirement
Blue = New Measure

Other 2025 Adjustments

New clinical optional measure: Reducing Healthcare Disparity

- Rationale - incentivize providers to reduce disparity in a race/ethnicity group within an assigned measure of focus during the measurement year.

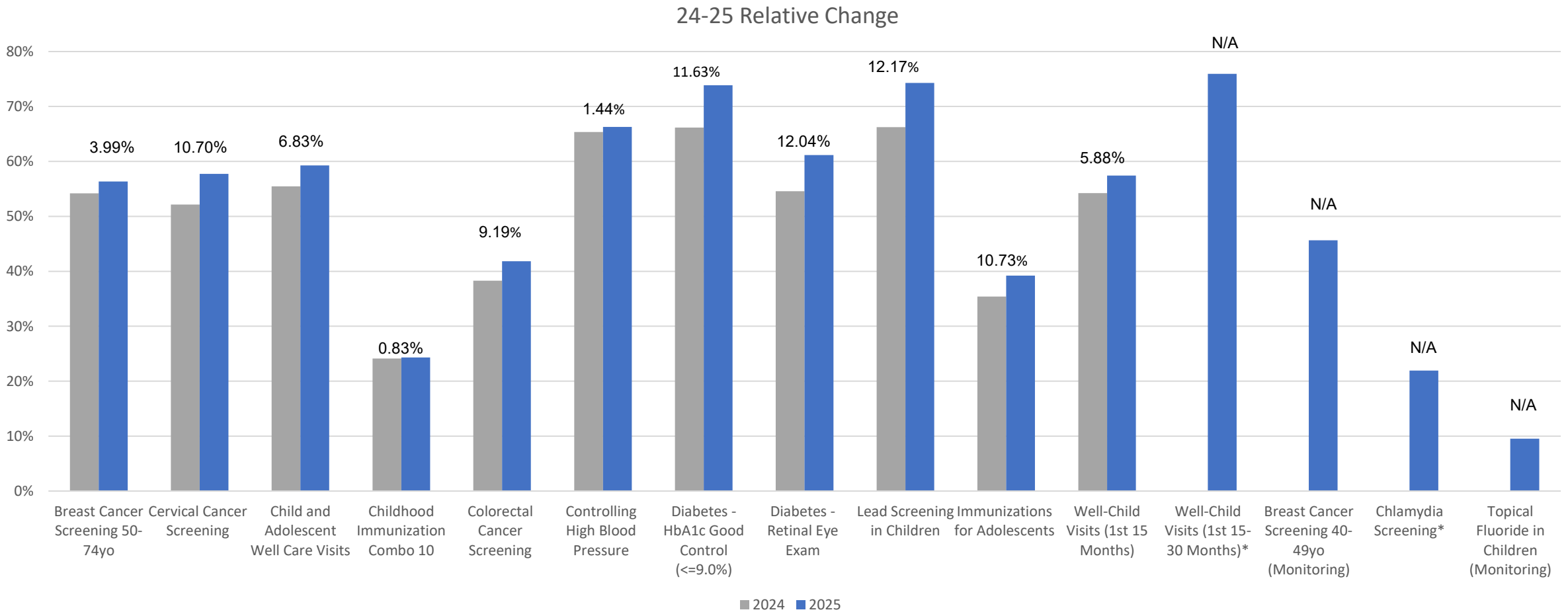
Clinical Thresholds

- Partial points targets raised to the 75th percentile

2025 PCP Program Performance

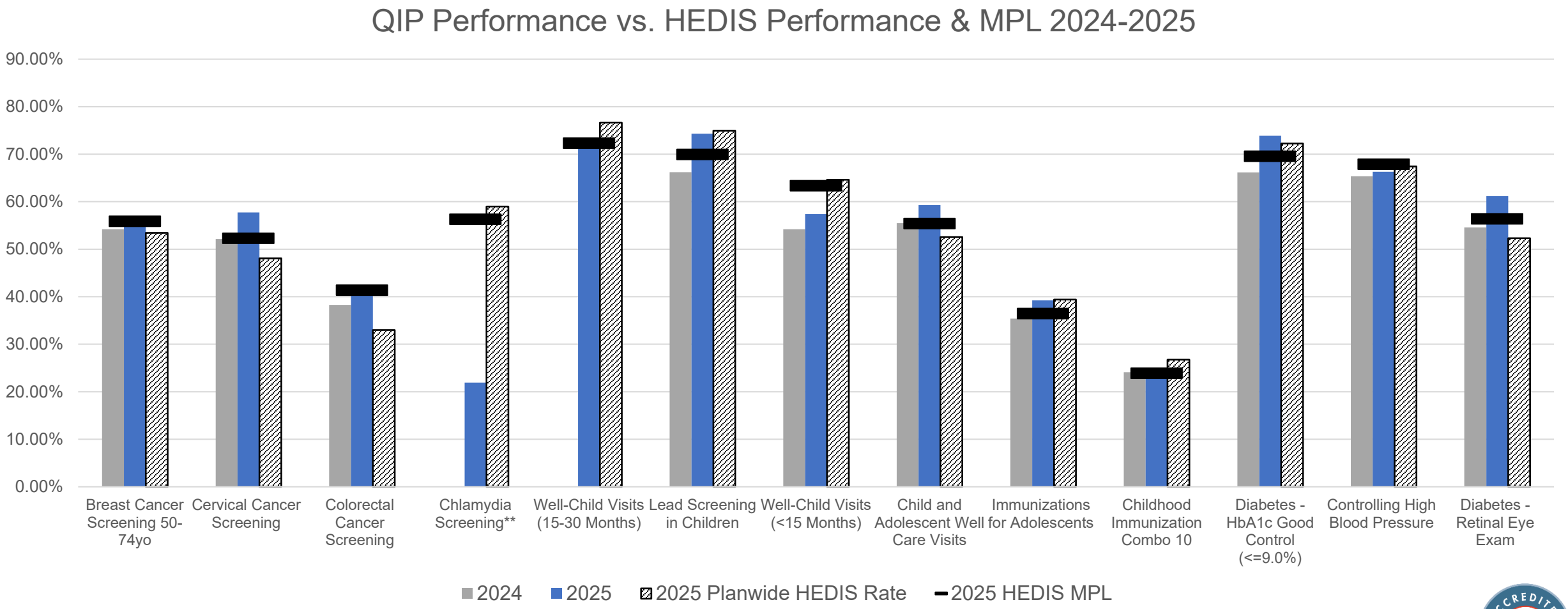


Plan-wide Performance Clinical Domain YoY



*Active Measure for Peds Only

2025 Planwide QIP Performance



** Significant measure difference between QIP and HEDIS

Relative Improvement (RI)

Available for most existing clinical measures where a provider site was eligible for scoring/payment in the previous measurement year

A site's performance on an existing clinical measure must:

- Meet the ***75th percentile target****

  AND

- Achieve an ***RI score of 15%*** or higher

- Thereby achieving performance equal to or exceeding the 75th percentile and not exceeding the 90th percentile, **to earn full points**

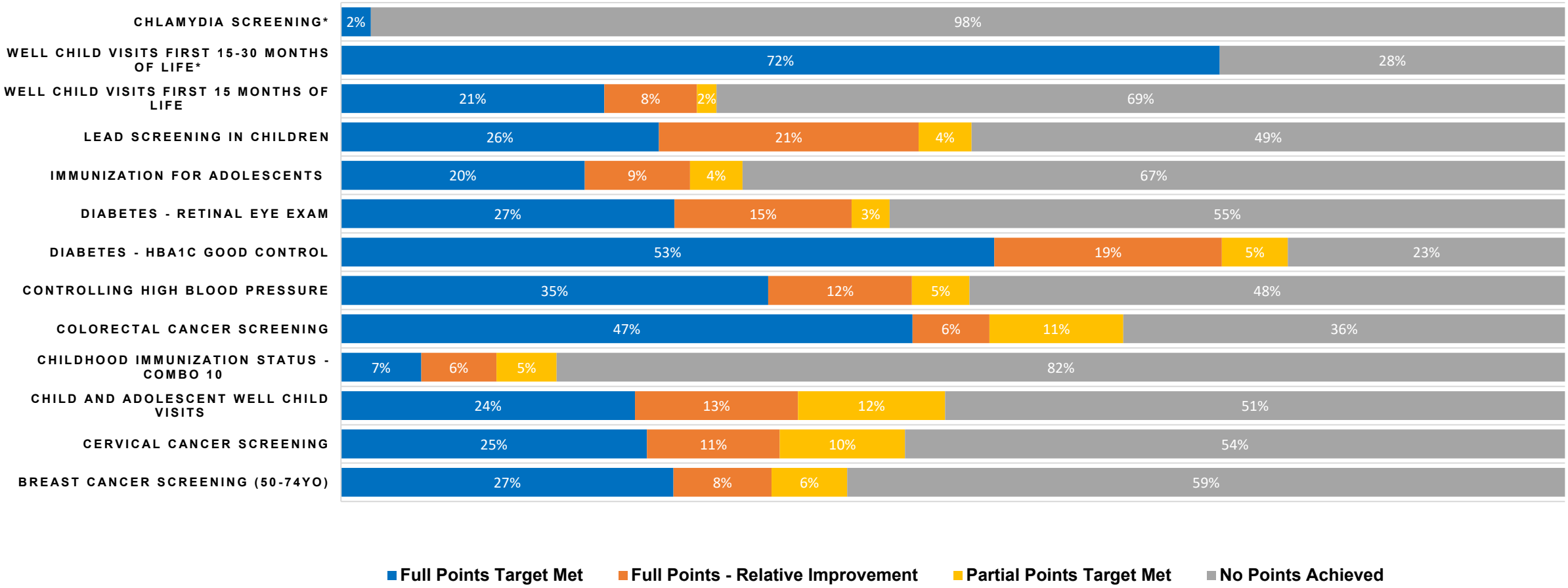
$$\frac{\text{(Current year performance) – (previous year performance)}}{\text{(100 – Previous year performance)}}$$

This method of calculating RI is based on a Journal of the American Medical Association article authored by Jencks et al in 2003. It is widely used by the Integrated Healthcare Association's commercial P4P program and CMS.



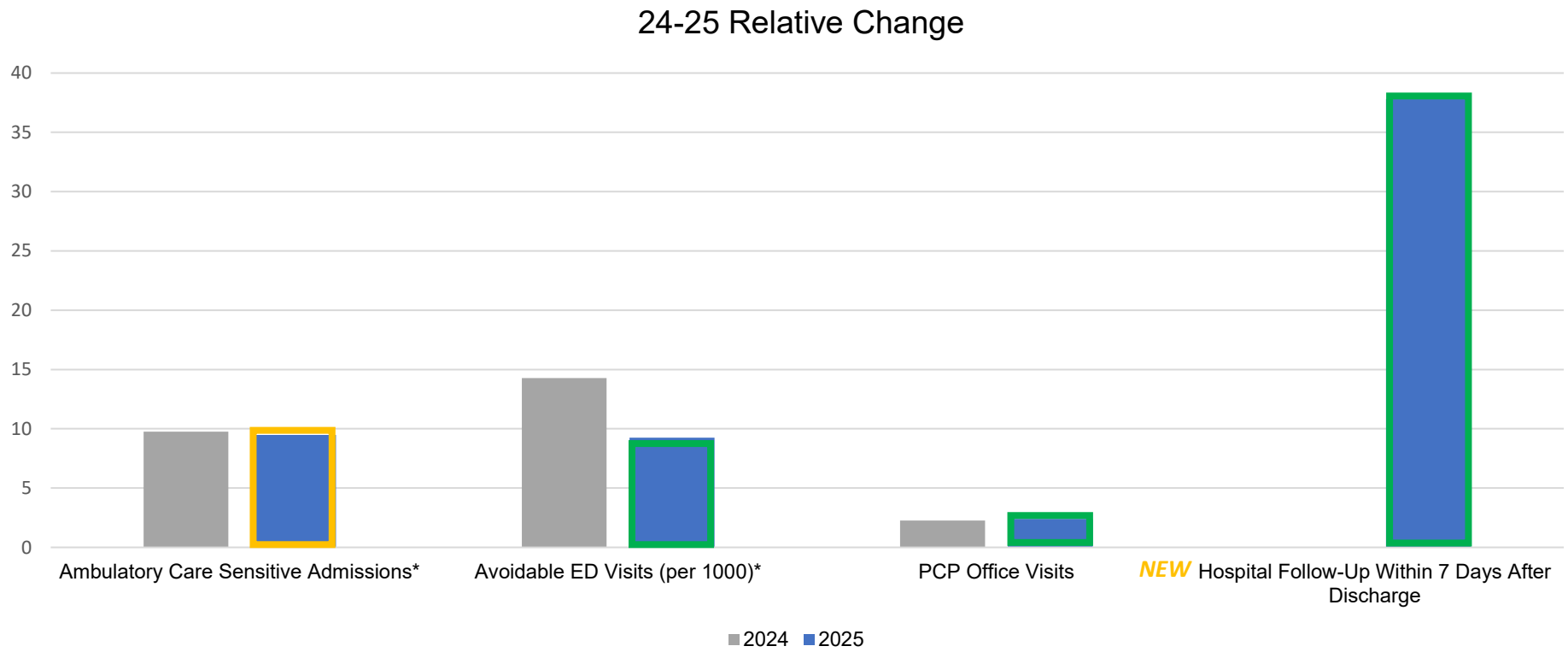
*Higher RI target than prior years

2025 Points Earning Distribution for Clinical Measures (Plan-wide)



*New measure – No Partial Points & does not qualify for RI

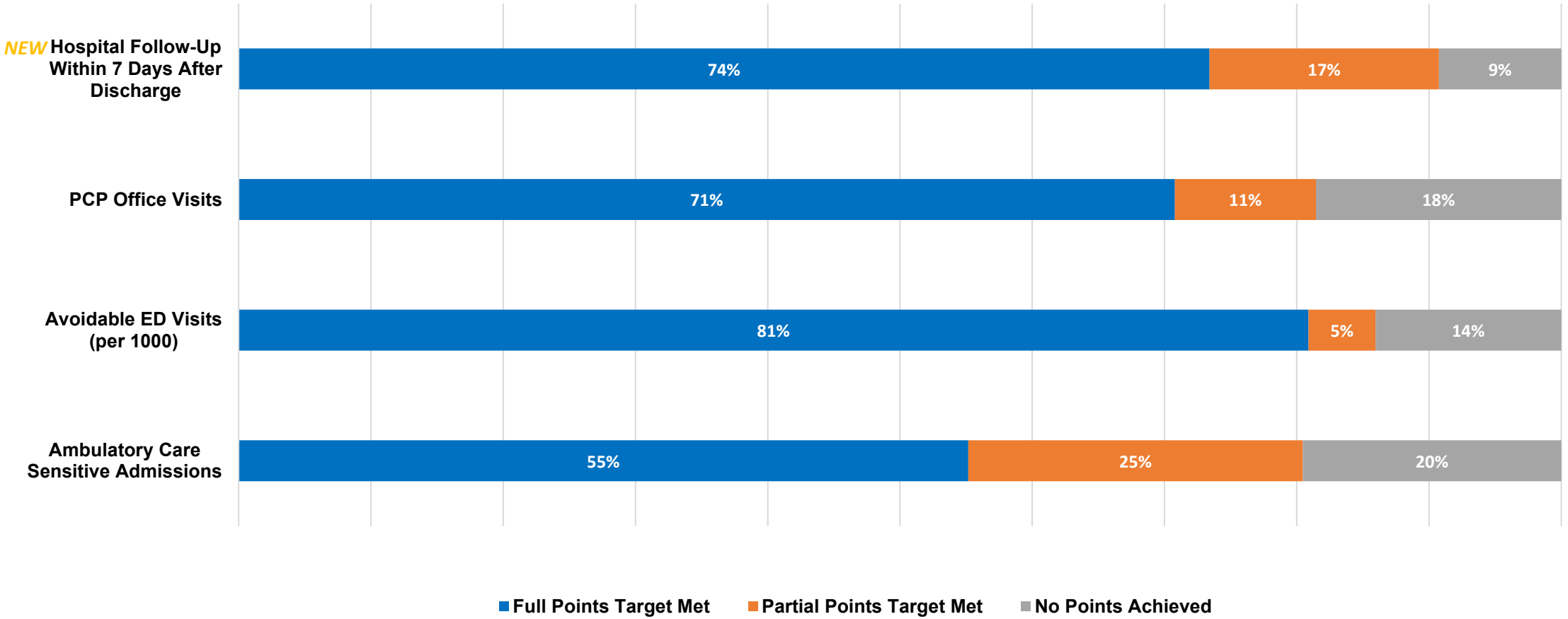
Plan-wide Performance
Non-Clinical Domain YoY



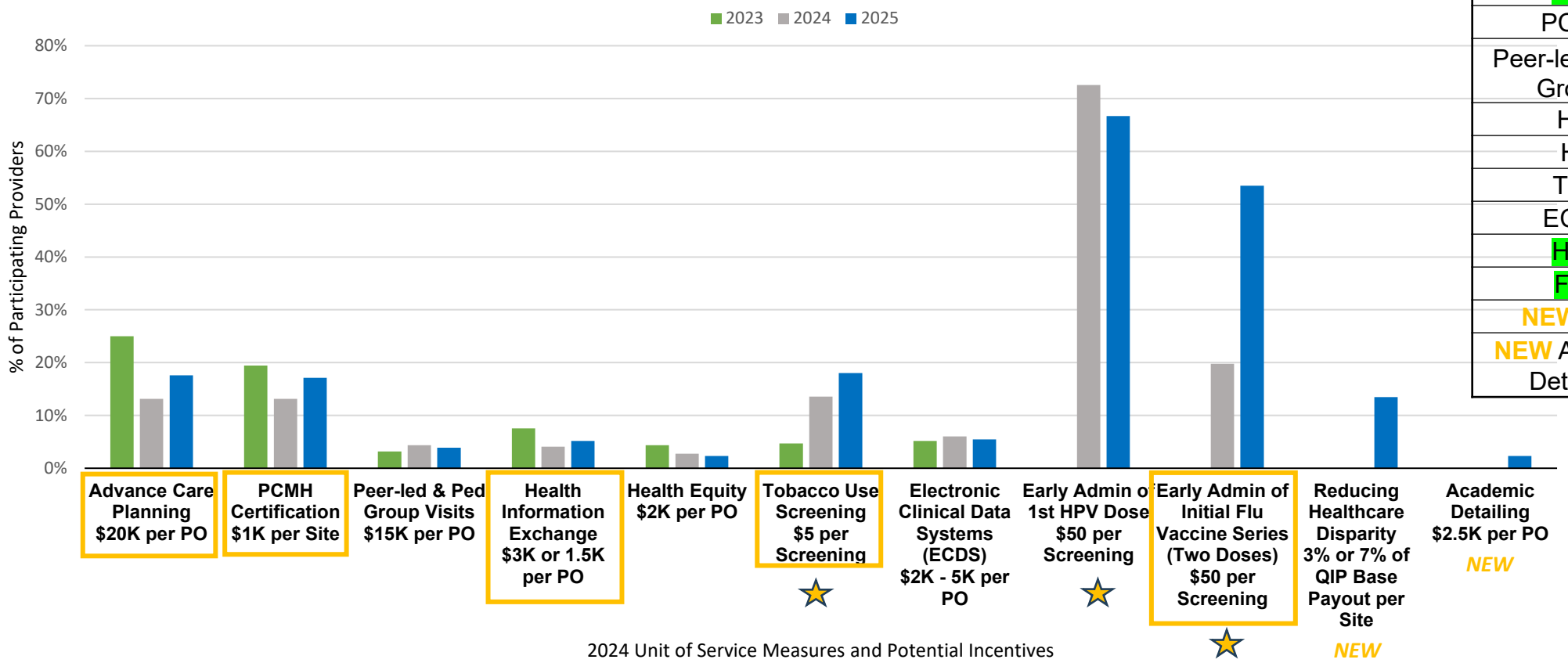
*Inverted Measure: Decrease Rate = Increased Performance

Compliance Key
Partial point threshold met
Full point threshold met

2025 Points Earning Distribution for Non-Clinical Measures (Plan-wide)



Unit of Service Participation YoY



2024 Unit of Service Measures and Potential Incentives

UOS Measures	2025
ACP	$ 524,000.00
PCMH	$ 66,000.00
Peer-led & Ped Groups	$ 28,000.00
HIE	$ 31,500.00
HE	$ 18,000.00
TUS	$ 40,730.00
ECDS	$ 20,000.00
HPV	$ 358,850.00
FLU	$ 118,300.00
NEW RHD	$ 344,802.57
NEW Academic Detailing	$ 18,500.00

Higher Participation from the prior year

2024 UOS Measures with highest payouts

★ Only appliable to Family & Pediatric Practices only

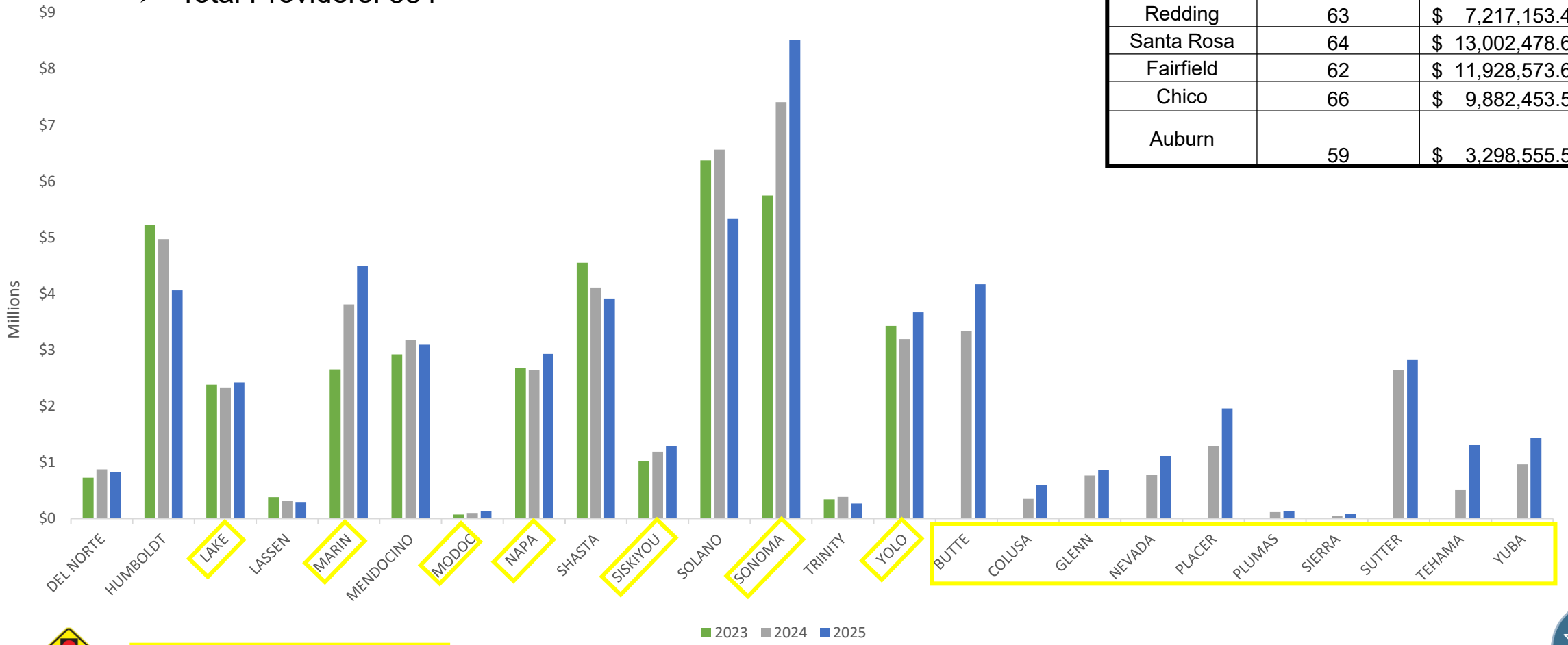
2025 PCP Payout Overview



2025 PCP QIP Payment
County Y-o-Y Payouts

- Total Incentive Payout: $55.7M
- Total Providers: 384

Region	# of Providers	2025 Payouts
Eureka	70	$ 10,402,352.79
Redding	63	$ 7,217,153.43
Santa Rosa	64	$ 13,002,478.62
Fairfield	62	$ 11,928,573.64
Chico	66	$ 9,882,453.56
Auburn	59	$ 3,298,555.56



Higher Payout from the prior year

2025 Summary



2025 Programmatic Changes

Added 6 Measures

- **4 Clinical monitoring measures**:
  - Breast Cancer Screening 40-49yo
  - Chlamydia Screening
  - Well-Child Visits in the first 15-30 months of life
  - Topical Fluoride in Children
- **1 UOS measures**:
  - Academic Detailing
- **1 (Optional) Clinical measure**:
  - Reducing Healthcare Disparity
- **1 Non-clinical measure**:Follow-up within 7-days after Hospital Discharge

Removed 2 Measures

- 1 Non-clinical measure: Risk Adjusted Readmissions
- 1 Unit of Service (UOS) measure: Dental Fluoride Varnish

Increased thresholds

- Partial Points increased from 50th to the 75th Percentile

2025 Program Performance

Clinical:

- Increased plan-wide QIP performance in all 11 Clinical measures from the prior year
- 9 Clinical measures ended above the MPL:
  - 5 measures >=50th
  - 3 measures >=75th
  - 1 measures at 90th
- 3 Clinical measures ended under the MPL

Non-Clinical

- Increased plan-wide QIP performance in 3 Non-clinical measures from the prior year
- 3 Non-clinical measures met full points thresholds, includes the new 2025 measure: Hospital Follow-up within 7 Days After Discharge
- 1 Non-clinical measures met partial points thresholds

2027 Program Changes

Measure Set	Measure	Change in 2027	Justification
Clinical	Reducing Health Disparities (Optional Measure)	Remove	Alignment with DHCS
	Retinal Eye Exams Chlamydia Screening	Move to monitoring	Alignment with DHCS (MCAS)
	Controlling High BP	Increase Thresholds • Partial: 75th → 90th • Full: 90th → HP 2030 (80%)	MCAS measure below MPL Stagnant improvement
	BCS CCS COL LCS IMA CIS10	Transition to ECDS • no uploads	Alignment with DHCS
Non-Clinical	Patient Experience	Increase Thresholds +Improvement Plan requirement	DHCS Withold Measures 5-Star HPA Goal
	Ambulatory Care Sensitive Admissions Avoidable ED Visits	Renamed: • "Potentially Preventable Admissions" • "Low-Acuity Non-Emergent ED Visits"	Alignment with DHCS

2027 Program Changes

Measure Set	Measure	Change in 2027	Justification
Unit of Service	Tobacco Use Screening	Move to monitoring	Alignment with HEDIS
	Electronic Clinical Data Systems (ECDS)	Remove	Alignment with DHCS reporting requirements

Questions



Prior Authorization Metrics Report Q1 2026	Health Care Plan Code (Auto populates)	Plan County (Auto populates)	Total standard Prior Authorization requests received (Enter total count)	Total expedited Prior Authorization requests received (Enter total count)	Total standard and expedited Prior Authorization requests received (Enter total count)	Percentage of standard Prior Authorization requests that were approved (Enter percentage)	Percentage of standard Prior Authorization requests that were denied (Enter percentage)	Percentage of standard Prior Authorization requests approved after appeal (Enter percentage)	Average time to decision for standard Prior Authorizations (Enter number of days)	Median time to decision for standard Prior Authorizations (Enter number of days)	Percentage of expedited Prior Authorization requests that were approved (Enter percentage)	Percentage of expedited Prior Authorization requests that were denied (Enter percentage)	Average time to decision for expedited Prior Authorizations (Enter number of hours)	Median time to decision for expedited Prior Authorizations (Enter number of hours)	Percentage of total Prior Authorization requests approved with extended timeframe (Enter percentage)	If Artificial Intelligence is used to make Prior Authorization decisions, does a qualified human review the request if it is denied or modified? (Select from drop down)
Partnership Health Plan of California	504	Solano	10699	2375	13074	69.74%	30.26%	0.09%	4.52	4.00	78.48%	21.52%	28.73	22.00	3.79%	N/A (AI is not used)
	507	Napa	2800	605	3405	72.07%	27.93%	0.07%	4.25	4.00	76.53%	23.47%	18.55	5.00	3.44%	N/A (AI is not used)
	509	Yolo	5376	1389	6765	69.98%	30.02%	0.06%	4.55	4.00	69.04%	30.96%	41.24	40.00	4.20%	N/A (AI is not used)
	510	Marin	4031	905	4936	69.88%	30.12%	0.05%	4.44	4.00	74.25%	25.75%	21.66	12.00	3.44%	N/A (AI is not used)
	511	Lake	3379	792	4171	73.01%	26.99%	0.09%	4.54	4.00	77.53%	22.47%	28.20	25.00	3.91%	N/A (AI is not used)
	512	Mendocino	3845	695	4540	76.38%	23.62%	0.05%	4.39	4.00	74.96%	25.04%	17.03	6.00	2.64%	N/A (AI is not used)
	513	Sonoma	10217	2178	12395	72.24%	27.76%	0.16%	4.23	4.00	79.94%	20.06%	37.27	40.00	3.55%	N/A (AI is not used)
	517	Humboldt	5937	1162	7099	74.36%	25.64%	0.07%	4.39	4.00	78.31%	21.69%	41.22	43.00	2.86%	N/A (AI is not used)
	518	Lassen	568	128	696	71.83%	28.17%	0.00%	4.38	4.00	67.97%	32.03%	32.99	28.00	6.61%	N/A (AI is not used)
	519	Modoc	371	77	448	72.51%	27.49%	0.00%	4.22	4.00	71.43%	28.57%	39.43	46.00	5.13%	N/A (AI is not used)
	520	Shasta	10407	1599	12006	77.15%	22.85%	0.05%	4.33	4.00	76.80%	23.20%	44.28	46.00	3.97%	N/A (AI is not used)
	521	Siskiyou	1447	345	1792	73.19%	26.81%	0.00%	4.29	4.00	79.13%	20.87%	40.10	40.00	5.47%	N/A (AI is not used)
	522	Trinity	392	108	500	78.06%	21.94%	0.26%	4.34	4.00	81.48%	18.52%	40.93	45.50	5.60%	N/A (AI is not used)
	523	Del Norte	1074	275	1349	72.53%	27.47%	0.00%	4.97	4.00	79.64%	20.36%	42.29	46.00	4.08%	N/A (AI is not used)
	543	Butte	10789	2376	13165	73.72%	26.28%	0.06%	4.30	4.00	72.98%	27.02%	39.08	43.00	4.28%	N/A (AI is not used)
	544	Colusa	1075	196	1271	64.74%	35.26%	0.09%	4.59	5.00	77.55%	22.45%	38.67	43.00	2.83%	N/A (AI is not used)
	545	Glenn	1398	270	1668	73.75%	26.25%	0.14%	4.32	4.00	78.15%	21.85%	39.26	44.50	3.54%	N/A (AI is not used)
	546	Nevada	2697	699	3396	63.89%	36.11%	0.04%	4.95	5.00	71.82%	28.18%	38.09	40.00	4.74%	N/A (AI is not used)
	547	Placer	6036	1378	7414	62.49%	37.51%	0.07%	4.57	5.00	75.83%	24.17%	39.03	41.00	4.14%	N/A (AI is not used)
	548	Plumas	556	103	659	62.23%	37.77%	0.00%	4.27	4.00	73.79%	26.21%	43.16	44.00	3.95%	N/A (AI is not used)
	549	Sierra	84	20	104	73.81%	26.19%	0.00%	3.55	4.00	60.00%	40.00%	44.15	35.50	4.81%	N/A (AI is not used)
	550	Sutter	4331	959	5290	68.92%	31.08%	0.07%	4.26	4.00	74.45%	25.55%	43.05	47.00	3.12%	N/A (AI is not used)
	551	Tehama	3032	581	3613	73.52%	26.48%	0.03%	4.29	4.00	78.66%	21.34%	40.61	44.00	4.21%	N/A (AI is not used)
	552	Yuba	3938	901	4839	70.47%	29.53%	0.00%	4.50	4.00	76.25%	23.75%	45.25	47.00	3.99%	N/A (AI is not used)

Prior Authorization Metrics Report Q2 2026	Health Care Plan Code (Auto populates)	Plan County (Auto populates)	Total standard Prior Authorization requests received (Enter total count)	Total expedited Prior Authorization requests received (Enter total count)	Total standard and expedited Prior Authorization requests received (Enter total count)	Percentage of standard Prior Authorization requests that were approved (Enter percentage)	Percentage of standard Prior Authorization requests that were denied (Enter percentage)	Percentage of standard Prior Authorization requests approved after appeal (Enter percentage)	Average time to decision for standard Prior Authorizations (Enter number of days)	Median time to decision for standard Prior Authorizations (Enter number of days)	Percentage of expedited Prior Authorization requests that were approved (Enter percentage)	Percentage of expedited Prior Authorization requests that were denied (Enter percentage)	Average time to decision for expedited Prior Authorizations (Enter number of hours)	Median time to decision for expedited Prior Authorizations (Enter number of hours)	Percentage of total Prior Authorization requests approved with extended timeframe (Enter percentage)	If Artificial Intelligence is used to make Prior Authorization decisions, does a qualified human review the request if it is denied or modified? (Select from drop down)
Partnership Health Plan of California	504	Solano	9393	2185	11578	69.78%	30.22%	0.07%	4.40	4.00	81.56%	18.44%	36.25	26.00	3.97%	N/A (AI is not used)
	507	Napa	2835	597	3432	74.11%	25.89%	0.14%	3.91	4.00	81.24%	18.76%	18.14	6.00	3.29%	N/A (AI is not used)
	509	Yolo	5154	1409	6563	69.44%	30.56%	0.06%	4.05	4.00	67.71%	32.29%	51.18	47.00	6.45%	N/A (AI is not used)
	510	Marin	3750	808	4558	71.01%	28.99%	0.05%	4.45	4.00	78.59%	21.41%	23.33	9.00	3.91%	N/A (AI is not used)
	511	Lake	3301	735	4036	68.22%	31.78%	0.06%	4.74	4.00	80.00%	20.00%	41.80	31.00	3.87%	N/A (AI is not used)
	512	Mendocino	3653	700	4353	73.28%	26.72%	0.08%	4.77	4.00	79.57%	20.43%	26.69	17.00	3.40%	N/A (AI is not used)
	513	Sonoma	10124	2172	12296	73.60%	26.40%	0.13%	4.40	4.00	79.05%	20.95%	41.14	44.00	3.94%	N/A (AI is not used)
	517	Humboldt	5627	1124	6751	73.15%	26.85%	0.09%	4.66	4.00	77.94%	22.06%	51.10	47.00	3.61%	N/A (AI is not used)
	518	Lassen	543	111	654	65.75%	34.25%	0.00%	4.70	5.00	66.67%	33.33%	37.45	42.00	9.33%	N/A (AI is not used)
	519	Modoc	352	64	416	67.61%	32.39%	0.00%	4.30	4.00	64.06%	35.94%	33.44	28.50	2.88%	N/A (AI is not used)
	520	Shasta	10318	1532	11850	76.03%	23.97%	0.06%	4.91	4.00	76.11%	23.89%	47.93	49.00	4.95%	N/A (AI is not used)
	521	Siskiyou	1211	302	1513	69.03%	30.97%	0.17%	4.33	4.00	72.85%	27.15%	41.35	47.00	6.68%	N/A (AI is not used)
	522	Trinity	423	115	538	74.94%	25.06%	0.00%	4.35	4.00	76.52%	23.48%	39.42	44.00	3.90%	N/A (AI is not used)
	523	Del Norte	935	254	1189	68.02%	31.98%	0.00%	3.99	4.00	87.80%	12.20%	44.54	47.00	5.63%	N/A (AI is not used)
	543	Butte	10117	2630	12747	72.15%	27.85%	0.06%	4.91	5.00	75.21%	24.79%	43.49	46.00	5.00%	N/A (AI is not used)
	544	Colusa	1092	232	1324	61.63%	38.37%	0.00%	4.68	4.00	74.14%	25.86%	42.38	46.50	3.85%	N/A (AI is not used)
	545	Glenn	1289	265	1554	71.06%	28.94%	0.16%	4.55	4.00	84.91%	15.09%	40.59	47.00	3.86%	N/A (AI is not used)
	546	Nevada	2423	648	3071	62.44%	37.56%	0.12%	4.43	4.00	76.08%	23.92%	45.34	46.00	6.55%	N/A (AI is not used)
	547	Placer	5704	1338	7042	62.73%	37.27%	0.12%	4.42	4.00	74.22%	25.78%	44.39	46.00	4.79%	N/A (AI is not used)
	548	Plumas	500	109	609	64.00%	36.00%	0.00%	4.14	4.00	73.39%	26.61%	40.99	46.00	5.09%	N/A (AI is not used)
	549	Sierra	65	13	78	58.46%	41.54%	0.00%	3.48	3.00	69.23%	30.77%	32.85	30.00	6.41%	N/A (AI is not used)
	550	Sutter	4109	972	5081	67.68%	32.32%	0.12%	4.47	4.00	75.00%	25.00%	44.10	47.00	4.41%	N/A (AI is not used)
	551	Tehama	2844	547	3391	72.08%	27.92%	0.18%	4.62	4.00	77.51%	22.49%	41.14	46.00	5.01%	N/A (AI is not used)
	552	Yuba	3772	848	4620	68.13%	31.87%	0.08%	4.66	4.00	73.82%	26.18%	45.42	48.00	5.02%	N/A (AI is not used)

2026 ANNUAL OVERSIGHT AUDIT

Carelon

NOTICE OF FINAL AUDIT RESULTS

January 1, 2025 – December 31, 2025

August 13,2026
Attention:
Kaneisha Willis, AP Regional Operations

Dear Kaneisha,

Partnership Health Plan of California (PHC) writes this notice to advise you regarding the conclusion of this year's annual delegation compliance oversight audit. As a result of the supplemental documentation and feedback we received from your organization, you will find the final audit results on the next page. Each of the finalized CAP forms for the preliminary deficiencies we reviewed during the audit are also attached with this notice for your records.

This year's **audit scope** is outlined below:

SCOPE AREA	REVIEW TYPE	CURRENT CAP STATUS
Basic Case Management	**Program Review**	**0-CAP**
Care Coordination	**Program/File Review**	**0- CAP**
Claims/PDR	**Program Review/File Review**	**0-CAP**
Compliance (HIPAA/FWA)	**Program Review/File Review pending**	**3CAPs**
Credentialing	**Program Review Special Review (Credentialing Timeliness)**	**0-CAP**
Cultural and Linguistics	**Program Review Pending**	**0-CAP**
DEI and Transgender	**Program Review**	**0CAP**
Grievance & Appeals	**Program Review/File Review**	**2 CAPS**
Member Services	**Program Review**	**0CAP**
Mental Health Services	**Program Review/File Review**	**0-CAP**
Net Management	**Program Review**	**0-CAP**
QIHETP	**Program Review**	**3 CAPS**
Quality Improvement/QIPQI	**Program Review /File Review** Special Review (Identification, Reporting and Processing of PQI)	**2-CAPS**
Utilization Management	**Program/File Review**	**0-CAP**

Please be advised that the completion of this annual audit does not preclude any future Partnership auditing or oversight activities and should not be construed as a substitute for any other reviews required by law, license, or accreditation. Partnership values the services provided to our members by Carelon and we look forward to a continued partnership.

If you have any further questions or concerns, feel free to contact me directly.

Sincerely,

APPROVED
By Robert Moore, MD MPH MBA at 5:38 pm, Aug 24, 2026

Charo Patio
Compliance Auditor
Regulatory Affairs and Compliance Department
Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534
Phone: (800) 863-4155
E-mail: cpatio@partnershiphp.org
Normal work hours: 8 a.m. – 5 p.m. Monday - Friday (*Note: I am off every other Friday*)

Our website: www.partnershipHP.org
PHC Mission: *To help our members, and the communities we serve, be healthy*
cc: Kenzie Hanusiak, Dani Ogren

2026 ANNUAL OVERSIGHT AUDIT

Carelon

FINAL AUDIT RESULTS REPORT

January 1, 2025 – December 31, 2025

August 13, 2026

RECOMMENDATIONS/COMMENTS: *The following description(s) address opportunities for improvement, as observed during audit, and does not represent a formal finding or request for corrective action plan. PHC will review cited opportunities for improvement through monitoring and future oversight audits. Recommendations that require collaboration will be initiated by Partnership.*
N/A
N/A

ASSIGNED CAPs: *Any preliminary deficiencies, which have not been justified or corrected, result in a formal Corrective Action Plan (CAP). Every CAP listed below must be satisfied and closed by the given deadline. Should there be any justifiable reason that The Delegate needs additional time or would like to discuss a CAP further, please let us know immediately.*

SCOPE AREA	DEFICIENCY/CAP DESCRIPTION	INSTRUCTION TO CLOSE	DEADLINE
Grievance and Appeal	Carelon's current process does not document the DHCS requirements to fully address and resolve the member's concerns for a grievance submitted to Carelon before September 2025. On pages 10 and 18 of QM 306B, it states "Upon receipt of a grievance, a coordinator is assigned to resolve the grievance. Resolution involves attempts to resolve the satisfaction of the grievant through a process involving:" with no additional text detailing what a resolution entails.	The policy has not been updated. We have included a highlighted version showing where the missing information is located with our response. -(Please refer to page 9 Investigation (E), Policy and procedure QM 306 B) -page 18 (Policy and Procedure QM 306B) Investigation (D)	09/13/2026
Grievance and Appeal	Submitted Language Taglines are outdated based on DHCS APL 25-005.	The Notice of Availability 9/5/25 has errors in the Cambodian, Hindi, and Punjabi. I highlighted a copy of the document titled: Notice-of-Availability 9-5-25 highlighted.	09/13/2026
QIHETP	Identify person who will act as liaison to Partnership's QIHEC committee in the report.	Unable to identify person who is the liaison in the documentation.	09/13/2026
QIHETP	Unable to find any MCAS measure description that is associated with BH (FUH, IET, SSD, FUA, FUIFUM, APP)	In addition to survey data, consider identifying a clinical measure to assess BH (FUH, IET, SSD, FUA, FUIFUM, APP)	09/13/2026
QIHETP	Unable to find Performance Improvement Projects associated with disparity measures	Consider identifying planned improvement project based upon a clinical BH measure	09/13/2026

QIPQI	Policy does not include actions for when an out of network provider refuses to participate in a PQI investigation. •TE 2025 18758- An Out of Network provider was investigated under this PQI. The provider did not bill for the services, however, was agreeable to answer the concerns. •Q42-46_QM 004.53 Member Safety Program- Carelon Behavioral Health can attempt to investigate out of network providers; however, without a contract/agreement, that provider may refuse to participate in the investigation.	We understand Carelon's position in that it has limited authority to enforce corrective actions with out-of-network providers. However, when a member has a complaint and Carelon is unable to investigate due to the provider being out-of-network providers or out of jurisdiction, there should be an escalation or referral when appropriate to an entity that can investigate. This will "close the loop" on member complaints to ensure it is addressed by Carelon or an appropriate agency/entity. Please update your policy.	09/13/2026
QIPQI	Policy does not include actions to close the loop when a case cannot be investigated and scored as "Unable to Determine". • TE 2025 20675- "In a conversation with Dr. Langenhan we determined that we are not able to review any of Dr. Weixler's work." "This case is being closed as unable to determine as we were unable to evaluate the work of the provider the member complained about."	We understand that some cases cannot be scored/rated, however, if a case cannot be reviewed or falls outside Carelon's jurisdiction, there should be an escalation or referral to another entity better positioned to investigate. This will "close the loop" on member complaints to ensure it is addressed by Carelon or an appropriate agency/entity. Please update your policy.	09/13/2026
FWA	Partnership Regulatory Affairs and Compliance (RAC) conducted a review of six Carelon FWA cases as selected from the Carelon FWA universe for the period 2024 - current. Of the cases reviewed, Carelon deemed 2 of the 6 cases reportable to DHCS and Partnership. Of the two reportable cases, Carelon did not meet the 10-day timely reporting requirement for one case (CB-2024-79). Upon such time that Carelon had enough information to request medical records to further their investigation, an initial MC609 should have been prepared and submitted to DHCS and Partnership. Additionally, Partnership observed significant delays in the investigation progress in 3 of the 6 cases reviewed (CB-2024-79, CB-2024-67, and CB-2024-287).	While Partnership agrees with the proposed action to retrain staff, we are requesting to see the content in advance of the training to ensure that the issues are appropriately addressed. Additionally, recommend a meeting prior to training content development to ensure Carelon understands Partnership's findings. CAP evidence must include pre-training meeting, training curriculum, and proof of completed training	09/13/2026
FWA	Per the cited authorities, CARELON must conduct a complete investigation of all FWA referrals received from PARTNERSHIP, and/or other State and federal agencies relating to CARELON's Subcontractors, Downstream Subcontractors, and Network Providers. Of the cases reviewed, Carelon deemed 4 of the 6 cases not reportable to DHCS and Partnership. In 3 of the 4 "non-reportable" cases (CB-2025-159, CB-2025-219, CB-2025-333) Carelon provided insufficient documentation. Partnership cannot confirm the appropriateness of the handling of these FWA referrals due to the incomplete	Partnership is requesting that Carelon propose an internal process that ensure meeting outcomes and leadership directives are sufficiently documented and that supporting documentation is included within the case. Further, Carelon should be conferring with Partnership prior to determining that a case can be closed and make available to Partnership the rationale for the exposure ranking and data and documentation to support this recommendation. Once Carelon has developed a Partnership approved desk procedure, Partnership is requesting staff training and proof of completed training.	09/13/2026

	records provided for the case. It is unclear what the initial allegation was, what data and documentation was reviewed, and how Carelon concluded that they did. Likewise, Partnership cannot confirm that through these referrals Carelon confirmed that services that have been represented have been delivered by Network Providers were received by Members.		
FWA	Per the cited authorities, CARELON must submit a completed investigation report and a quarterly status report. In all 6 cases reviewed, Carelon failed to provide complete investigative records. In all instances Carelon failed to provide copies of the initial (raw) data or report that reflected billing abnormality or source of referral and copies of the records reviewed to reach the final disposition. Within the case notes for all but one case (CB-2024-79), case notes were insufficient to illustrate the actions taken including the methodology for selecting medical records for review, the outcomes of the review, and as applicable, what was communicated to the provider	Partnership is requesting that Carelon propose an internal process that ensure meeting outcomes and leadership directives are sufficiently documented and that supporting documentation is included within the case. Further, Carelon should be conferring with Partnership prior to determining that a case can be closed and make available to Partnership the rationale for the exposure ranking and data and documentation to support this recommendation. Once Carelon has developed a Partnership approved desk procedure, Partnership is requesting staff training and proof of completed training	09/13/2026

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCBP8015 *(previously MCUP3103)*			**Lead Department: Health Services** **Business Unit:** Behavioral Health	
Policy/Procedure Title: Coordination of Care for Child Welfare-Involved Members			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/21/2010		**Next Review Date:** ~~11/12/2026~~11/04/2027 **Last Review Date:** ~~11/12/2025~~11/04/2026		
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☐ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~11/12/2025~~11/04/2026	

I. RELATED POLICIES:

A. MPUP3039 - Direct Members
B. MCCP2024 - Whole Child Model for California Children's Services (CCS)
C. MPAP7003 - CalAIM Community Supports (CS)
D. MCAP7002 - CalAIM Enhanced Care Management (ECM)
E. MPQD1001- Quality and Performance Improvement Program Description

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Assembly Bill 2083: (Chapter 815, Statutes of 2018) System of Care for Children and Youth Memorandum of Understanding (MOU). This assembly bill requires each county to develop and implement an MOU outlining the roles and responsibilities of the various local entities that serve children and youth in foster care who have experienced severe trauma. Entities must develop a coordinated, timely, and trauma-informed system-of-care approach, implementing related MOUs on the county level and establishing a joint interagency resolution team on the state level to assist counties in serving those children and youth.
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. Child Welfare-Involved Youth: Children and youth who meet one or more of the following conditions:
   1. Are under age 21 and are currently receiving foster care in California
   2. Are under age 21 and previously received foster care in California or another state within the last 12 months
   3. Have aged out of foster care up to age 26 (having been in foster care on their 18th birthday or later) in California or another state
   4. Are under age 18 and are eligible for and/or in California's Adoption Assistance Program;
   5. Are under age 18 and are currently receiving or have received services from California's Family Maintenance program within the last 12 months
D. Child Welfare Liaison: A Child Welfare Liaison in a Managed Care Plan (MCP) is a designated professional who serves as the key point of contact between the health plan and child welfare agencies. Their role is to

ensure that children and youth in foster care receive coordinated, timely, and appropriate health services.

E. Children in Foster Care: Children who are in out-of-home placement under the care and custody of county welfare and probation departments.

F. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status may be based on the Member's aid code, prime insurance, demographics or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.

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

H. ECM Lead Care Manager: A Member's designated care manager for ECM, who works for the ECM Provider organization. The Lead Care Manager operates as part of the Member's multidisciplinary care team and is responsible for coordinating all aspects of ECM and any Community Support (CS). To the extent a Member has other care managers, the Lead Care Manager will be responsible for coordinating with those individuals and/or entities to ensure a seamless experience for the Member and non- duplication of services.

I. 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.

~~I. The provider identified as the Member's medical home or primary care provider (PCP) is responsible for managing the Member's primary care needs and coordinating specialty services.~~

J. Resource Family: In California, a Resource Family is a caregiver who provides out-of-home care for children in foster care. The Resource Family is approved to provide care on a temporary (foster care) and/or permanent (adoption and legal guardianship) basis and includes all types of caregivers in the child welfare and probation systems, formerly known as foster parents, approved relatives or approved Non-Relative Extended Family Member.

K. Whole Child Model: ~~This program provides comprehensive treatment for the whole child and care coordination in the areas of primary, specialty, and behavioral health for Partnership HealthPlan of California (Partnership) pediatric Members with a CCS-eligible condition(s).~~A comprehensive program for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas or primary, specialty, and behavioral health for any pediatric Member with CCS eligible conditions insured by Partnership.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe Partnership HealthPlan of California's coordination of care for child welfare-involved youth.

VI. POLICY / PROCEDURE:

A. Partnership communicates with foster care agencies, group homes and resource families for those Members identified as child welfare-involved by the Medi-Cal Eligibility Data System (MEDS).

B. If a Member is identified as being a child welfare-involved youth, a review of medically necessary services that require prior authorization will be performed by Partnership's Utilization Management (UM)

Department.

1. Foster care Members will be assigned to Direct Member status. (See policy MPUP3039 Direct Members)
2. Medically necessary services will be authorized to the in-network or out-of-network provider when indicated and medically necessary and appropriate.
3. Members identified as being high risk are referred to case management. Referrals are indicated for Members who are in need of multiple referrals and services, complex medical needs, or need for coordination of services with multiple agencies.
3.
4. Child welfare-involved youth who are also medically eligible for services under the Whole Child Model (CCS children) are assigned a medical home. The provider identified as the child's medical home is responsible for managing the child's primary care needs and coordinating the child's care for both the CCS-eligible condition(s) and the non-CCS-eligible condition(s).
5. Family caregivers of foster care program beneficiaries may be eligible for respite services through CalAIM Community Supports Services as per Partnership policy MPAP7003.

C. The Child Welfare Liaison shall be the primary internal and external contact for any concerns or assistance needed for child welfare-involved youth.
   1. Effective January 1, 2024, as per the Department of Health Care Services (DHCS) All Plan Letter (APL) 24-013 "Managed Care Plan Child Welfare Liaison," Partnership designates a Child Welfare Liaison to ensure the needs of Members involved with child welfare and foster care are met.
   2. Partnership designates an appropriate number of staff to serve as Child Welfare Liaison(s) to meet the health care needs of children and youth involved in child welfare in each county of Partnership's service area.
      a. Additional Child Welfare Liaisons are designated as needed to ensure the health care needs of children and youth involved in child welfare are met. Staffing is commensurate to the number of Members involved in child welfare enrolled with Partnership.
      b. Partnership reassesses staffing levels at regular intervals to ensure effectiveness in serving children and youth involved in child welfare throughout Partnership's service areas.
   3. Roles and Responsibilities of the Child Welfare Liaison
      a. The Child Welfare Liaison assists staff who coordinate care on behalf of children and youth involved in child welfare to ensure the health care needs of these Members are met.
      b. The Child Welfare Liaison serves as a leader within Partnership to advocate on behalf of children and youth involved in child welfare by serving as a point of contact to identify and resolve escalated case specific, systematic, and operational obstacles for accessing services.
      c. The Child Welfare Liaison provides assistance and resources to staff responsible for the Member's care coordination, including contracted ECM Lead Care Manager or the Children and Youth Involved in Child Welfare Population of Focus and applicable county child welfare staff as described in APL 24-013.
      d. The Child Welfare Liaison's duties are not intended to duplicate care coordination activities provided by other staff members or Providers, but rather to support and act as a resource to solve escalated issues regarding Partnership's services as they arise.
      e. A centralized internal and external facing mailbox is designated to access support from the Child Welfare Liaisons (ChildWelfareLiaison@partnershiphp.org).
      f. The Child Welfare Liaison's roles and responsibilities include, but are not limited to, the following:
         1) Technical Assistance: Supports internal and external staff in care coordination and issue resolution
         2) Contact Point: Serves as a contact for resolving member service access issues
         3) Referral Pathways: Collaborates with County Child Welfare as well as internal and external ECM staff to ensure effective ECM referral processes

4) Enrollment Support: Assists with member enrollment/disenrollment during County changes
5) Service Coordination: Navigates and coordinates various benefits and services
6) Internal Coordination: Works with additional internal liaisons for specific member populations
7) County Liaison Coordination: Collaborates with designated county liaisons as needed
8) Quarterly Meetings: Attends meetings with county child welfare agencies
9) Quality Improvement Input: Participates in quality improvement activities, including identifying trends, barriers, and escalated issues affecting children and youth involved in child welfare and communicating improvement opportunities to Partnership leadership and quality improvement staff.
10) Training Compliance: Ensures adherence to training provisions of the MOU
11) Foster Youth Rights: Educates staff on the Foster Youth Bill of Rights
12) Trauma-Informed Care: Promotes trauma-informed approaches in interactions

4. To enhance relationships between Partnership and county child welfare agencies for youth involved in child welfare, the Child Welfare Liaison shall:
   a. Participate in Partnership's Community Advisory Committee (CAC), the Quality Improvement Health Equity Committee (QIHEC) Committee, and additional committees and meetings that potentially impact Members involved in child welfare and foster care.
   b. Collaborate with Counties to identify opportunities for coordination of, and alignment with, each County Interagency Leadership Team's efforts in implementing the AB 2083 System of Care for Children and Youth MOU, and participate in the Systems of Care Local Interagency Leadership Team meetings to which Partnership is invited.
   c. Collaborate with other Child Welfare Liaisons internally and with Child Welfare Liaisons in other Managed Care Plans to discuss best practices, lessons learned, and sharing of information and resources.
5. Partnership designates staff for the Child Welfare Liaison position who can competently fulfill their roles and responsibilities and meet the criteria of having the expertise, demonstrable experience, or sufficient training in the following programs, processes, and practices:
   a. Child welfare services and county behavioral health services
   b. County care coordination and assessment processes, which may include, the full spectrum of requirements pertaining to service coordination, including referral requirements and processes, care management, and authorization processes
   c. Trauma-informed care practices
6. The Child Welfare Liaison's additional expertise, experience, and training shall include, but is not limited to, the following:
   a. Have a Master's degree and/or other additional training in social work, public health nursing, or another related field
   b. Have familiarity with Medi-Cal enrollment and disenrollment processes, as well as county social services agency processes for updating addresses and other eligibility information
   c. Have experience or training in coordinating care within child welfare services and juvenile justice systems and understand the Foster Youth Bill of Rights.
7. Partnership will notify the county child welfare agency and DHCS of a change in the designated Child Welfare Liaison as soon as practicable, but no later than five working days from the change.
8. Partnership will submit the Child Welfare Liaison contact information to the "Liaison Directory" section available on the Managed Care Operations Division (MCOD)-MCP Submission Portal.
   a. For delegated Subcontractors that serve children and youth involved with child welfare, Partnership will submit contact information of the Subcontractor's Child Welfare Liaison(s) to the MCOD-MCP Submission Portal. Partnership shall monitor and ensure Subcontractors' compliance with the requirements of APL 24-013 and applicable delegated oversight requirements.

9. Partnership conducts quality improvement activities pursuant to policy MPQD1001 Quality and Performance Improvement Program Description.

D. As necessary, the Department of Social Services Foster Care Program's Social Workers may be contacted by Partnership Member Services Representatives, the County Child Welfare Liaison, and/or Health Services Case Management staff to facilitate coordination of care.

E. If the child has been placed outside of the counties Partnership serves, the County Child Welfare Liaison, a Member Services Representative, and/or the Care Coordination Department will assist ~~in~~ with ~~the~~ coordination of care and facilitate the change of county process by connecting the foster caregiver, county welfare services agency, county probation department, or ~~any~~ other ~~person~~ authorized decision-maker~~to make medical decision~~ to the Department of Health Care Services (DHCS) Ombudsman as per Assembly Bill (AB) 1512, Torrico Medi-Cal: Foster Children, October 2007.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All County Welfare Directors Letter (ACWDL) 97-02 "Participation of Foster Care and Adoption Assistance Program Children in Medi-Cal Managed Care" (Jan. 13, 1997)

B. DHCS ACWDL 00-22 "Letter To Notify Counties of Three New Aid Codes For Children in the Kinship Guardian Assistance Payment and Adoption Assistance Programs" (April 10, 2000)

C. Other applicable DHCS All County Welfare Directors Letters (ACWDLs) regarding Foster Care as cataloged on this website: https://www.dhcs.ca.gov/services/medi-cal/eligibility/letters/Pages/ACWDLbyyear.aspx

D. Assembly Bill (AB) 1512, Torrico. Medi-Cal: Foster Children approved and filed October 11, 2007.

E. DHCS All Plan Letter (APL) 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities (~~10/11/2023~~revised Aug. 11, 2025)

1. County Social Services Programs and Child Welfare MOU template (DHCS Contract Attachment B)

F. DHCS All Plan Letter (APL) 24-013 Managed Care Plan Child Welfare Liaison (Sept. 18, 2024)

G. California Foster Youth Bill of Rights

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

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

X. REVISION DATES:

04/18/12; 02/18/15; 02/17/16; 02/15/17; *03/14/18; 03/13/19; 03/11/20; 02/10/21; 05/11/22; 05/10/23; 05/08/24; 03/12/25; MCBP8015: 11/12/25; 11/04/26

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

PREVIOUSLY APPLIED TO:

MCUP3103 (04/21/20210 - 11/12/2025)

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPBP8007 (previously MCUP3101)</td><td colspan="3">Lead Department: Health Services
Business Unit: Behavioral Health</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Screening and Treatment for Substance Use Disorders</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 03/21/2012</td><td colspan="4">Next Review Date: ~~11/12/2026~~11/04/2027
Last Review Date: ~~11/12/2025~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/12/2025~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPBP8011 – Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines
B. MPBP8003 – Mental Health Services
C. MCQP1021 – Initial Health Appointment
D. MPQP1022 – Site Review Requirements and Guidelines
E. MCQG1015 – Pediatric Preventive Health Guidelines
F. MPQG1005 – Adult Preventive Health Guidelines
G. MCUP3144 – Residential Substance Use Disorder Treatment Authorization
H. CMP26 – Verification of Caller Identity and Release of Information.

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Covered Program: pursuant to 42 CFR Part 2 §2.11, means and includes: (a) an individual or entity (other than a general medical facility) who holds itself out as providing, and provides Substance Use Disorder Diagnosis, Treatment, or referral for Treatment; or (b) an identified unit within a general medical facility that holds itself out as providing, and provides, Substance Use Disorder Diagnosis, Treatment, or referral for Treatment; or (c) medical personnel or other staff in a general medical facility whose primary function is the provision of Substance Use Disorder Diagnosis, Treatment, or referral for Treatment and who are identified as such providers.

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

C. Records: pursuant to 42 CFR Part 2 §2.11, means any information, whether recorded or not, created by, received, or acquired by a part 2 program relating to a patient (e.g., Diagnosis, Treatment and referral for

Treatment information, billing information, emails, voice mails, and texts). The act of recording information about a substance use disorder and its treatment does not by itself render a medical record which is created by a non-part 2 treating provider (Covered Program) subject to the restrictions of part 2.

D. **SABIRT**: Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment: An expanded term stemming from the evidence-based Screening, Brief Intervention, and Referral to Treatment (SBIRT) construct used to identify, reduce, and prevent problematic use, misuse, and dependence on alcohol and illicit drugs. SBIRT interventions are generally delivered by primary care clinicians and related health care staff to assist patients in adopting, changing, or maintaining behaviors proven to affect health outcomes and health status including alcohol and other substance use. The SBIRT model was recommended by the Institute of Medicine which called for community-based screening for health risk behaviors, including substance use. SBIRT consists of three major components:
   1. Screening - a healthcare professional assesses a patient for risky substance use behaviors using standardized screening tools. Screening can occur in any healthcare setting.
   2. Brief intervention - a healthcare professional engages a patient showing risky substance use behaviors in a short conversation, providing feedback and advice.
   3. Referral to treatment - a healthcare professional provides a referral to brief therapy or additional treatment to patients who screen in need of additional services.

   SABIRT represents an expansion of SBIRT with the addition of "brief assessment" (e.g., use of a validated assessment tool to determine if unhealthy alcohol of drug use or a SUD is present) into the SBIRT construct and serves as the basis of Medi-Cal provider and Managed Care Plan (MCP) obligations and service reimbursement structures related to alcohol and drug screening, assessment, brief interventions, and referral to treatment.

E. Standard Alcohol Drink (US definition): 0.6 fl oz or 14 grams of pure alcohol = (approximately) one 12 oz regular beer (about 5% alcohol), 5 fl oz of table wine (about 12% alcohol), one 1.5 fl oz "shot" of hard liquor (about 40% alcohol)

F. Substance Use Disorders (SUD) – According to the Substance Abuse and Mental Health Services Administration (SAMHSA), substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The term is often used synonymously with "addiction." According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, negative consequences of use, and substance-dependent pharmacological criteria (e.g., tolerance and/or withdrawal). Substance use disorders occur in a range of severity including mild, moderate, or severe. Substances can be obtained illicitly or prescription medications can be misused for purposes other than the intended prescription (also known as "non-medical use" of prescription medications). The most common substance use disorders in the United States include the following:
   1. Alcohol Use Disorder
   2. Tobacco Use Disorder
   3. Cannabis Use Disorder
   4. Stimulant Use Disorder (including cocaine, methamphetamine, and prescription stimulants)
   5. Opioid Use Disorder

G. Unhealthy Alcohol Use (UAU): Unhealthy alcohol use refers to a spectrum of alcohol-related behaviors ranging from risky use (e.g., drinking more than the recommended daily, weekly, or per-occasion amounts, resulting in increased risk for negative health consequences) to alcohol use disorder (e.g., constellation of behavioral and pharmacological manifestations of clinical disorder of addiction, as above). The National Institute on Alcohol Abuse and Alcoholism (NIAAA) defines categories of risky drinking as follows:
   1. Binge Drinking – a pattern of drinking that produces blood alcohol concentrations (BAC) of greater than 0.08 g/dL. This usually occurs after 4 standard drinks for adult women and 5 standard drinks

for adult men over a 2-hour period.

2. Heavy Drinking – exceeding 4 standard drinks per day or 14 standard drinks per week for adult men or 3 standard drinks per day or 7 standard drinks per week for adult women.

H. Unhealthy Drug Use (UDU): The United States Preventive Services Taskforce (USPSTF) defines UDU as "the use of substances (not including alcohol or tobacco products) that are illegally obtained or the nonmedical use of prescription psychoactive medications; that is, use of medications for reasons, for duration, in amounts, or with frequency other than prescribed or by persons other than the prescribed individual." Furthermore, Partnership HealthPlan recognizes that DSM-5 clinical diagnostic standards do not include consideration of the legality of how one procured the substance(s) that they use, and rather focuses on the behaviors associated with use of any substance. Therefore, Partnership expands upon this definition of UDU to include unhealthy use of substances (other than alcohol and tobacco) regardless of means by which the substance was obtained.

I. Unhealthy Drug Use Screening (UDUS): According to USPSTF, UDUS is defined as "asking one or more questions about drug use or drug-related risks in face-to-face, print, or audiovisual format." It does not refer to body fluid substance screening.

IV. ATTACHMENTS: Recommended

A. Recommended Tools and Training Resources for SABIRT
B. Pocket Screening and Brief Intervention for Alcohol Use Disorders
C. Youth Pocket Screening and Brief Intervention for Alcohol Use Disorders

V. PURPOSE:

To establish procedures for identification, assessment, referral and coordination of care for members with unhealthy alcohol or drug use and/or substance use disorders, and align these procedures with state requirements.

VI. POLICY / PROCEDURE:

A. Covered Services:

1. Alcohol and Other Drug Treatment Services covered through the Counties:
   Except as noted in VI.A.2. below, substance use disorder treatment services available under the Drug Medi-Cal program as defined in Title 22, CCR Section 51341.1 and outpatient detoxification services defined in Title 22 CCR Section 51328 are excluded from Partnership HealthPlan of California's (Partnership's) contract with the California Department of Health Care Services (DHCS). These services include all drugs used for the treatment of substance use disorders covered by the State of California Alcohol and Drug Programs (ADP), Drug Medi-Cal Substance Use Services, as well as specific drugs listed in the Medi-Cal Provider Manual section that lists the specific medications for treating substance use disorders not currently covered by the ADP, but reimbursed through the Medi-Cal Fee For Service (FFS) program.
2. Wellness and Recovery Benefit through Partnership:
   Effective July 1, 2020, Partnership Members have access to alcohol and substance use disorder treatment services through the Wellness and Recovery program if they meet all of the following criteria:
   a. Member has been determined eligible for full scope Medi-Cal
   b. Member is not institutionalized
   c. Member has a substance-related and addictive disorder per the current "Diagnostic and Statistical Manual of Mental Disorders—Fifth Edition" (DSM5) criteria (excluding tobacco use disorder and gambling disorder)
   d. Member meets the medical necessity criteria to receive Drug Medi-Cal (DMC) covered services AND

e. Member resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano County

3. Basic alcohol and substance use disorder (SUD) counseling and treatment is within the scope of practice for office-based medical providers (both primary care clinicians and medical specialists) outside the specialized Drug Medi-Cal system. (See policy MPBP8011 Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines.) SUD services provided by Partnership medical providers should be billed to Partnership as any other encounter, using appropriate encounter and management CPT codes.
   a. Many of the medications used to treat addictions (often referred to as Medications for Addiction Treatment, or [MAT]) require no special or additional training or certification.
      1) Primary care clinicians may prescribe naltrexone, acamprosate or disulfiram for the treatment of alcohol use disorder.
      2) Treating opioid use disorder with buprenorphine/buprenorphine-naloxone, or naltrexone extended release injection is within the scope of primary care practice.
         a) Special DEA registration (X-Waiver) is no longer required for prescribing FDA-approved buprenorphine products for the treatment of opioid use disorder (OUD).
         b) Methadone for the treatment of opioid use disorder is relegated almost exclusively to sanctioned Narcotic Treatment Programs (NTP), with some exceptions for acute care hospitals and emergency department settings.
   b. To protect the confidentiality of patients wishing to be treated for SUD without notifying their primary care provider (PCP), medical specialists providing office visits for substance use disorder treatment may use the ICD 10 code F11.xx or F10.xx to avoid the requirement for a Referral Authorization normally required for assigned patients.
   c. Adjunctive counseling for SUD by non-licensed providers is not covered by Partnership, except as part of a cardiac rehabilitation program (see policy MCUP3128 Cardiac Rehabilitation), or if the Member is a qualifying Member for SUD services through the Wellness and Recovery Program.
4. SABIRT: These services are covered by Partnership HealthPlan of California as part of the Medi-Cal Benefit, as outlined in All Plan Letter (APL) 21-014. These services include those related to both unhealthy alcohol and/or drug use and/or substance use disorders, and are to be provided for all Members aged 11 years and older, including pregnant Members.
   a. Minor consent to SABIRT services and related access to information about diagnosis, treatment, and/or records are subject to requirements as set forth in 42 CFR § 2.14 and may be released in compliance with Partnership policy CMP-26 Verification of Caller Identity and Release of Information.
5. Screening for tobacco use as well as unhealthy alcohol or drug use and/or substance use disorders is considered a part of the standard of care for primary care of Members between the ages of 11 and under the age of 21, as noted in policy MCQG1015 Pediatric Preventive Health Guidelines.
6. For adults, providers are expected to employ SABIRT to screen for/briefly intervene and assess/refer to treatment for unhealthy alcohol or drug use and/or other substance use, as part of routine adult preventive care, as noted in policy MPQG1005 Adult Preventive Health Guidelines.

B. Partnership Responsibility, Related to SUD Services
1. Identification
   a. Partnership may identify a Member in need of SUD services through one of the following:
      1) Telephone inquiries from Member or Provider
      2) During Prior Authorization and/or Concurrent Review Processes
      3) Through Care Coordination programs activity
      4) Through call center activities performed by Partnership's delegated managed behavioral health organization
2. Referral

a. Partnership, or its designated subcontractor, will assist Members in locating available treatment sites. A list of phone numbers for accessing Substance Use Disorder Treatment Services in each county can be found on the Partnership website (see VI.C.8.c. below for details). If a placement within the Member's service area is not available, the Member will be referred to the most appropriate site that can provide the appropriate services. No prior authorization from Partnership is required for referral to outpatient substance use services. (Please note, in Partnership's Wellness & Recovery benefit, prior authorization is required for placement in a residential treatment facility. Please refer to policy MPUP3144 Residential Substance Use Disorder Treatment Authorization for further information.)

3. Coordination of Care
   a. Partnership will continue to cover the provision of primary care and other medical services unrelated to the treatment for substance use disorders and coordinate services between the Primary Care Providers and the Alcohol and Other Drug Treatment Programs. Since the physical health needs of Members entering treatment for Substance Use Disorder (SUD) have often been deferred, a health maintenance visit with the Member's Primary Care Provider is advisable within 30 days of initiating SUD treatment. The purposes of this health maintenance visit are to screen for undiagnosed or untreated medical or mental health problems, ensure age-appropriate and risk-factor appropriate preventive health activities are brought up to date, and to ensure chronic medical conditions are brought under optimal control. With the patient's consent, the problem list and action plan for this health maintenance visit may be shared with SUD treatment staff.
   b. Wherever possible, Partnership will support the efforts of primary care and other providers to integrate care, including unhealthy alcohol and/or drug use and/or substance use disorder related care, to other health care services.

C. SABIRT services for unhealthy alcohol or drug use and/or substance use disorders.
   1. Overview.
      a. These benefits are covered under Medi-Cal, Medicare and all Covered California Health Coverage, as part of the Affordable Care Act's requirement that all clinical prevention services recommended at a Class A or Class B level by the US Preventive Services Task Force (USPSTF) be covered by health plans. Specifically, the USPSTF recommends that clinicians screen adults age 18 years or older for unhealthy alcohol use and provide persons engaged in risky or hazardous drinking with Brief Behavioral Counseling Interventions to reduce unhealthy alcohol use. Please note that youth aged 11 – 21 are eligible for additional screening benefits under Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit. Additionally, the USPSTF recommends that clinicians screen adults 18 years or older for unhealthy drug use, and this screening should be implemented when services for accurate diagnosis, effective treatment, and appropriate care can be offered or referred. While the USPSTF determined that the current evidence is insufficient to assess the balance of benefits and harms of screening for unhealthy drug use in adolescents, it nonetheless remains the standard of care for providers to screen Members between the ages of 11 and under the age of twenty-one for alcohol, tobacco, and other drug use, as noted in policy MCQG1015 Pediatric Preventive Health Guidelines. As articulated in APL 21-014, the American Academy of Pediatrics (AAP) recommends alcohol and drug use screening and assessment with appropriate follow up action as necessary, beginning at age 11.
      b. Unhealthy Alcohol Use: Counseling interventions in the primary care setting can positively affect unhealthy drinking behaviors in adults engaging in risky or hazardous drinking. Positive outcomes include reducing weekly alcohol consumption and long-term adherence to recommended drinking limits. Because Brief Behavioral Counseling Interventions can decrease the proportion of persons who engage in episodes of heavy drinking (which results in high blood

alcohol concentration), indirect evidence supports the effect of screening and Brief Behavioral Counseling Interventions on important health and social welfare outcomes, such as the probability of traumatic injury or death especially that related to motor vehicles.

c. Unhealthy Drug Use: Brief counseling interventions in the primary care setting can positively affect unhealthy drug use behaviors in adults engaging in unhealthy drug use, although the research base is less robust and more mixed than it is in relation to alcohol misuse. Several studies and systematic reviews have highlighted positive outcomes including increased likelihood of abstaining from unhealthy drug use and decreases in specific drug use such as cocaine and heroin. However, studies have demonstrated significantly positive benefits from various forms of unhealthy drug use *treatment* (e.g. pharmacotherapies, other behavioral treatments such as cognitive behavioral therapy). Connections to treatment services are more likely to be made if screening for UDU is accomplished in the primary care setting.

2. Non-Covered Services
   a. Pre-screen is considered part of routine primary care and is not separately reimbursed. An example of a pre-screen is "Have you consumed **any** beer, wine or other alcoholic beverage in the past year."
3. Covered Services
   a. SABIRT services in primary care settings are covered benefits. Information about these services is made available to Partnership Members via the evidence of coverage and via Partnership's external website. Screening and Brief Behavioral Counseling Intervention(s) are more fully defined below.
      1) Providers may submit for reimbursement for screening and brief intervention for unhealthy alcohol and drug use using Medi-Cal codes as specified below in VI.C.11.a. Screening codes are limited to 1 per day, and 1 per 6-month period. The Brief Behavioral Counseling Intervention code may be billed up to 3 units per 6-month period without additional medical justification. If the Member declines referral to substance use treatment services, is benefiting from Brief Behavioral Counseling Intervention, and the counselor feels further therapy will be helpful, additional Brief Behavioral Counseling Intervention visits may be performed. Justification for more than 3 Brief Behavioral Counseling Interventions must be noted in the medical record. No TAR is required. If a patient changes primary care providers, the new PCP should endeavor to obtain prior records that include documentation of prior SABIRT services. Nonetheless, the new PCP may perform SABIRT services as a consequence of the initial health appointment, even if SABIRT services were performed and billed in less than 6 months by a previous provider; the new provider will be reimbursed at the usual rate in this instance.
      2) Screening and Brief Behavioral Counseling Intervention services may be provided on the same day as other Evaluation & Management services.
      3) Brief Behavioral Counseling Intervention services may be provided on the same date of services as the full screen, or on subsequent days.
   b. Definition of Primary Care: For the purposes of this policy, primary care settings are those where primary care physicians and non-physician clinicians provide services including: prevention, diagnosis and treatment of acute and chronic medical conditions, and continuity of care over time. For pregnant Members, primary care includes clinicians caring for the pregnant Member for her pregnancy. These clinicians may be seeing a patient in any setting, including private practice, Community Health Centers, medical groups or Comprehensive Perinatal Services Programs.
   c. Subcontracting of SABIRT services: If a primary care setting lacks the expertise or has other barriers making Brief Behavioral Counseling Intervention impossible, the PCP may refer the

Member for SABIRT services to clinicians outside the Primary Care Setting. This may include emergency department and emergency department physicians, Partnership contracted medical specialists and credentialed SUD counselors. PCPs may also utilize Partnership's delegated managed behavioral health organization using the referral forms and process described in Partnership policy MPBP8011 Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines. SABIRT is considered standard of care for mental health professionals providing mental health services, so these services will not be reimbursed in this setting.

4. Training and Proficiency - Primary Care Providers

Primary Care Providers (PCPs) may offer SABIRT in the primary care setting, as follows:

a. SABIRT services must be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider. The following licensed health care providers are eligible to provide services or supervise staff that are providing services.
   1) Licensed Physician
   2) Physician Assistant
   3) Nurse Practitioner
   4) Psychologist

b. The following licensed and registered providers also may perform SABIRT in the primary care setting, under the direction of one of the four provider types above.
   1) Licensed Marriage and Family Therapist
   2) Registered Nurse
   3) Certified Nurse Midwife
   4) Licensed Midwife
   5) Licensed Clinical Social Worker
   6) Licensed Professional Clinical Counselor

c. All health care providers listed above in sections VI.C.4.a. and b. must be trained in order to provide or supervise individuals providing SABIRT services. They should be trained and proficient in screening to provide screening services, and also trained and proficient in Brief Behavioral Counseling Intervention if they will provide Brief Behavioral Counseling Intervention services.

d. Other Members of the health care team (such as medical assistants, health educators or substance use disorder counselors) may also conduct alcohol misuse screening and counseling or unhealthy drug use screening components of SABIRT if:
   1) They have at least 100 hours of clinical experience in their current role.
   2) They are trained to provide the services they are providing
   3) The supervising Medical Director or physician is responsible for evaluating the capacity of the staff they are supervising, and assuring the quality of screening and Brief Behavioral Counseling Intervention provided by their non-licensed provider staff.

e. Providers must develop policies and procedures for SABIRT services. These should include:
   1) The PCP site will maintain a list of licensed and registered professionals and non-licensed Members of the health care team who have completed training in screening and/or Brief Behavioral Counseling Intervention and are proficient in its administration and are thus approved to provide screening and/or Brief Behavioral Counseling Intervention services at the PCP site. This list should be signed by the Medical Director or supervising physician.
   2) A quality assurance process for SABIRT services
   3) Partnership and DHCS may request verification of the required documentation as part of their audit and oversight responsibilities.

f. Providers seeking technical assistance on developing policies and procedures for SABIRT services may contact the Behavioral Health Administrator or the Senior Director of Health Services at Partnership.

5. Training and Proficiency – Brief Behavioral Counseling Intervention/Referral to Treatment Providers
   a. Brief Behavioral Counseling Intervention services must be provided by a licensed health care provider or staff working under the supervision of a licensed health care provider. The following licensed health care providers are eligible to provide services or supervise staff that are providing services.
      1) Licensed Physician
      2) Physician Assistant
      3) Nurse Practitioner
      4) Psychologist
   b. The following licensed and registered providers also may perform Brief Behavioral Counseling Intervention/Referral to Treatment under the direction of one of the four provider types above.
      1) Licensed Marriage and Family Therapist
      2) Registered Nurse
      3) Certified Nurse Midwife
      4) Licensed Midwife
      5) Licensed Clinical Social Worker
      6) Licensed Professional Clinical Counselor
   c. All health care providers listed above in sections VI.C.5.a. and b. must be trained in order to provide or supervise individuals providing Brief Behavioral Counseling Intervention services.
   d. Other Members of the health care team (such as health educators or substance use disorder counselors) may also conduct Brief Behavioral Counseling Intervention if:
      1) They have at least 100 hours of clinical experience in their current role.
      2) They are trained to provide the services they are providing
      3) The supervising Medical Director, physician or psychologist is responsible for evaluating the capacity of the staff they are supervising, and assuring the quality of screening and Brief Behavioral Counseling Intervention provided by their non-licensed provider staff.
   e. Brief Behavioral Counseling Intervention providers must develop policies and procedures for SABIRT services. These should include:
      1) The Brief Behavioral Counseling Intervention provider will maintain a list of licensed and registered professionals who have completed training in Brief Behavioral Counseling Intervention and are proficient in its performance and are thus approved to provide Brief Behavioral Counseling Intervention services. This list should be signed by the Medical Director, supervising physician, or supervision psychologist. A minimum of 4 hours of specific training is required for every person/clinician who will be performing or supervising the performance of Brief Behavioral Counseling Intervention Services, and a minimum of 8 hours of training (or equivalent experience) in motivational interviewing/stages of change.
      2) A quality assurance process for SABIRT services
      3) Partnership and DHCS may request verification of the required documentation as part of their audit and oversight responsibilities.
6. Screening and Brief Assessment
   a. Unhealthy alcohol and drug use screening must utilize a validated screening questionnaire to assess a patient for risky substance use behaviors.
   b. When a screening is positive, validated assessment tools should be used to determine if unhealthy alcohol use or SUD is present. Validated alcohol and drug assessment tools may be used without first using validated screening tools.
   c. The screening and brief assessment process does not diagnose a disorder, but it does determine whether a problem exists. Providers should consider risks and benefits of administration of

screening and assessment tools, including discussion of these as part of informed consent, as well as consideration of issues related to mandatory reporting, documentation, and privacy. Screening should not be punitive and treatment recommendations based on screening and assessment results should have demonstrated effective evidence base. Results will be used to classify the beneficiary's pattern of drinking or drug use and determine the need for brief intervention and/or referral to treatment services.

d. Screening and Brief Assessment Tools
   1) Please refer to Attachment A for a chart of recommended screening and brief assessment tools for unhealthy alcohol and/or drug use as well as training resources.
   2) Note that a validated screening question for unhealthy alcohol use is a required part of an Individual Health Appointment. Regardless of the drug screening and assessment tools used, at least one of the following validated alcohol misuse screening or assessment tools must be used, as only these screening/ assessment tools are acceptable for NCQA/HEDIS measures:
      a) AUDIT (10 question screening and assessment)
      b) AUDIT-C (3 question screening also validated in pregnant individuals)
      c) NIAAA Single Alcohol Screening Question (SASQ)

7. Brief Intervention:
   i. SABIRT to include discussion of the results of the screening and proposing additional interventions for Brief Behavioral Counseling Intervention if the screen is positive. Providers should offer Brief Behavioral Counseling Intervention(s) to Members who are identified as having risky or hazardous alcohol use.
   b. Brief Behavioral Counseling Interventions include motivational interviewing and cognitive behavioral techniques tailored to the Member's stage of readiness to make a change. Elements of Brief Behavioral Counseling Interventions may include:
      1) Personalized feedback
      2) Education and resources
      3) Negotiated action plans
      4) Drinking use diaries, and
      5) Stress management.
   c. The Brief Behavioral Counseling Intervention(s) can be provided by the PCP or a supervised or other health care team Member as described above who is trained and competent in providing Brief Behavioral Counseling Intervention. The Brief Behavioral Counseling Intervention includes one to three sessions, 15 minutes in duration per session, offered in-person or via telemedicine. As noted earlier (VI.C.3.a.1), additional sessions are permitted under certain circumstances. Brief interventions must include the following:
      1) Feedback to the patient regarding screening and assessment results
      2) Discussion of negative consequences that have occurred and the overall severity of the problem
      3) Supporting the patient in making behavior changes
      4) Discussing and agreeing on plans for follow-up with the patient, including referral to other treatment if indicated
         a) Providers must make good faith efforts to confirm whether Members receive referred treatments and document the outcome of referral efforts, including when, and where, and any ~~next~~ follow-up actions taken in the medical record.~~steps following treatment.~~

8. SABIRT Referral to Treatment
   a. No prior authorization is required for SABIRT services or for referral to services related to substance use or abuse.
   b. Members who are found, upon screening and further evaluation, to meet criteria for SUD as defined by the DSM-5, or those whose diagnoses are uncertain, should be referred for further

evaluation and treatment.

c. PCPs in counties without Partnership Wellness and Recovery coverage should refer Members to their County Alcohol and Drug Program for provision of treatment, as medically necessary. California county contacts for local substance use disorder treatment information and referrals can be found on the Partnership website: http://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx under the heading "Alcohol and Drug Treatment." In Partnership Wellness and Recovery counties, the referral process is outlined on the Partnership website at this page: https://www.partnershiphp.org/Providers/BehavioralHealth/Pages/Substance-Use-Disorder-Services.aspx. Referrals to treatment must be documented in the medical record.

9. SABIRT results, interpretation and any resulting patient-specific recommendations must be documented in the medical record. This should include the specific intervention employed with the Member and the time spent with the Member, if greater than 15 minutes of Brief Behavioral Counseling Intervention is claimed at one visit.
   a. Pursuant to 42 CFR Part 2 §2.11, the act of recording information about a SUD and its treatment does not by itself render a medical record which is created by a non-part 2 treating provider (Covered Program per III.G above) subject to the restrictions of part 2.
   b. Documentation should also include:
      1) The service provided (e.g., screen and brief intervention)
      2) The name of the screening instrument and the score on the electronic health record
      3) The name of the assessment instrument (when indicated) and the score on the assessment (unless the screening tool is embedded in the electronic health record)
      4) If and where a referral to an alcohol or substance use disorder program was made
10. Provider Review Process:
   a. The following will be evaluated as part of the Medical Record Review (MRR) process to monitor the SABIRT process.
      1) Review Member's response to an age-appropriate, validated alcohol or drug use screening question
      2) Offer an expanded questionnaire, such as the AUDIT-C tool, or the ASSIST tool
      3) Conduct Brief Behavioral Counseling Intervention sessions
      4) Refer Members with potential unhealthy alcohol or drug use and/or SUD for treatment
   b. Facility Site reviews include a review of the SABIRT policy/procedure and associated documentation, as noted in section VI.C.4 e. above.
   c. The results of these reviews will be shared with the site being reviewed, and the policy on SABIRT will be reinforced. Deficiencies in the SABIRT process will not be applied to the overall site review score.
11. SABIRT Billing Codes
   a. The following billing codes should be used for billing SABIRT services to patients with:
      1) Medi-Cal and no other primary insurance coverage (such as Medicare):
         a) Annual alcohol misuse screening: G0442
         b) Drug use screening: H0049 (*Although HCPCS defines this code as used for alcohol and/or drug screening, Medi-Cal requires this code to only be used for drug use screening.*)
         c) Alcohol and/or drug services, brief Intervention (each 15 minutes): H0050
      2) Medicare/Medi-Cal Members should have SABIRT billed through Medicare, using approved Medicare codes.

VII. REFERENCES:

A. For clinician support: NIAAA's Clinician Guide "Helping Patients Who Drink Too Much" provides two methods for screening: a "single question" to use during a clinical interview and a written self-report

instrument (AUDIT). http://www.niaaa.nih.gov/guide

B. The AUDIT and AUDIT-C screening instruments for alcohol misuse are available from the Substance Abuse and Mental Health Services Administration -Health Resources and Services Administration (SAMHSA-HRSA) Center for Integrated Health Solutions https://www.samhsa.gov/national-coe-integrated-health-solutions
C. Quick reference guide for screening for drug use in general medical settings: screening_qr.pdf (nih.gov)
D. NIDA Quick Screen and NIDA Modified ASSIST: https://www.drugabuse.gov/sites/default/files/pdf/nmassist.pdf
E. World Health Organization (WHO) manual for administration of ASSIST in primary care settings: https://www.who.int/publications/i/item/978924159938-2
F. Tobacco, Alcohol, Prescription Medication and Other Substance Use Tool (TAPS) online platform for either self or clinician-administration: https://www.drugabuse.gov/taps/#/
G. CRAFFT: Chang G, Orav EJ, Jones JA, Buynitsky T, Gonzalez S, Wilkins-Haug L. Self-reported alcohol and drug use in pregnant young women: a pilot study of associated factors and identification. J Addict Med. 2011 Sep;5(3):221-6.
H. A complete guide to clinical implementation of the AUDIT screening instrument is available by the World Health Organization https://www.who.int/publications/i/item/WHO-MSD-MSB-01.6a
I. Information on the Medicare SBIRT benefit and requirements: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/sbirt_factsheet_icn904084.pdf
J. Substance Abuse and Mental Health Services Administration (SAMHSA) website: https://www.samhsa.gov/disorders/substance-use
K. Operational Instructional Letter (OIL) 398-13
L. DHCS: All Plan Letter (APL) 21-014 Alcohol and Drug Screening, Assessment, Brief Interventions and Referral to Treatment. (10/11/2021)
M. Department of Health Care Services (DHCS) Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services Drug Medi-Cal Organized Delivery System (DMC-ODS) webpage
N. DHCS APL 23-029 Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (~~10/11/2023~~ Revised 8/11/2025)
    1. Specialty Mental Health Services Memorandum of Understanding Template
    2. Substance Use Disorder Treatment Services Memorandum of Understanding Template
O. United States Preventative Services Task Force (USPSTF) Recommendation Statement: Screening for Unhealthy Drug Use (https://uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening)
P. Title 42 Code of Federal Regulations (CFR) Section 438.210 (a)(4), Part 2 §2.11 and § 2.14
Q. Title 22 California Code of Regulations (CCR) Sections 51303 and 51340.1
R. InterQual® Behavioral Health Criteria
S. Medicare Claims Processing Manual 100-04: Chapter 18 Preventive and Screening Services, Section 180 Alcohol Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse. Implementation date 12/27/2011 or any subsequent updates published by CMS.
T. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Section 210.8 Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse Implementation date 12/27/2011 or any subsequent updates published by CMS.

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 20287)
11/12/25; 11/04/26

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

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

PREVIOUSLY APPLIED TO: N/A

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

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

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

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

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

	Validated Tool Type		Agencies	Populations			Substances Types		
Name of Tool	**Screening Tools**	**Brief Assessment Tools**	**Recommending Agencies**	**Appropriate for Pregnancy**	**Appropriate for Adolescents**	**Appropriate for Geriatric**	**Alcohol**	**Drugs**	**Tobacco**
AUDIT NIDA - The Alcohol Use Disorders Identification Test (10 questions) ******Meets* **HEDIS** *measure for IHA*	X	X	NIDA DHCS NCQA				X		
AUDIT-C NIDA - The Alcohol Use Disorders Identification Test – Concise (3 questions) ******Meets* **HEDIS** *measure for IHA*	X		NIDA NIAAA USPSTF DHCS	X			X		
SASQ NIAAA Single Alcohol Screening Question ******Meets* **HEDIS** *measure for IHA*	X		NIAAA USPSTF	X			X		
TAPS-1 Tobacco, Alcohol, Prescription medication, and other Substance use Tool (4 questions)	X		NIDA DHCS ACOG	X			X	X	X
TAPS-2 Brief assessment if TAPS-1 is positive		X	NIDA	X			X	X	X
NIDA Quick Screen (4 questions) *(Recommended by DHCS,ACOG and USPSTF, but NIDA now recommends TAPS-1 instead)*	X		NIDA DHCS USPSTF ACOG	X			X	X	X
NIDA-Modified ASSIST NIDA-Modified Alcohol, Smoking and Substance Involvement Screening Test (8 questions) *(Recommended by DHCS and USPSTF, but NIDA now recommends TAPS-2 instead)*		X	NIDA DHCS USPSTF				X	X	X

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

	Validated Tool Type		Agencies	Populations			Substances Types		
Name of Tool	**Screening Tools**	**Brief Assessment Tools**	**Recommending Agencies**	**Appropriate for Pregnancy**	**Appropriate for Adolescents**	**Appropriate for Geriatric**	**Alcohol**	**Drugs**	**Tobacco**
DAST-10 Drug Abuse Screening Test (10-item self-report instrument that has been condensed from the 28-item DAST)	X	X	DHCS NIDA		X			X	
DAST-20 Drug Abuse Screening Test (20 questions)		X	DHCS NIDA	X	X			X	
4P's Parents, Partner, Past and Present	X		ACOG DHCS	X	X		X	X	
4 P's Plus *(Plus includes additional questions about depression and domestic violence)*		X	ACOG	X			X	X	X
CRAFFT Car, Relax, Alone, Forget, Friends, Trouble	X	X	ACOG DHCS NIDA	X	X *(Appropriate for non-pregnant adolescents)*		X	X	
MAST-G Michigan Alcoholism Screening Test Geriatric	X		DHCS			X	X		
PRO (Prenatal Risk Overview) *(Recommended by USPSTF but official website is no longer available)*			USPSTF	X			X	X	X

*As per VI.C.6.d.2) of policy MPBP8007, a validated screening question for unhealthy alcohol use is a required part of an Individual Health Appointment. Three screening/ assessment tools are acceptable for NCQA/HEDIS measures as indicated in this chart.

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Acronyms, Agencies and Resources (Tools and Trainings):

Acronym	Agency	Resources and Website Information
ACOG	The American College of Obstetricians and Gynecologists	Committee Opinion on At-Risk Drinking and Alcohol Dependence: Obstetric and Gynecologic Implications https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2011/08/at-risk-drinking-and-alcohol-dependence-obstetric-and-gynecologic-implications Opioid Use and Opioid Use Disorder in Pregnancy https://www.acog.org/clinical/clinical-guidance/committee-opinion/articles/2017/08/opioid-use-and-opioid-use-disorder-in-pregnancy
NCQA/ HEDIS	National Committee for Quality Assurance/ Healthcare Effectiveness Data and Information Set (HEDIS)	Screening and Follow-Up for Unhealthy Alcohol Use: Quality Improvement Change Package for Health Plans https://www.ncqa.org/wp-content/uploads/2020/09/20200914_NCQA_Change_Package_2020.pdf
NIAAA	National Institute on Alcohol Abuse and Alcoholism (part of the National Institutes of Health (NIH)	NIAAA Evidence-Based Products for Health Professionals and Community Leaders: https://www.niaaa.nih.gov/health-professionals-communities • Underage and College Drinking Research • Treatment Navigator tool • Surveillance Reports and Epidemiologic Resources • Additional Reports and Resources
NIDA	National Institute on Drug Abuse	Screening and Assessment Tools: https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/chart-screening-tools
SBIRT Training 4 hrs CME/CE	Screening, Brief Interventions, and Referral to Treatment	SBIRT Core Training Activity: Screening, Brief Interventions, and Referral to Treatment (V2) https://sbirt.clinicalencounters.com/activity/sbirt-core/ • Four hour training: $49 per individual; group rates are available • CME/CE NYS OASAS Credit approved

Partnership HealthPlan of California

Recommended Tools and Training Resources for

Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)

Acronyms, Agencies and Resources (Tools and Trainings):

Acronym	Agency	Resources and Website Information
SAMHSA	Substance Abuse and Mental Health Services Administration	SAMHSA - Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS) Video Trainings https://www.samhsa.gov/brss-tacs/video-trainings • Access free video trainings on a variety of topics related to crisis intervention services and support services for treatment and recovery including Motivational Interviewing:
USPSTF	United States Preventive Services Task Force	• Alcohol screening and intervention tools: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/unhealthy-alcohol-use-in-adolescents-and-adults-screening-and-behavioral-counseling-interventions • Unhealthy Drug Use Screening Tools: https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/drug-use-illicit-screening • USPSTF Recommendation: Screening for Unhealthy Drug Use Podcast Describing the Taskforce's 2020 Recommendation https://edhub.ama-assn.org/jn-learning/audio-player/18514824

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPBP8013 (previously MCUP3145)</td><td colspan="3">Lead Department: Health Services
Business Unit: Behavioral Health</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Eating Disorder Management Policy</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 08/10/2022 (MCUP3145)</td><td colspan="4">Next Review Date: ~~11/12/2026~~11/04/2027
Last Review Date: ~~11/12/2025~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="3">☒ Medi-Cal</td><td>☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="3">☐ P & T</td><td>☒ 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="2">Approval Date: ~~11/12/2025~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPBP8003 - Mental Health Services
B. MCUG3024 - Inpatient Utilization Management
C. MPUP3014 - Emergency Services
D. MCUP3052 - Medical Nutrition Therapy (MNT) Services
E. MPCD2013 - Care Coordination Program Description
F. MCCP2022 - Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services
G. MPBP8005 - Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Behavioral Health Plan (BHP) : A county Behavioral Health Plan in Partnership's service area. BHPs are required to provide and cover all medically necessary SMHS and Substance Use Disorder (SUD) treatment services in accordance with their contracts with DHCS.
B. Eating Disorder: Per the Diagnostic and Statistical Manual of Mental Disorders (DSM) Fifth Edition, feeding and eating disorders are characterized by a persistent disturbance of eating or eating-related behavior that results in the altered consumption or absorption of food and that significantly impairs physical health or psychosocial functioning.
C. Eating Disorder Treatment Levels of Care:
   1. **Outpatient**: Patient lives at home and attends weekly (usually 1:1) sessions with their provider. Patient is determined to not need daily medical monitoring and patient is psychiatrically stable enough to live at home and engage in prescribed treatment programming. Eating disorder symptoms are under sufficient control such that individual can function normally in social, educational, or vocational situations and continue to make progress in treatment.
   2. **Intensive Outpatient**: Patient lives at home and attends treatment program at a specialized setting (virtually, hospital based, or eating disorder treatment center). Treatment typically involves programming that occurs 2 to 3 times per week for at least three (3) hours each time, and groups in addition to 1:1 treatment may be part of the program. The patient is medically and psychiatrically stable enough to live at home, and they will often maintain work and/or school obligations while

engaging in treatment.

3. **Partial Hospital**: Patient lives at home and attends treatment program at a specialized setting (virtually, hospital based, or eating disorder treatment center). Treatment typically involves programming that occurs five (5) days per week for 6-8 hours per day and can consist of a range of services such as 1:1 therapy, group-based therapy, family therapy, nutrition counseling, along with supportive meals. Patient remains medically and psychiatrically stable enough to live at home, but requires highly structured, intensive, eating disorder treatment to reduce eating disorder symptoms and achieve progress towards recovery.
4. **Residential**: Patient lives at a specialized eating disorder program because they require 24-hour care/supervision in order to control and reduce active eating disorder behaviors. Patient is medically stable. Treatment typically involves programming that occurs daily for 6-8 hours per day and can consist of a range of services such as 1:1 therapy, group-based therapy, family therapy, nutrition counseling, along with supportive meals, and co-occurring psychiatric care. All meals and snacks are supervised and provided in a supportive environment. Depending on the program, more complex medical needs such as nasogastric tube feeding may or may not be available.
5. **Inpatient Eating Disorder Program**: Patient lives at specialized eating disorder program because they require 24-hour care/supervision in order to control and reduce active eating disorder behaviors, and lower levels of care have often proven to provide insufficient structure and monitoring to improve eating disorder symptoms. Oftentimes, the patient requires additional medical or psychiatric oversight for complex issues or needs that are not able to be handled in Residential level of care (e.g., nasogastric tube feeding, significant mood or psychiatric instability that requires active daily management). Focus is on weight restoration.
6. **Inpatient Acute Care Medical Hospital**: Patient is medically unstable (i.e., unstable or depressed vital signs, laboratory findings indicative of acute physiologic risk, complications from coexisting medical conditions such as diabetes) and often also psychiatrically unstable (i.e., suicidality, rapidly worsening mood or other psychiatric symptoms). Focus is on weight restoration and stabilization of acute medical abnormalities.
7. **Inpatient Acute Care Psychiatric Hospital**: In most instances, patient is not acutely medically unstable (see Inpatient Acute Care Medical Hospital above), but has active psychiatric symptoms that require specialty inpatient psychiatric care (e.g., significant mood symptoms, suicidality/homicidality, psychosis). Most units will not be equipped to manage lines/tubes. Focus is on achieving stabilization of acute psychiatric symptoms, not necessarily eating disorder treatment.

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

E. Non-Specialty Mental Health Services (NSMHS): *aka Mild to Moderate Mental Health Services* Managed Care Plans (MCPs) are responsible for providing or arranging for medically necessary NSMHS provided to Members which include *(per Reference VII.D)*:

1. Individual and group mental health evaluation and treatment, including psychotherapy, family therapy, and dyadic services
2. Psychological testing, when clinically indicated to evaluate a mental health condition
3. Outpatient services for the purposes of monitoring drug therapy
4. Psychiatric consultation
5. Outpatient laboratory, medications[1], supplies, and supplements

[1] As per APL 22-012 *Revised*, the pharmacy (prescription) benefit was carved-out to State Medi-Cal as of January 1, 2022. Please refer to the State Medi-Cal Rx webpage: https://medi-calrx.dhcs.ca.gov/home/cdl/.
Effective January 1, ~~2027~~2028, the pharmacy benefit for Partnership Advantage Members is delegated to a pharmacy benefit manager.

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

G. Specialty Mental Health Services (SMHS): *aka Serious and Persistent Mental Health Services* County Behavioral Health Plans (BHPs) are required to provide and cover all medically necessary SMHS for Medi-Cal Members in accordance with their contracts with the California Department of Health Care Services (DHCS).

1. For Partnership Advantage Members who meet criteria for SMHS 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 as described in section VI.D. of this policy.

IV. ATTACHMENTS:

A. Eating Disorder Process Flow Chart
B. Eating Disorder Bidirectional Form

V. PURPOSE:

To delineate how appropriate and effective services and treatments for Partnership members with eating disorders are coordinated between Partnership, which provides medically necessary physical health and non-specialty mental health services, and the county Behavioral Health Plans in Partnership's service area, which provide all medically necessary specialty mental health services.

VI. POLICY / PROCEDURE:

A. Coordinating appropriate and effective services and treatment for Members with eating disorders is a shared responsibility between Partnership HealthPlan (Partnership) and each county Behavioral Health Plan (BHP) in Partnership's service area.

1. When evaluating requests for Members under age 21, both Partnership and BHPs will consider EPSDT criteria, including assessment of whether the service is necessary to correct or ameliorate the condition and whether or not the service is generally only available to Members over age 21 (*see policy MCCP2022 Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services*).
~~1.~~2. For Members under age 21, determinations regarding medically necessary eating disorder treatment services shall be made in accordance with EPS~~SP~~DT requirements, including services needed to correct or ameliorate the Member's condition.
~~2.~~3. Effective January 1, 2027, Partnership will coordinate appropriate and effective services and treatment for Partnership Advantage Members who receive both Medi-Cal and Medicare services. For service information specific to Partnership Advantage Members, see section VI.E. of this policy.

B. As a Managed Care Plan, Partnership is responsible for all medically necessary physical health components of eating disorder treatment and providing or arranging medically necessary non-specialty mental health services (NSMHS) (*see III.E. above*) for our Members.

1. Partnership provides inpatient hospitalization for Members with physical health conditions, including those who require hospitalization due to physical complications of an eating disorder and

who do not meet criteria for psychiatric hospitalization. Partnership also provides or arranges for NSMHS for Members requiring these services.

2. Partnership covers and pays for emergency room professional services as described in Section 53855 of Title 22 of the California Code of Regulations. Emergency services include professional services and facility charges claimed by emergency departments including, but not limited to the following: professional physical, mental, and substance use treatment services, including screening examinations necessary to determine the presence or absence of an emergency medical condition and, if an emergency medical condition exists, for all services that are medically necessary to stabilize the Member.
3. If a Member requires partial hospitalization or a residential eating disorder program, Partnership is responsible for the medically necessary physical health components of the treatment, including locating, arranging, and following up to ensure services were rendered. (The BHP is responsible for the medically necessary Specialty Mental Health Services (SMHS) components.)
~~3.~~4. Partnership shall coordinate with the county Behavioral Health Plan to ensure timely authorization reviews, treatment planning, discharge planning, and continuity of care for Members receiving eating disorder treatment services involving shared responsibility.
~~4.~~5. Partnership provides case management to coordinate and ensure the provision of all medically necessary services, including out of network services if necessary.
~~5.~~6. Registered Dieticians (RDs) may bill Partnership for CPT codes 98970 thru 98972 for monitoring meal plan journals virtually between sessions when treating a Member who has been diagnosed with an eating disorder. No TAR is required for up to 72 units (12 hours) in a rolling 12-month period, inclusive of all three codes, when the Member has an eating disorder diagnosis code on record. Please see policy MCUP3052 Medical Nutrition Therapy (MNT) Services for more information.

C. BHPs are responsible to provide and cover all medically necessary Specialty Mental Health Services (SMHS), *aka Serious and Persistent Mental Health Services*, for Medi-Cal Members in accordance with their contracts with the Department of Health Care Services (DHCS).
   1. If a Member requires partial hospitalization or a residential eating disorder program, the BHP is responsible for the medically necessary SMHS components, and Partnership is responsible for the medically necessary physical health components of the treatment.
   2. Partnership and each county BHP shall execute a Specialty Mental Health Services Memorandum of Understanding (MOU) to document the following:
      a. The division of financial responsibility. In the absence of a written agreement to share costs, Partnership will default to sharing costs equally with the BHP for residential level treatment for eating disorders pursuant to APL 22-003.
      b. A plan in the event that Partnership and the BHP cannot agree on how to divide financial responsibility. (*see policy MPBP8005 Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services*)
      c. Details about which plan will be responsible for establishing contracts detailing payment mechanisms with providers.
      d. A requirement that any medically necessary service requiring shared responsibility (such as partial hospitalization and residential treatment for eating disorders) requires coordinated case management and concurrent review by both Partnership and the BHP.
      e. Specification of procedures to ensure timely and complete exchange of information by both the BHP and Partnership for the purposes of medical and behavioral health care coordination to ensure the Member's medical record is complete and Partnership can meet its care coordination obligations. These procedures are either incorporated in the MOU or shared with the BHP as part of the related policies which further describe how the provisions on the MOU are carried out.

D. Partnership will not delay the case management and care coordination, as well as the coverage of,

medically necessary services pending the resolution of a dispute. *(see policy MPBP8005 Dispute Resolution Between Partnership and BHPs in Delivery of Mental Health Services*) Members shall continue to receive medically necessary covered services during the dispute resolution process in accordance with applicable DHCS requirements.

~~D.~~

E. Partnership Advantage Members
   1. Partnership Advantage Members in need of eating disorder treatment will be provided care coordination to ensure they have full access to all medically necessary services for the treatment of eating disorders to which they are entitled.
   2. Partnership is fully responsible for the following levels of care for eating disorders for Partnership Advantage Members:
      a. acute and psychiatric inpatient treatment
      b. partial hospitalization
      c. intensive outpatient program services
      d. outpatient services
   3. Residential treatment for eating disorders is not a Medicare-covered service ~~under Medicare~~. Partnership Advantage Members who require ~~in need of~~ this level of care will ~~be~~ receive ~~provided~~ care coordination to facilitate access to medically necessary services.~~,~~ ~~and treatment services~~ The provision and funding of treatment services will be ~~a~~ shared ~~responsibility~~ between ~~with the~~ Partnership and the Member's county BHP ~~pursuant~~ in accordance with~~to~~ the cost-sharing arrangement ~~agreed~~ established ~~to~~ between Partnership and the respective BHP.
   4. For Partnership Advantage Members who meet criteria for Specialty Mental Health Services (SMHS) and/or substance use disorder treatment services provided by a county BHP, Partnership will coordinate with BHP providers to ensure Members have access to, and are connected with, medically necessary services delivered by the BHP.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-003 Medi-Cal Managed Care Health Plan Responsibility to Provide Services to Members with Eating Disorders (03/17/2022)
B. DHCS APL 21-013 Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans (10/04/2021)
C. DHCS APL 22-012 *Revised* Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits From Managed Care to Medi-Cal Rx (12/30/2022)
D. Welfare and Institutions Code (WIC) Section 14184.402 (b)-(d), (f), (i)(1)
E. Title 22 of the California Code of Regulations (CCR) Section 53855
F. DHCS APL 23-029 *Revised* Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third Party Entities (~~01/08/2025~~ Revised 08/11/2025)
   1. Specialty Mental Health Services Memorandum of Understanding Template
G. Practice Guideline for the Treatment of Patients with Eating Disorders: Third Edition. https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/eatingdisorders.pdf
H. Alliance for Eating Disorders: Types of Eating Disorder Treatment. https://www.allianceforeatingdisorders.com/types-of-eating-disorder-treatment-levels-of-care/
I. Centers for Medicare & Medicaid Services (CMS) Medicare Coverage Database
   1. Article A57480 Billing and Coding: Psychiatry and Psychology Services
   2. Medicare National Coverage Determinations (NCD) Manual 100-03

~~J. State Medicare Advantage Contract, Exhibit A, Exclusively Aligned Enrollment D-SNP, currently in draft (2025).~~

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer; Behavioral Health Clinical Director

X. REVISION DATES:
MPBP8013:
06/11/25; 11/12/25; 11/04/26

PREVIOUSLY APPLIED TO:
MCUP3145 08/10/2022 – 06/11/2025

Eating Disorder Process

(Inpatient, Residential, PHP, and IOP)

Note: Partnership HealthPlan of California (PHC) and County share UM responsibilities. PHC may maintain provider lists and contracts with providers

Eating Disorder Identification
PCP, Carelon, County, Health Plan, Hospital, UM identifies Eating Disorder and submits referral for assessment

APL 22-003/ BHIN 22-009

See Provider List below for assessment/Refer Outpatient to Partnership BH Access

Partnership BH Access: Partnership BH Access will locate and refer member to outpatient ED provider based on recommendation **(855) 765-9703**

Screening/Assessment:
- Provider conducts screening & recommends level of care
- Provider notifies PHC BH Team of completed assessment and level of care recommendation
- Member reaches out to PHC and County
- *If member meets criteria for higher level of care, provider will notify PHC CC Team/BH Team to coordinate care*

PHC Team:
Member reaches out to PHC via ED_Collab@partnershiphp.org email address

County Mental Health:
Member reaches out to County Mental Health via Access Team

If member is in Acute Hospital BH Team/County will coordinate services based on need.

Urgent member:
- Members in an acute setting needing transition to another program
- Cases should be handled in an Urgent manner
- BH Team will contact county to discuss coordinate of care
- BH Team/County will determine needed assessments
- Strike Team will meet as needed within a timely manner
- PHC CC Team will provide case management services Partnership and County Behavioral Health will coordinate on members transition of care or placement into facility

Acute/Urgent Cases

County Mental Health:
- County monitors county compliance with MOU
- County pays Share of Cost invoices to Partnership based on agreements
- For disagreements: PHC Strike Team will meet with near immediate response to discuss next steps for complex case. Member will have access to care during determination.
- County will enroll member in appropriate mental health services/programs, if not already enrolled.
- County will maintain clinical coordination with provider.

Email Coordination Bidirectional Form

PHC Strike Team
Strike team can be called to discuss cases as needed

Partnership BH Team:
- BH will track members and status of members
- Monitor/report analytics to stakeholders and provide training on program
- BH will coordinate with County on all care
- BH Team will maintain provider lists, contracts with providers
- BH Team will monitor PHC compliance with agreements
- BH Team will notify County Mental Health of referrals.

Partnership Care Coordination:
- Provides case management for ED members
- Consults with BH Team
- Ensures member has medical necessary services such as dietitians
- CC Coordinates placement provider with County/BH Team
- CC/BH Team schedules admit date, tests, and transportation as needed once approved by PHC UM and County UM. CC will ensure approval prior to placement.

Approval:
- County Behavioral Health will notify Partnership of approval within 48 hours, excluding weekends and holidays via Bidirectional form

Disagreements:
- Partnership Strike Team will meet with near immediate response to determine next steps for complex case. Partnership Strike Team will include Partnership staff and County staff can attend.

Treatment without Prior Authorization:
- Should disputes arise between parties that cannot be resolved at the MCP and MHP level, MCP will follow the dispute resolution process contained in APL 21-013/BHIN 21-034 (“Dispute Resolution Process Between Mental Health Plans and Medi-Cal Managed Care Health Plans”)

Eating Disorder Process

(Inpatient, Residential, PHP, and IOP)

Note: Partnership and County share UM responsibilities. Partnership may maintain provider lists and contracts with providers

Step 1:

- Ensure member has Eating Disorder assessment, can be from any Eating Disorder specialist, BHH preferred.
- Members without assessment can be referred to Bright Heart Health for assessment by calling **925-621-8526** and requesting "Eating Disorder Level of Care Assessment" or by calling Equip Health at (855) 387-4378.

Step 2:

- Partnership and county should be notified of referral to Bright Heart Health at **BH_Collab@partnershiphp.org**
- Once assessment is received, Partnership and/or county will coordinate with the other to determine services needed, locate provider and coordinate next steps
- County and Partnership can coordinate care by sending Bidirectional between parties

Step 2a:
For immediate assistance needed

- Notify Partnership at **BH_Collab@partershiphp.org** for members needing immediate assistance/services
- Partnership will reach out to Member's county and provider submitting referral
- Partnership and county will coordinate care via bidirectional form

Step 3:

- Partnership Care Coordination will reach out and assist member in connecting with PCP for medical needs
- Partnership Care Coordination will coordinate with BH Team for next steps on ED placement
- Partnership Care Coordination will assist member with transportation or other medical services needed

Step 4:

- County and Partnership BH Team will coordinate with provider and make referrals to providers as needed
- Partnership BH Team will submit bidirectional form to leadership for LOA approval
- Partnership BH Team and County will agree on who will contract with provider
- Contracting entity (Partnership or County) will complete contracts with provider
- BH Team will provide County clinical contact to provider

Step 5:

- Partnership and County will share costs on inpatient, residential, PHP and IOP providers based on agreed upon percentage
- County and Partnership will receive UM updates from providers
- Partnership BH Team and County will coordinate follow on care for members

Step 6:

- Claims adjudication
- For Medi-Cal only, Partnership and county will share costs on inpatient, residential, PHP and IOP providers based on agreed upon percentage
- For Partnership Advantage Members, Partnership shall be responsible for PHP and IOP levels of care
- Contracting entity (Partnership or County) will adjudicate claims and bill the other party for share of cost
- Contracting entity (Partnership or County) will provide other party copy of claims/invoice for payment

BH Administrator approval
Stamp will go here

Eating Disorder Bidirectional Form

Please submit the form to the Partnership Behavioral Health (BH) Team at ED_Collab@partnershiphp.org

DATE OF REQUEST:

REQUESTER NAME: **EMAIL:**

URGENT (SAME DAY, END OF BUSINESS) ☐ **PRIORITY** (WITHIN 2 BUSINESS DAYS) ☐ **ROUTINE** (WITHIN 4 BUSINESS DAYS) ☐

Level of care recommendation completed: **Yes** ☐ **No** ☐ (Please contact Partnership BH department for assistance with an assessment, if needed)

Member Information

Name:	Address:	Phone:	
PCP:	**County/Agency:**	**CIN:**	**DOB:**
	Select County		

Services Requested

Inpatient: ☐
Residential: ☐
Partial Hospitalization (PHP): ☐

Intensive Outpatient (IOP): ☐
Care Coordination: ☐
Dietitian: ☐

Do you want Partnership to contract with the provider:
Yes: ☐ No: ☐

** For outpatient services, refer to Carelon with standard referral process

Requested Provider Information

** The provider you would like member to be connected to.

Provider:	Address:	Admission Phone:
Contact Name:	**Phone:**	**Email:**

Referral Submitted: **Yes** ☐ No ☐

Admission Date: (If known) Length of Stay: (If known)

Clinical Information

(Included information should be BMI, height, weight, any medical conditions, co-occuring disorders, diagnosis(es), family or social concerns, homelessness, etc.)

Contact Information

BH Team Coordinator:	Eric Rushing	**Phone:**	(530) 351-9027	**Email:**	erushing@partnershiphp.org
Partnership Care Coordinator Name:		**Phone:**		**Email:**	
County Clinician Name:		**Phone:**		**Email:**	
County Fiscal Name:		**Phone:**		**Email:**	
Primary Care Doctor:		**Phone:**		**Email:**	

Would you like the provider to send clinical updates to your clinician? **Yes** ☐ **No** ☐

Approval Signatures:

Partnership Behavioral Health Representative

County Representative

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCQP1021 (previously QP100121)</td><td colspan="2">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Initial Health Appointment</td><td colspan="2">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 10/18/2000</td><td colspan="4">Next Review Date: ~~03/11/2027~~11/04/2027
Last Review Date: ~~03/11/2026~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~03/11/2026~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MPQG1005 – Adult Preventive Health Guidelines
B. MCQG1015 – Pediatric Preventive Health Guidelines
C. MPBP8007 – Screening and Treatment for Substance Use Disorders
D. MCUG3118 – Prenatal and Perinatal Care
E. MCQP1022 – Site Review Requirements and Guidelines
F. CMP36 – Delegation Oversight and Monitoring
G. MPUP3039 – Direct Members
H. MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. An Initial Health Appointment (IHA) is defined as a member's visit to his or her Primary Care Provider (PCP) or other provider of primary care services, within stipulated timelines for an evaluation that consists of a history and physical examination sufficient to assess and manage the acute, chronic and preventive health needs of the member. The IHA must be documented in the member's medical record.
B. Partnership HealthPlan of California (Partnership) defines newly assigned members as those individuals never before enrolled to the health plan or a previously enrolled member's first month back to the plan, who was not continuously enrolled for 120 days in the past eight months, prior to the new member month.
C. Direct Members are those whose service needs are such that PCP assignment would be inappropriate. Assignment to Direct Member status is based on the member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP. When a PCP is not assigned, Partnership supports coordination of care among providers.

IV. ATTACHMENTS:

A. PCP New Member Letter MC

B. IHA Applicable Visit Codes
C. Two- Attempt Outreach Tracker Template

V. PURPOSE:

~~To describe the Policy & Procedure for conducting an Initial Health Appointment (IHA) for Medi-Cal members.~~To describe the Policy & Procedure for conducting an Initial Health Appointment (IHA) for Medi-Cal members. The IHA occurs during a Member's Encounter with a Provider within the Primary Care medical setting. During the IHA, the Provider assesses and manages the acute, chronic, and preventative health needs of the Member. The IHA policy is built on the requirements in the California Code of Regulations (CCR), the Population Health Management (PHM) Policy Guide, and the MCP Contract.

VI. POLICY / PROCEDURE:

A. To meet the Department of Health Care Services (DHCS) contractual requirements, an IHA is to be performed:
   1. Within 120 days of a member's enrollment in Partnership HealthPlan of California (Partnership) or within 120 days of a member's assignment to a PCP (whichever is most recent).
      a. Refer to ~~Medi-Cal Managed Care Division policy letter APL 22-030 (Dec. 27, 2022~~Department of Health Care Services (DHCS) All Plan Letter (APL) 26-001 (Jan. 7, 2026 supersedes APL 22-030 and 13-017 and Policy Letters 13-001 and 08-003).
      b. Exceptions to this requirement are specified in Section E of this policy.
B. An IHA must be performed by a Provider within the primary care medical setting and must be provided in a way that is culturally and linguistically appropriate for the member.
C. An IHA must include all of the following:
   1. A history of the member's physical and mental health;
      a. History of present illness
      b. Past medical history
      c. Social history
      d. Review of organ systems (ROS) including dental assessment
   2. An identification of risks;
   3. An assessment of need for preventive screens or services; see Section D
   4. Health education
      a. The provider should assure documentation, at initial and subsequent visits, of health education interventions including risk factors addressed, intervention codes, date and PCP's signature or initials. More extensive documentation in the progress notes is encouraged.
   5. The diagnosis and plan for treatment of any diseases.
   6. A Member Risk Assessment
D. Preventive Services
   1. The IHA must bring members up to date with all currently recommended preventive services, including immunizations, or arrange to have the member brought up-to-date if, for any reason, this objective cannot be fully accomplished at the time of the IHA.
   2. The IHA shall follow the United States Preventive Services Task Force (USPSTF) / Advisory Committee on Immunization Practices (ACIP) immunization protocols as set forth in DHCS' ~~APL 24-008.~~ APL 26-015.
      a. If the Medi-Cal provider manual outlines less restrictive criteria than ACIP, immunizations are provided according to the less restrictive guidelines.
   3. For members under the age of 21 years, the IHA shall follow these requirements:
      a. The IHA shall follow the requirements of Health and Safety Code (H&S), Sections 124025, et

seq., and Title 17, CCR, Sections 6l842 through l6852, except that the PCP shall follow the most recent periodicity schedule (*aka* Bright Futures Recommendations for Periodic Preventive Health Care) recommended by the American Academy of Pediatrics (AAP) as noted in Reference D of this document and in MCQG1015, the Pediatric Preventative Health Guidelines.

~~1) All active California Child Health and Disability Prevention Program (CHDP) providers as of June 30, 2024 were automatically enrolled as CPE (Children's Presumptive Eligibility Program) providers on July 1, 2024.~~

b. For asymptomatic members 21 years and older, the IHA shall follow these guidelines:
   1) The IHA shall include a history and physical examination sufficient to assess and manage the acute, chronic, behavioral, and preventive health needs of the member.
   2) The PCP shall provide the core set of preventive services for adult screening of asymptomatic health members over the age of 21years consistent with MPQG1005, Adult Preventive Health Guidelines and the Guide to Clinical Preventive Services of the USPSTF.

4. Perinatal Services
   a. Perinatal services for pregnant members will be provided according to the most current standards or guidelines of the American College of Obstetrics and Gynecology (ACOG). Refer to the policy MCUG3118, Prenatal and Perinatal Care. For members who are pregnant upon enrollment or who are discovered to be pregnant before an IHA has been performed, an IHA must be performed by the member's PCP, or other provider of primary care services (e.g., OB/GYN). The pregnancy must be noted and the Initial Prenatal Assessment for pregnant women completed, or referral made to another Partnership provider for initiation of pregnancy-related services, including the required prenatal assessment. The assessment must be administered at the initial prenatal visit, once each trimester thereafter, and at the postpartum visit. Risks identified must be followed up with appropriate interventions and documented in the medical record.
   b. Pregnant and breastfeeding members must be referred to the Women, Infants, and Children (WIC) program. Infant feeding plans should be documented during the prenatal period, and infant/breastfeeding status is documented during the postpartum period. See MPNP9008 — Women, Infants and Children (WIC) Supplemental Food Program.
5. Members with Chronic and/or Complex Conditions
   a. For members who have been receiving services for chronic and/or complex conditions prior to enrollment in Partnership, the clinician conducting the IHA must ask specific questions to identify services being provided to members by Local Education Agencies, Regional Centers, early intervention programs, the Whole Child Model (WCM) and other special programs outside of the Partnership network, including those serving aged and/or disabled members, to allow the PCP and Partnership to most effectively accomplish necessary coordination, continuity of care and case management functions.
6. Dual Eligible Members
   a. For members who are dually eligible for Medi-Cal and Medicare, Partnership must adhere to the IHA requirements in the PHM Policy Guide and the MCP Contract.

E. Excluded Members
1. Individual members may be excluded from the IHA requirement under the following circumstances:
   a. The medical records contain documentation of prior health assessments within the 12 months prior to enrollment, and which the member's primary care services provider determines meets the requirements for documentation of the IHA.
   b. Members who are not continuously enrolled in Partnership for 120 days.
   c. Members, including emancipated minors, or a member's parent(s) or guardian, who refuse an IHA. A declination should be documented in the member's medical record.
   d. Members with certain restricted aid codes, except pregnancy, which limit the services to which

members are entitled, or to members who are share-of-cost (SOC) Medi-Cal beneficiaries are exempted from the IHA.

e. The member was dis-enrolled from the plan before an IHA could be performed.

f. The member missed a scheduled PCP appointment and two additional documented attempts to reschedule have been unsuccessful. If these efforts prove to be unsuccessful, the documentation must include at least two attempts att~~o~~ outreach to the member.

F. IHA Training

1. Site Review:
   a. Partnership will provide training for our network providers and staff during the Site Review (SR) and via the Providers' Newsletter on an annual basis. Information includes:
      1) Adequate documentation,
      2) Timelines for performing IHAs, and
      3) Procedures to assure the visit(s) for the IHA are scheduled and that members are contacted for missed IHA appointments.
2. Provider Relations
   a. New member lists, with address labels, are distributed to providers. Providers may use these lists to document contact attempts. This documentation should be kept for three years.

G. Informing Members

1. Members will be informed of IHA requirements via the Member's Newsletter and Partnership's website regarding:
   a. Instructions on arranging IHA appointments with appropriate timelines
   b. Importance of scheduling and keeping the IHA appointment

H. IHA Monitoring

1. Partnership will monitor compliance to the timely provision of IHAs during the regularly scheduled Medical Record Review (MRR), as part of the Site Review. Reviewers provide PCPs with a list of members that claims data identifies as needing an IHA. Reviewers also provide templates for PCPs to document outreach attempts to bring members in for an IHA visit. PCPs or other providers of primary care services must document the performance of an IHA in the member's medical record or state that equivalent information is part of the medical record. All counseling, anticipatory guidance, risk factor reduction interventions and other follow-up treatment and/or referrals for problems noted during the IHA should be documented in the medical record. Exemptions from the IHA requirement must be appropriately documented in the medical record or on the PCP member list.
2. On an annual basis, Partnership pulls claims and encounters with specific visit codes (Attachment B – IHA Applicable Visit Codes) for primary care providers to identify the potential percentage of their newly assigned members who had a visit within 120 days of being newly assigned. Due to limitations and the lack of a singular IHA billing code, this report is only able to show potential IHA's completed.
3. For members who are dually eligible for Medi-Cal and Medicare, MCPs must adhere to the IHA requirements in the PHM Policy Guide and MCP Contract.

I. Direct Members: Since Direct Members are not generally assigned to a PCP, providers primarily responsible for their care should perform the IHA per the requirements outlined in this policy. For more information on Direct Members, see MPUP3039 – Direct Members.

J. Delegation of IHA monitoring functions

1. Organizations or groups who have one or more DHCS Certified Site Reviewers may be determined eligible, at Partnership discretion, to perform IHA monitoring functions as part of the Site Review Process. An organization or groups will perform these functions under a formal delegation agreement.

2. A formal delegation agreement is inclusive of a detailed grid outlining key functions and responsibilities of both Partnership and the delegated entity.
3. Delegated entities will perform IHA monitoring functions for all Primary Care Provider (PCP) sites no less than every three years.
4. Partnership conducts an audit not less than annually to ensure the appropriate policy and procedures are in place.
5. Results from Oversight and Monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~24-008~~26-015 Immunization Requirements (~~June 21, 2024~~) (July 14, 2026 supersedes APL ~~18-004~~24-008
B. DHCS 26-001 Initial Health Appointment (Jan. 7, 2026 supersedes APL 22-030
C. DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (Oct. 11, 2021)
D. American Academy of Pediatrics: Recommendations for Preventive Pediatric Health Care https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf (February 2025)
E. DHCS APL 23-005 Requirements For Coverage Of Early And Periodic Screening, Diagnostic, And Treatment Services For Medi-Cal Members Under The Age Of 21 (March 16, 2023 supersedes 19-010)
F. DHCS CHDP Provider Notice 22-06 Child Health and Disability Prevention Program Discontinuance (Oct. 21, 2022)
~~G. DHCS CHDP Transition Plan (March 2024)~~

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer (CMO)

X. REVISION DATES: 05/15/02; 04/20/05; 06/21/06; 06/20/07; 07/16/08; 10/21/09 11/17/10; 10/16/13; 02/19/14; 02/17/16; 02/15/17; *03/14/18; 06/13/18; 06/12/19; 06/10/20; 06/09/21; 03/09/22; 03/08/23; 03/13/24; 06/12/24; 01/08/25; 01/14/26; 03/11/26; 11/04/26

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

PREVIOUSLY APPLIED TO:
N/A

To: Primary Care Providers

From: Partnership HealthPlan of California
Provider Relations Department

RE: Mailing Labels/List of New Patients to your Practice

Attached is a list and address labels for members recently assigned to your practice. We are providing this information to assist you in welcoming new patients to your practice and to remind you of the importance of conducting an Initial Health Appointment (IHA) within 90 days of the member's enrollment into Partnership. If the member had a health history and physical exam completed by you or a previous provider within 1 year of joining Partnership, you do not have to complete another initial health appointment, provided that you have a copy in the member's chart. Conducting IHAs is a regulatory requirement by the Department of Healthcare Care Services (DHCS) and is therefore contractually required by Partnership.

The initial health appointment must include a history of the member's physical and behavioral health, an identification of risks, an assessment of need for preventive screenings or services, health education, and the diagnosis and treatment plan for any diseases. For children and youth (i.e., individuals under age 21) screenings should be conducted according to the American Academy of Pediatrics (AAP) Recommendations for Preventive Pediatric Health Care: Bright Futures periodicity schedule (https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf). For adults screenings should be conducted according to U.S. Preventive Services Task Force (USPSTF) guidelines.

We've attached sample letters in English, Spanish, Russian, ~~and~~ Tagalog, and Punjabi that you can use to welcome new members to your practice and to encourage them to make an appointment with you so that they can timely receive an IHA.

You should retain documentation of your efforts as Partnership will look for this documentation during your facility site review and sometimes, DHCS audits providers directly to ensure this requirement is met.

Please contact your Provider Relations Representative at (707) 863-4100 if you have any questions. We hope this information is helpful to your practice.

Thank you.

www.partnershiphp.org

SAMPLE WELCOME LETTER MEDI-CAL

Dear Partnership HealthPlan Member,

Welcome to our practice. As your primary care provider, I am looking forward to meeting you and would like to ask that you call the office to schedule a check-up. Both the Partnership HealthPlan and state Medi-Cal program ask that you have this visit within 3 months of becoming Medi-Cal eligible. During this check-up, we will review your past and current medical needs. I would also be happy to answer any questions that you have about your health.

Please take the time to schedule your appointment by calling (___) ___-____. Check-ups are a great way for you to know that you are in good health and also, a good time for your doctor to explain how you can prevent health problems.

Let's work together for your health.

Sincerely,

Estimado miembro del Partnership HealthPlan:

Bienvenido a nuestro consultorio. Como somos su proveedor medico principal, nos encantaría conocerle, y por eso le pedimos que nos llame para hacer una cita con su medico regular. Tanto el Partnership HealthPlan, como el Medi-Cal del Estado de California, requieren que usted haga cita con su médico antes de que pasen tres meses desde la fecha en que le dijeron que era elegible para Medi-Cal. Cuando venga a su cita para que le hagan un examen general, vamos a platicare de su cuidado medico del pasado, y del cuidado medico que necesita en estos momentos. También tendremos el gusto de darle respuesta a cualquier pregunta que tenga sobre su salud.

Por favor, llame al numero (___) ___-____ para hacer su cita para un examen general con el medico. Los exámenes generales son la mejor manera de saber si su salud es buena, y también es la mejor oportunidad de que su doctor le explique en que forma puede prevenir ciertos problemas médicos que pueda tener.

Vamos a colaborar juntos para mantenerlo sano.

Atentamente,

ОБРАЗЕЦ ПРИВЕТСТВЕННОГО ПИСЬМА MEDI-CAL

Уважаемый участник плана Partnership HealthPlan,

Добро пожаловать в нашу организацию. Как ваш основной поставщик медицинских услуг я жду знакомства с вами и прошу вас позвонить администратору, чтобы запланировать проверку здоровья. Правила плана Partnership HealthPlan и программы штата Medi-Cal требуют, чтобы вы посетили нас в течение 3 месяцев с момента получения права на Medi-Cal. Во время этой плановой проверки мы оценим ваши текущие и прошлые потребности в медицинском обслуживании. Я также с удовольствием отвечу на все ваши вопросы о вашем здоровье.

Запишитесь на прием по телефону (___) ___-____. Плановые проверки помогут установить состояние вашего здоровья и обсудить с врачом способы профилактики проблем со здоровьем.

Вместе мы сможем позаботиться о вашем здоровье.

С уважением,

HALIMBAWA NG WELCOME LETTER SA MEDI-CAL

Minamahal na Miyembro ng Partnership HealthPlan,

Welcome sa aming panununungkulan. Bilang inyong tagapagbigay ng pangunahing pangangalaga, inaabangan ko ang ating pagkikilala at gusto kong hilingin sa inyo na tawagan ang opisina para magtakda ng check-up. Hinihingi ng kapwa Partnership HealthPlan at programang Medi-Cal ng estado na pumunta kayo para sa pagbisitang ito sa loob ng 3 na buwan matapos maging kwalipikado para sa Medi-Cal. Sa check-up na ito, rerepasuhin namin ang inyong mga medikal na pangangailangan sa nakaraan at sa kasalukuyan. Ikagagalak ko ring sagutin ang anumang mga tanong ninyo tungkol sa inyong kalusugan.

Maglaan sana ng oras para itakda ang inyong appointment sa pamamagitan ng pagtawag sa (___) ___-____. Ang mga check-up ay magandang paraan para malaman ninyo na nasa mabuting kalusugan kayo at mabuti ring panahon para ipaliwanag ng doktor ninyo kung paano ninyo maiiwasan ang mga problema sa kalusugan.

Magtulungan tayo para sa inyong kalusugan.

Taos-pusong sumasainyo,

ਸਤਿਕਾਰਯੋਗ Partnership HealthPlan ਮੈਂਬਰ,

ਸਾਡੇ ਕਲੀਨਿਕ ਵਿੱਚ ਤੁਹਾਡਾ ਸਵਾਗਤ ਹੈ। ਤੁਹਾਡੇ ਮੁੱਢਲੇ ਦੇਖਭਾਲ ਪ੍ਰਦਾਤਾ ਵਜੋਂ, ਮੈਂ ਤੁਹਾਨੂੰ ਮਿਲਣ ਲਈ ਉਤਸੁਕ ਹਾਂ ਅਤੇ ਤੁਹਾਨੂੰ ਬੇਨਤੀ ਕਰਦਾ/ਕਰਦੀ ਹਾਂ ਕਿ ਤੁਸੀਂ ਆਪਣੀ ਸਿਹਤ ਜਾਂਚ ਦਾ ਸਮਾਂ ਤੈਅ ਕਰਨ ਲਈ ਦਫ਼ਤਰ ਵਿੱਚ ਕਾਲ ਕਰੋ। Partnership HealthPlan ਅਤੇ ਸਟੇਟ Medi-Cal ਪ੍ਰੋਗਰਾਮ, ਦੋਵਾਂ ਵੱਲੋਂ ਇਹ ਬੇਨਤੀ ਕੀਤੀ ਜਾਂਦੀ ਹੈ ਕਿ ਤੁਸੀਂ Medi-Cal ਦੇ ਯੋਗ ਹੋਣ ਦੇ 3 ਮਹੀਨਿਆਂ ਦੇ ਅੰਦਰ ਇਹ ਮੁਲਾਕਾਤ ਜ਼ਰੂਰ ਕਰੋ। ਇਸ ਸਿਹਤ ਜਾਂਚ ਦੌਰਾਨ, ਅਸੀਂ ਤੁਹਾਡੀਆਂ ਪਿਛਲੀਆਂ ਅਤੇ ਮੌਜੂਦਾ ਡਾਕਟਰੀ ਲੋੜਾਂ ਦੀ ਸਮੀਖਿਆ ਕਰਾਂਗੇ। ਮੈਨੂੰ ਤੁਹਾਡੀ ਸਿਹਤ ਬਾਰੇ ਤੁਹਾਡੇ ਕਿਸੇ ਵੀ ਸਵਾਲ ਦਾ ਜਵਾਬ ਦੇਣ ਵਿੱਚ ਵੀ ਖੁਸ਼ੀ ਹੋਵੇਗੀ।

ਕਿਰਪਾ ਕਰਕੇ (___) ___-____ 'ਤੇ ਕਾਲ ਕਰਕੇ ਆਪਣੀ ਅਪਾਇੰਟਮੈਂਟ ਦਾ ਸਮਾਂ ਤੈਅ ਕਰਨ ਲਈ ਸਮਾਂ ਕੱਢੋ। ਸਿਹਤ ਜਾਂਚ ਕਰਵਾਉਣਾ ਤੁਹਾਡੇ ਲਈ ਇਹ ਜਾਣਨ ਦਾ ਇੱਕ ਵਧੀਆ ਤਰੀਕਾ ਹੈ ਕਿ ਤੁਹਾਡੀ ਸਿਹਤ ਠੀਕ ਹੈ, ਅਤੇ ਨਾਲ ਹੀ, ਇਹ ਤੁਹਾਡੇ ਡਾਕਟਰ ਲਈ ਇਹ ਸਮਝਾਉਣ ਦਾ ਵੀ ਢੁਕਵਾਂ ਸਮਾਂ ਹੁੰਦਾ ਹੈ ਕਿ ਤੁਸੀਂ ਸਿਹਤ ਸਬੰਧੀ ਸਮੱਸਿਆਵਾਂ ਤੋਂ ਕਿਵੇਂ ਬਚ ਸਕਦੇ ਹੋ।

ਆਓ ਤੁਹਾਡੀ ਸਿਹਤ ਲਈ ਮਿਲ ਕੇ ਕੰਮ ਕਰੀਏ।

ਸਤਿਕਾਰ ਸਹਿਤ,

INITIAL HEALTH APPOINTMENT (IHA)

MCQP1021- Attachment B rev. 03/11/2026

New Patient Age	CPT Code
0-12 Months	99381
1-4 Years	99382
5-11 Years	99383
12-17 Years	99384
18+ Preventative Visit	99385
18-64 Office Visit	99386
65+ Office Visit	99387
Tribal Health Visit	0520
Any Age During Pregnancy	59400, 59510, 59610, 59618

New Patient Visit Location	Visit Duration	CPT Code
Office Visit	15-29 Minutes	99202
Office Visit	30-44 Minutes	99203
Office Visit	45-59 Minutes	99204
Office Visit	60-74 Minutes	99205
Home Visit	30 Minutes	99342
Home Visit	60 Minutes	99344
Home Visit	75 Minutes	99345
SNF Visit	25 Minutes	99304
SNF Visit	35 Minutes	99305
SNF Visit	45 Minutes	99306

Established Patient Age	CPT Code
0-12 Months	99391
1-4 Years	99392
5-11 Years	99393
12-17 Years	99394
18+ Preventative Visit	99395
18-64 Office Visit	99396
65+ Office Visit	99397
Tribal Health Visit	0520

Established Patient Location	Visit Duration	CPT Code
Office Visit	20-29 Minutes	99213
Office Visit	30-39 Minutes	99214
Office Visit	40-54 Minutes	99215
Home Visit	30 Minutes	99348
Home Visit	60 Minutes	99349
Home Visit	75 Minutes	99350

Screenings	CPT Code
Developmental Screening	96110
Health Risk Assessment	96160
Cognitive Health Assessment	99483

If you have any questions, please feel free to contact the Member Safety Inspections team at fsr@partnershiphp.org

What is required to complete the Initial Health Appointment (IHA)?

- A history of the Member's physical and mental health;
- An identification of risks;
- An assessment of need for preventive screens or services;
- Health education; and
- The diagnosis and plan for treatment of any diseases.
- A Member Risk Assessment

The Initial Health Appointment (IHA) is required to be completed within 120 days of Partnership enrollment and is:

- To be performed by a Provider within the primary care medical setting.
- Not necessary if the Member's Primary Care Physician (PCP) determines that the Member's medical record contains complete information that was updated within the previous 12 months.
- To be provided in a way that is culturally and linguistically appropriate for the Member.
- To be documented in the Member's medical record.

What if I cannot get in contact with a newly assigned member?

If you are unable to complete an IHA within 120 days of Partnership enrollment, make sure to document your two attempts of outreach.

ICD-10 Description	ICD-10 Code
General medical without abnormal finding	Z00.00
General medical with abnormal finding	Z00.01
Child health exam with abnormal finding	Z00.121
Child health exam without abnormal finding	Z00.129
Potential organ donor	Z00.5
Examination as part of a clinical trial	Z00.6
Exam for period of delayed growth	Z00.70
General examination	Z00.8
Exam for admission to educational institute	Z02.0
Pre-employment examination	Z02.1
Admission to residential institute	Z02.2
Exam for driver's license	Z02.4
Exam for sports	Z02.5
Exam for insurance purposes	Z02.6
Pregnancy	Z1032
Other administrative examinations	Z02.89
ACEs High Risk	G9919
ACEs Low Risk	G9920
SDOH Risk Assessment	G0136

PCP ID	Patient Name:	CIN:	DOB:	Date of Enrollment	Date of Attempt 1: How was attempt made?	Date of Attempt 2: How was attempt made?

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3032 (previously UG100332)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Guideline/Procedure Title: Orthotic and Prosthetic Appliances Guidelines			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 02/21/1995		**Next Review Date:** ~~11/12/2026~~11/04/2027 **Last Review Date:** ~~11/12/2025~~11/04/2026		
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~~11/04/2026	

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process

B. MCUP3013 – Durable Medical Equipment (DME) Authorization

~~B.~~C. MPUP3139 – Criteria and Guidelines for Utilization Management

II. IMPACTED DEPTS:

~~A. Health Services~~

~~B.~~A. Claims

~~C.~~B. Member Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the criteria for approval of orthotic and prosthetic appliances.

VI. GUIDELINE / PROCEDURE:

A. Partnership HealthPlan of California (Partnership) covers orthotic and prosthetic appliances when such appliances are necessary for the restoration of function or replacement of body parts, or to support a weakened or deformed body member, when~~as~~ prescribed in writing (or electronic equivalent) by a physician, ~~a~~ podiatrist, dentist or a non-physician medical practitioner functioning within the scope of their license.

1. Partnership utilizes Medi-Cal guidelines and ~~InterQual®~~ other criteria as defined in policy MPUP3139 Criteria and Guidelines for Utilization Management to determine medical necessity for authorizations of orthotic and prosthetic devices.
2. External independent consultants may be utilized on a case-by-case basis.
~~1.~~3. Exceptions to these guidelines may be made based on the individual needs of the Member or the unique characteristics of the delivery system.

B. The definition of medical necessity is health care services that are necessary to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, prescribed appliances will be covered only as medically necessary to restore bodily functions essential to activities of daily living (ADLs) or instrumental activities of daily living (IADLs), to prevent significant disability or serious deterioration of

health, or to alleviate severe pain.

1. The prescribing physician, ~~or~~ podiatrist, dentist, or non-physician medical practitioner must supply the vendor with information required to document the medical necessity for the requested item.
2. The appliance or service requested must be consistent with the recipient's previous abilities and limitation as they relate to activities of daily living prior to the onset of disability or injury, or must be ~~is~~ appropriate to the recipient's chronological and developmental age.
~~2.~~3. The appliance or service requested ~~is~~must be consistent with the recipient's overall medical condition.

~~B.~~C. A Treatment Authorization Request (TAR) is required when the cost for repair/maintenance, purchase or rental exceeds $250 for orthotics or $500 for prosthetics.

1. TAR requests for orthotic or prosthetic appliances must include the diagnosis related to the functional disability, a copy of prescribing physician prescription, a statement concerning the Member's functional disability that would benefit from the appliance, and a statement explaining the reason more cost-~~-~~effective options would not meet the Member's needs.

~~C.~~D. A repair of an appliance will not be authorized when the repair cost is equal to or exceeds the purchase cost of a new appliance.

~~D.~~E. For appliance claims submitted by report, the vendor must list the item description, manufacturer name, model number, catalog page, suggested retail price, cost of part(s) used, cost of labor per hour and total cost/hours, description of and medical justification for any special features (custom modification or special accessories) and medical condition necessitating the appliance.

~~E.~~F. Orthopedic Shoes

1. Stock orthopedic and stock conventional shoes are a covered benefit when a. or b. is met below:
   a. At least one of the shoes is an integral part of a leg brace and is medically necessary for the proper functioning of the brace or
   b. The recipient has a diagnosis of Diabetes Mellitus and one or more of the following conditions:
      1) Current foot ulcers or a history of foot ulceration
      2) Previous foot amputation
      3) Peripheral neuropathy with evidence of callous formation of either foot
      4) Peripheral vascular disease
      5) Positive monofilament examination indicating diabetic neuropathy
      6) Deformity of either foot, such as rocker bottom foot or Charcot foot
2. Modification of stock conventional shoes or stock orthopedic shoes is covered when the patient's medical need can be satisfied with such modification.
3. Custom-made orthopedic shoes are reimbursable if the recipient's medical need cannot be met by modifications to stock orthopedic or stock conventional shoes. Clinical conditions that might require custom-made shoes include but are not limited to Charcot or rheumatoid foot deformities, some partial foot amputations, or when a patient requires a muscle flap to cover a large or unusual soft tissue foot defect that then is too bulky to be accommodated by an in-depth shoe.
4. The prescribing physician must document the nature, cause and severity of the foot problem leading to the conclusion that a custom-made orthopedic shoe is the only alternative (CCR, Title 22, Section 51315). A custom-made shoe has the following characteristics:
   a. Made and molded to patient model for a specific patient
   b. Constructed over a positive model of the patient's foot
   c. Made from leather or other suitable material of equal quality
   d. Has removable inserts as an integral part of the shoe that can be altered or replaced as the patient's condition warrants
   e. Has some form of shoe closure

~~F.~~G. Custom Foot Orthotics

1. Orthotics are covered when medically necessary for the following acute or chronic foot conditions:

a. Rehabilitative foot orthotics following foot surgery or trauma
b. Plantar fasciitis
c. Inflammatory conditions such as bursitis of the foot, tenosynovitis, plantar fascial fibromatosis
d. Neurologically impaired feet
e. Vascular conditions of the foot including poor circulation or peripheral vascular disease
f. Musculoskeletal deformities such as bunions, hallux valgus, talipes deformities, toe deformities

2. Foot orthotics are not medically necessary and are not covered for the following conditions:
   a. Back pain
   b. Knee pain
   c. Pes planus (flat feet)
   d. Pronation
   e. Corns or calluses
   f. Hip osteoarthritis
   g. Lower leg injuries

H. Compression Garments
   1. Effective October 1, 2024, Partnership covers over-the-counter (OTC) compression garments as follows:
      a. Procedure code A6593 may be billed for OTC compression garments and will be limited to two units (per limb) every six months.
      b. Claims billed for greater than two units every six months will be denied for exceeding the service limitations.
      c. No prior authorization is required for this service and no invoice needs to be billed with the claim. A written physician prescription is required but does not have to be attached to the claim.
      d. The maximum allowable for this code is $50 per unit.

I. Dynamic Splinting
   1. Partnership reviews authorization requests for dynamic splints for the knee (E1810) on a ~~case by case~~case-by-case basis as described in policy MCUP3013 Durable Medical Equipment (DME) Authorization.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Orthotic and Prosthetic Appliances and Services *(ortho)*
~~B. InterQual® Durable Medical Equipment Criteria~~
B. Title 22 California Code of Regulations (CCR) 51315 and 51315.1
C. Partnership Benefits Review and Evaluation Workgroup (BREW) Form #24 OTC/Off-the-Shelf Compression Garments. (07/25/2024)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

06/1/00; 09/20/00; 12/19/01; 11/20/02; 09/15/04; 10/19/05; 08/20/08; 11/18/09; 05/18/11; 02/20/13; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 11/13/19; 10/14/20; 10/13/21; 10/12/22; 11/08/23; 11/13/24; 11/12/25; 11/04/26

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

Guideline/Procedure Number: MCUG3032 (previously UG100332		**Lead Department: Health Services** **Business Unit: Utilization Management**
Guideline/Procedure Title: Orthotic and Prosthetic Appliances Guidelines		☒ **External Policy** ☐ **Internal Policy**
Original Date: 02/21/1995	**Next Review Date: 11/12/202611/04/2027** **Last Review Date: 11/12/202511/04/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PREVIOUSLY APPLIED TO: N/A

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3020 (previously UP100320)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Hospice Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 12/12/1995</td><td colspan="4">Next Review Date: ~~01/14/2027~~11/04/2027
Last Review Date: ~~01/14/2026~~11/04/2026</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>☐ 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~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
B. MPUP3039 - Direct Members
C. MPUP3137 - Palliative Care: Intensive Program (Adult)
D. MCUP3140 - Palliative Care: Pediatric Program for Members Under the Age of 21
E. MCCP2022 - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services
F. MCCP2024 - Whole Child Model for California Children's Services (CCS)

II. IMPACTED DEPTS:

~~A. Health Services~~
~~B.~~A. Claims
~~C.~~B. Member Services

III. DEFINITIONS:

A. Authorized Representative: An adult Member has the right to designate a friend, family Member, or other person to have access to certain protected health information (PHI) to assist the Member with making medical decisions. The Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership HealthPlan of California for review prior to releasing PHI. Until the form has been submitted and validated by Partnership staff, the Member can give verbal consent to release non-sensitive PHI to a designated person. Verbal consent expires at close of business the following business day. The Member can give additional Verbal Consent when the prior Verbal Consent window of time has expired.
B. 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. Terminal Illness: A condition caused by injury, disease, or illness from which, to a reasonable degree of certainty, there can be no restoration of health, and which, absent artificial life-prolonging procedures, will inevitably lead to natural death.
D. 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 a CCS-eligible condition(s) insured by Partnership.

IV. ATTACHMENTS:

A. Medi-Cal Hospice Program Election Notice *DHCS 8052* (07/2023)
B. Patient Notification of Hospice Non-Covered Items, Services, and Drugs *DHCS 8053* (07/2023)
~~B.~~C. Partnership Application to be a Contracted Hospice Provider

Policy/Procedure Number: MCUP3020 (previously UP100320)		**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Hospice Services		☒ **External Policy** ☐ **Internal Policy**
Original Date: 12/12/1995		**Next Review Date: 01/14/202711/04/2027** **Last Review Date: 01/14/202611/04/2026**
Applies to:	☒ **Medi-Cal**	☐ **Employees**

V. PURPOSE:

The purpose of the guideline is to delineate the requirements for a Member to be admitted to a hospice program and to outline compensation structures for hospice services.

VI. POLICY / PROCEDURE:

A. Criteria for Admission to a Hospice Program

1. A patient will be admitted to the hospice program when the following conditions are met:
   a. The patient has a limited life expectancy of 6 months or less, if the terminal illness follows its normal course.
      1) The patient's physician or the hospice medical director must certify that the Member has a terminal illness by providing specific clinical findings or other documentation to support a life expectancy of 6 months or less.
   b. A member may elect hospice services in lieu of curative care for the terminal illness. (For specific pediatric hospice guidelines, please see VI.C.4. below.)
   c. The primary goal for the patient is to focus on comfort, pain control, and emotional, spiritual, and psychological support.
   d. It is appropriate to direct treatment to improve the quality of the remaining days for the patient and family.
   e. It is agreed by doctor and patient and/or family that advanced technology is used solely for the purpose of sparing the patient discomfort or limitations they would otherwise suffer.
   f. The patient, family, and physician are all willing to participate in the program with the understanding that withdrawal from the hospice program is possible at any time.
2. Election of hospice care for Partnership Medi-Cal Members occurs when the Member (or authorized representative) voluntarily completes and signs the Department of Health Care Services (DHCS) Medi-Cal Hospice Program Election Notice *DHCS 8052* (Attachment A) and selects a hospice provider. Signing this form indicates the Member's understanding that hospice care is intended to alleviate pain and suffering, rather than to cure the disease, and that certain benefits are waived by election of this service.
   a. Members who qualify for and elect to receive hospice care services, remain enrolled in Partnership while receiving hospice services.
   b. Hospice care services may be initiated or continued in a home or clinical setting. Partnership will remain responsible for the provision or payment of all Medi-Cal covered services not related to the terminal illness, including those of the Member's primary care physician.
   c. A Member who is a resident of a skilled nurse facility (SNF) or an Intermediate Care Facility (ICF) may elect hospice care, and Partnership will provide payment to the hospice for hospice care services at the appropriate level of care.
   d. Partnership does not deny any completed Hospice Program Election Notices nor deny any late referrals to hospice.
   e. Upon receipt of a completed hospice election form, or the member is flagged by DHCS in data sent to the health plan that the member is receiving hospice services, the member is placed into HP 6; a restricted Direct Member designation category. This designation in Partnership's system and online provider portal informs the Member's primary care provider and/or other contracted providers, that the member is currently enrolled in hospice and receiving those services. For more information, see Partnership policy MPUP3039 Direct Members.

B. Hospice Provider Requirements

1. Consistent with contractual requirements for covered Medi-Cal benefits, and Continuity of Care provisions, hospice coverage is restricted to hospice providers who are contracted with Partnership. Any ~~f~~Federally approved Medicare ~~h~~Hospice in the Partnership ~~s~~Service ~~a~~Area or~~and~~ adjacent

counties may apply to have a contract with Partnership (see Aattachment C), but is not guaranteed approval. If medically necessary services are not available in-Network, or if a member is currently receiving hospice care at the time they become a Partnership member, Partnership will seek an agreement with an out-of-network provider to cover hospice services.

a. An agreement with an out-of-network hospice provider will require the hospice provider to submit necessary documentation for Partnership to ensure that hospice services are provided in accordance with coverage policy, including medical necessity.
b. For out-of-network hospice providers, Partnership will ensure the hospice provider has Medicare certification, is licensed by the California Department of Public Health (CDPH), and has a National Provider Identifier (NPI) prior to payments of claims.
c. To avoid possible delays in hospice services with out-of-network hospice providers, while Partnership confirms hospice provider qualifications and enters into an agreement with the serving hospice provider, Partnership shall ensure the agreement start date commences with the start of services for those providers who meet necessary criteria.
    1) For providers who are not deemed eligible, a referral to Partnership's Care Coordination department shall occur so that Members are referred timely to an in-network hospice provider.
d. A Partnership Member who lives in an area remote from Medi-Cal Hospice providers may be cared for under the intensive palliative care benefit at a higher reimbursement rate as described in policy MPUP3137 Palliative Care: Intensive Program (Adult).

2. The hospice Provider is responsible for the coordination of hospice services. To ensure proper hospice claim processing and reimbursement, all licensed and certified hospice providers must submit the Medi-Cal Hospice Program Election Notice form *DHCS 8052* (Attachment A) to Partnership **within five calendar days** of a Medi-Cal Member's certification and election of hospice services.
    a. In instances where the hospice provider does not timely submit the election form to Partnership, Partnership is not obligated to cover and pay for the days of hospice care from the hospice admission date to the date the election form is submitted to and accepted by Partnership. These non-covered days are a hospice provider's liability, and the hospice provider cannot bill the Member for them.
    b. DHCS and Partnership may conduct medical and site reviews, such as prepayment review, and/or request additional information as part of our claims processing and Utilization Management functions regarding a Member's certification and election, including supporting documentation.
    c. While no Treatment Authorization Request (TAR) is required to elect hospice care, Partnership will conduct a prepayment review of each claim to verify that the appropriate documentation has been received in order to avoid fraud, waste, and abuse.
        1) See section VI.E. below for further clarification of TAR requirements for inpatient care.
        2) For Mmembers electing hospice in a home or facility (outside of the inpatient setting), the following documents may be required to assure appropriateness for hospice care:
            a) Properly and completely filled out hospice election form.
            b) Medical record of a non-hospice clinician caring for the Mmember that indicates the diagnosis and prognosis of the patient (for example, an oncologist for a Mmember with cancer, a cardiologist for a Mmember with heart failure).
            c) Record of tThe in-person hospice medical director or nurse visit with the Mmember: progress note.
            d) The attestation of the hospice medical director that the Mmember has a terminal medical condition with less than 6 months to live.
            e) The reason that this member cannot be cared for by a hospice contracted by Partnership.

f) (For recertification only):
   i. A copy of the completed POLST form

C. Hospice Benefit
1. Members who elect hospice become case managed Direct Members at Partnership as described in policy MPUP3039 Direct Members.
   a. The status change effective date is the date the hospice election form was signed by the Member or Authorized Representative.
2. All services related to the terminal illness must then be provided or authorized by the hospice provider.
   a. Note that palliative items or services in the context of medical hospice benefits are defined separately from palliative care services as referenced in the DHCS Palliative Care guidelines *(palli care)* or as defined in DHCS APL 18-020 *Palliative Care* (or subsequent revisions).
3. Partnership facilitates Member election of hospice care services by engaging in practices that avoid unnecessary delays and complications, while also placing appropriate safeguards to validate Member elections and to prevent Fraud, Waste, and Abuse.
4. Members who elect hospice care are entitled to curative treatment for conditions unrelated to their terminal illness. Services not related to the terminal illness are the responsibility of Partnership. The Member can continue to obtain services that are unrelated to the terminal illness from any Medi-Cal provider subject to Partnership's Treatment Authorization Request (TAR) processes. (Refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process for a list of services that require a TAR.)
5. A Member under 21 years of age may be eligible for hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302, as detailed in CMS Letter #10-018. For more information on services under EPSDT see Partnership policy MCCP2022 Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Services.
   a. Hospice and palliative care is available for California Children's Services (CCS)-eligible children as detailed in CCS Numbered Letter (NL) 06- 1011 Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care and in CCS NL 12-1119 Palliative Care Options for CCS Eligible Children.
      1) For more information on CCS services for Partnership Members, see policy MCCP2024 Whole Child Model For California Children's Services (CCS).
      2) For more information on pediatric palliative care services, see policy MCUP3140 Palliative Care: Pediatric Program for Members Under the Age of 21
      3) Partnership will facilitate Continuity of Care as described in policies MCCP2024 Whole Child Model For California Children's Services (CCS) and MCCP2014 Continuity of Care.
   b. Hospice care, if elected, for children with terminal illnesses requires close consultation and coordination between Partnership (the Managed Care Plan), local CCS programs (when applicable), and/or other caregivers. Hospice counseling services, including grief, bereavement, and spiritual, may be necessary during this transition and will be provided as part of hospice care services as described below at VI.C.6.
6. The following services are part of the hospice benefit and separate payment is not made. The hospice provider is responsible for having contracts with the appropriate providers and for paying the rate agreed upon in the contract for the service. Payment for these services comes out of the hospice per diem. The hospice provider must authorize all of the services related to care of the terminal illness. Physician, and or other Medi-Cal benefits and services not described below must be billed to Partnership separately.
   a. Nursing services
   b. Physical, occupational, and speech therapy
   c. Medical social services under the direction of a physician

d. Home health aide and homemaker services
e. Medical supplies and durable medical equipment
f. Medications and infusion therapy (based on the Hospice Formulary)
g. Hospice physician services
h. Counseling services related to the adjustment of the Member's approaching death, including bereavement, grief, dietary, and spiritual counseling
i. Continuous Nursing services which may be provided on a 24-hour basis only during periods of crisis and only as necessary to maintain the terminally ill Member at home.
j. Inpatient respite care provided on an intermittent, non-routine and occasional basis for up to five consecutive days at a time in a hospital, SNF or hospice facility
k. Short-term in-patient care for pain control or symptom management in a hospital, SNF or hospice facility (Note that general inpatient care under the hospice benefit is not equivalent to a hospital level of care under the Medicare hospital benefit)
l. Nutritionist services
m. Medical transportation

7. Due to the highly specialized services provided by hospices, federal law mandates that the hospice designate an interdisciplinary group to plan, provide, and/or supervise the care and services offered by the hospice provider.
8. Skilled nursing care may be needed by a Member whose home support has broken down, making it no longer appropriate to furnish needed care in the home setting.
9. Hospice services are not categorized as long term care (LTC) services, regardless of the Member's expected or actual length of stay in a nursing facility while also receiving hospice care.
10. Payment and/or hospice care services coverage may be denied if it is determined, based on documentation, that the hospice care services are not medically necessary or the Member is not terminally ill, with liability placed on the hospice Provider.

D. Services Not Covered by a Hospice Provider
1. Private pay room and board or residential care
2. Acute in-patient hospitalization unrelated to the terminal illness
3. Level A or Level B Nursing Facility for unrelated issues
4. Physician and/or consulting physician services not related to the terminal illness or physician services where the physician is not an employee of hospice or providing services under an arrangement with the hospice
5. Other necessary services for conditions unrelated to the terminal illness

E. Treatment Authorization Requests (TARs) for Inpatient Care
1. A Partnership TAR is <u>not</u> required for the following services:
   a. Hospice physician services
   b. Routine home care
   c. Continuous home care*
   d. Respite Care*
   e. Hospice Care room and board provided in a SNF or ICF
      1) If a Member currently resides in an Intermediate Care Facility-Developmentally Disabled (ICF-DD) facility or is admitted to an ICF-DD facility, Partnership continues to be financially responsible for the ICF-DD per diem payment.

   *Note: Although no TAR is required, Partnership may require documentation of medical justification for continuous home care and/or respite home care following the provision of general inpatient and continuous care. If documentation does not support the levels of care, reimbursement may be reduced to the rate for routine home care, in which case the hospice provider may submit an appeal for reconsideration of payment with additional documentation of the medical necessity for the increased level of care.

2. Only general inpatient care is subject to prior authorization, regardless of whether the services are to be rendered by an in-network and out-of-network provider, and the following documents must be submitted to Partnership with the TAR:
   a. A written prescription signed by the Member's attending physician
   b. Justification for the general inpatient care level of care
   c. A copy of the certification of the Member's terminal condition
   d. A copy of the written initial plan of care; AND
   e. A copy of the Member's signed election form
3. Because the Medi-Cal Fee-For-Service (FFS) program does not permit prior authorization of hospice services, except for inpatient admissions, as outlined in state law, Partnership adheres to the same utilization review standards as required by federal law. Hospice providers must submit the Medi-Cal Hospice Program Election form DHCS 8052 (Attachment A) and addendum forms containing the necessary information and appropriate signatures to Partnership as previously outlined at VI.B.2.
4. For non-emergency inpatient care related to the terminal illness, the Hospice provider must submit a TAR using an appropriate inpatient code and attach a copy of the Hospice Inpatient Information Form.
5. Emergency admission related to the terminal illness is reviewed for medical necessity by the Partnership Utilization Management (UM) nurse and if appropriate, a length of stay assigned. Partnership must be notified within 24 hours of any emergency admission related to the terminal illness. The hospice provider must submit a TAR using an appropriate inpatient code and attach a copy of the Hospice Inpatient Information Form.
   a. The hospice provider is financially responsible for emergency room services related to complications of the terminal illness if the Hospice provider authorized the service.
   b. Partnership continues to authorize and be financially responsible for outpatient, inpatient and emergency medical services not related to the terminal illness.
6. For Members with Medicare/Medi-Cal coverage, Medicare is the first payer for the hospice daily care. Medi-Cal (Partnership) is financially responsible for medications not related to the hospice diagnosis[1] and the room and board per diem if the Member resides in a LTC facility (bed code 658 for SNF or ICF). ~~The claim must include a copy of the Medicare Explanation of Medical Benefits (EOMB) that shows that Medicare payment was made for hospice services during the period covered.~~
   a. For Members with Medicare/Medi-Cal coverage, the hospice provider must submit the Medi-Cal Hospice Program Election form *DHCS 8052* (Attachment A) and addendum forms containing the necessary information and appropriate signatures to both DHCS and Partnership when a dual eligible Member elects the Medicare hospice benefit.
7. For Members with other coverage, Medi-Cal is the secondary payer and the hospice must submit a copy of the Explanation of Benefits (EOB) from the other insurer when billing Medi-Cal.

F. Hospice Periods of Care
   1. Hospice is a covered Medi-Cal benefit with the following periods of care:
      a. Two 90-day periods, beginning on the date of hospice election
      b. Followed by unlimited 60-day periods
   2. A period of care starts the day the patient receives hospice care and ends when the 90-day or 60-day period ends.

[1] Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy (prescription) benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 25-013, "Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage," and all medications (Rx and OTC) which are dispensed from pharmacies and covered under Medi-Cal Rx must be billed to the State Medi-Cal/DHCS-contracted pharmacy administrator instead of Partnership. Refer to the Partnership website page for pharmacy authorization criteria: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

3. A Member may elect to receive hospice care during one or more of the following periods: (1) an initial 90-day period; (2) a subsequent 90-day period; or (3) an unlimited number of subsequent 60-day periods.

G. Patient Certification and Recertification Required
1. After a Member has met criteria for admission to a hospice program (section VI.A. above), the hospice provider must maintain an initial certification for the first 90-day period that the patient is terminally ill. Written certification statements must be obtained from the medical director of the hospice or physician designee or the physician member of the hospice group, AND the Member's primary care physician)
2. At the start of each subsequent period of care, the hospice provider must maintain a recertification that the patient is terminally ill. For recertification, a written certification statement must be obtained from the medical director of the hospice or physician designee or the physician member of the hospice group.
   a. No more than 30 calendar days prior to the start of the third benefit period, and no more than 30 calendar days prior to every subsequent benefit period thereafter, a hospice physician or nurse practitioner (NP) is required to have a face-to-face encounter with every hospice patient to determine the continued eligibility of that patient. When an NP performs the encounter, the attestation must state that the clinical findings of that visit were provided to the certifying physician for use in determining whether the patient continues to have a life expectancy of six months or less.

H. Revocation of Hospice Care Services
1. An individual's voluntary election may be revoked or modified at any time during a benefit period.
   a. To revoke the election of hospice care, the Member or Authorized Representative must file a signed statement with the hospice agency revoking the individual election for the remainder of the benefit period, including the effective date of the revocation. The effective date may not be retroactive.
   b. The hospice provider must submit the Member's signed hospice revocation statement to Partnership within five calendar days.
   c. At any time after revocation or a discharge by the hospice for cause, a Member may execute a new election, if they meet hospice coverage eligibility requirements, and the 90/90/unlimited 60-day benefit periods of care will restart.
      1) If the Member re-elects hospice care, the hospice provider must submit a new hospice election form to Partnership.
   d. A Member or Authorized Representative may change the designation of a hospice provider once in each benefit period; this is not a revocation of the hospice benefit.
   e. Members who move their legal residence out of Partnership's service area must notify the hospice provider and shall be disenrolled from Partnership.
      1) If members are transferring care to a new managed care plan, Hospice providers must provide transferring members with a transfer summary, including essential information relative to the members' diagnoses, pain treatment and management, medications, treatments, dietary requirements, rehabilitation potential, known allergies, and treatment plan, which must be signed by the physician.
      2) Consequently, upon enrollment in a new managed care plan, a "change in designated hospice" must be initiated. This may be done only once per benefit period.

VII. REFERENCES:

A. Medi-Cal Guidelines - Hospice Care *(hospic)*
B. Title 22, California Code of Regulations (CCR) / Hospice Care 51349
C. Title 22, CCR ICF Sections 51118, 51120 and 51510; SNF 51121, 51123, 51124, 51215, 51511

D. Title 42 Code of Federal Regulations (CFR) Sections 418.28 and 418.30
E. Social Security Act 1812(d)(1)
F. Section 2302 of the Patient Protection and Affordable Care Act (ACA)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020 Palliative Care (12/07/2018)
H. DHCS APL 25-008 Hospice Services and Medi-Cal Managed Care (05/05/2025)
I. DHCS APL 25-013 Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage (09/18/2025)
J. California Children's Services (CCS) Numbered Letter (NL) 06-1011 Authorization of Medically Necessary Concurrent Treatment Services for CCS Clients Who Elect Hospice Care (10/07/2011)
K. CCS NL 12-1119 Palliative Care Options for CCS Eligible Children (11/18/2019)
L. Centers for Medicare and Medicaid Services (CMS) Letter 10-018 Hospice Care for Children in Medicaid and CHIP (09/09/2010)

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; 11/28/01; 01/15/03; 02/01/03 vs. code changes; 09/15/04; 09/21/05; 08/20/08; 04/21/10; 03/20/13 – effective 04/01/13; 03/18/15; 03/16/16; 03/15/17; 06/21/17; *09/12/18; 08/14/19; 08/12/20; 01/13/21; 11/10/21; 11/09/22; 11/08/23; 11/13/24; 01/14/26; 11/04/26

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

PREVIOUSLY APPLIED TO: N/A

****

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

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

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

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

State of California – Health and Human Services Agency
Department of Health Care Services

Medi-Cal Hospice Program Election Notice

Email to: MCHospiceClerk@DHCS.CA.GOV **Questions, call: (916) 552-9200**

Section 1			
Recipient Name:			
Email:	Phone Number:	Medi-Cal ID:	Date of Birth:
Address:	City:	State:	Zip Code:

Section 2	
I and/or the Legal Representative/Agent of the Medi-Cal recipient identified above understand the following:	
I have a terminal illness with a life expectancy of six months or less if the illness were to run its normal course.	Initials:
Hospice care services alleviate pain and suffering and are intended to treat symptoms rather than to cure illness. Recipients younger than 21 years of age may concurrently receive both hospice care and curative treatments of the hospice-related diagnosis. The Medi-Cal Hospice Services and benefits have been explained to me and/or my legal representative. I understand that only recipients younger than 21 years of age may receive both hospice services and curative treatment concurrently.	Initials:
By choosing hospice, I waive my right to payment for all Medi-Cal services, except for: 1) services provided by my elected hospice, 2) services provided by another hospice through an arrangement made by my elected hospice provider, 3) services provided by my attending physician if that physician is not employed by my elected hospice, or receiving any compensation from the hospice for those services. 4) services that are unrelated to my terminal diagnosis.	Initials:
I understand that for recipients ages 21 and over: 1) All my care will be provided by my elected hospice provider for my terminal diagnosis and related conditions. 2) I am not eligible to receive services for my terminal diagnosis and related conditions from providers other than my elected hospice provider or attending physician. 3) I am still eligible for services needed for conditions not related to my terminal diagnosis, and related conditions, such as provider examinations, drugs, or other medical care.	Initials:
I and/or the Legal Representative/Agent of the Medi-Cal recipient identified above, understand that I may revoke my hospice election at any time by signing a statement to that effect, and that both I and/or the Legal Representative/Agent and the hospice provider must inform DHCS by submitting the hospice revocation form signed by me. I understand my rights to other Medi-Cal services will resume on that date if I continue to be Medi-Cal eligible. (This revocation is not to be pre-dated or post-dated).	Initials:
I understand that if I reach a point of stability and can no longer be certified as terminally ill, I will return to the traditional Medi-Cal benefits as long as I am eligible for Medi-Cal.	Initials:

I understand that the elected Hospice provider is responsible for any Home Health, Private Duty Nursing, or Personal Care Services, if related to my terminal diagnosis, and related conditions. Medi-Cal benefits will cover care for treatments not related to the terminal diagnosis and related conditions.	Initials:

Section 3

Admitting Terminal Diagnosis and related conditions ICD-10 Code(s):		
Recipient is currently being admitted from a medical facility.	☐ Yes ☐ No	
Facility Name:		NPI Number:
Recipient is currently being admitted from home.	☐ Yes ☐ No	
Home Address:		NPI Number:
Recipient is transferring from another Home Hospice Agency.	☐ Yes ☐ No	
Agency Name:		NPI Number:
Recipient and/or the Legal Representative/Agent choice of attending physician.		
Attending Physician:		NPI Number:
I and/or the Legal Representative/Agent of the recipient identified above, certify that the recipient DOES NOT have an attending physician separate from the hospice physician. Therefore, the hospice physician is my choice as an attending physician.		Initials:

Section 4

Services currently being provided to recipient by other Agencies:

Home Health Services	☐ Yes ☐ No	Agency Name & NPI:
Private Duty Nursing Services	☐ Yes ☐ No	Agency Name & NPI:
Personal Care Services	☐ Yes ☐ No	Agency Name & NPI:
Elected Hospice Provider Name:		NPI Number:

Recipient and/or Legal Representative/Agent Statement
I, (Recipient's Name) _____, have read and understand the statements in this document. Recipient Signature: _____ Date: _____
I, (Legal Representative/Agent Name) _____, as the Legal Representative/Agent for (Recipient's Name) _____, have read and understand the statements in this document. Relationship to Recipient: _____ Legal Representative/Agent Signature: _____ Date: _____
Hospice Provider Statement
I, (Hospice Representative Name) _____, Hospice Representative for (Hospice Provider's Name) _____, understand that the The hospice provider is responsible for the coordination of services to ensure that there are no duplication of services. Hospice Representative Title: _____ Signature: _____ Date: _____

State of California – Health and Human Services Agency Department of Health Care Services

Patient Notification of Hospice Non-Covered Items, Services, and Drugs

Patient Name: _____ **MRN:** _____

Hospice Agency: _____ **Date Furnished:** _____

(Hospice must furnish this addendum within 5 days if requested at the time of hospice election and within 72 hours if requested during the course of hospice care.)

Diagnoses Related to Terminal Illness and Related Conditions (hospice is responsible to cover all items, services, and drugs):

1.	4.
2.	5.
3.	6.

Diagnoses Unrelated to Terminal Illness and Related Conditions:

1.	4.
2.	5.
3.	6.

Non-covered items, services, and drugs determined by hospice as not related to my terminal illness and related conditions:

Note: The hospice provider makes the decisions whether or not conditions, items, services, and drugs are related to the terminal diagnosis for each beneficiary. This addendum should be shared with other healthcare providers from whom you seek items, services, or drugs unrelated to your terminal illness and related conditions to assist in making treatment decisions.

Right to Immediate Advocacy

You have the right to appeal the decision of the hospice agency on items not being covered because the hospice provider has determined they are unrelated to the individual's terminal illness and related conditions. If you are enrolled in a managed care plan, you have the right to contact the Managed Care Ombudsman at (888) 452-8609. Email: MMCDOmbudsman@dhcs.ca.gov.

Acknowledgement of non-covered items services, and drugs not related to my terminal illness and related conditions.

The purpose of this addendum is to notify the beneficiary (or representative) in writing of those conditions, items, services, and drugs that hospice will not be covered because the hospice provider has determined they are unrelated to the individual's terminal illness and related conditions not being covered by hospice.

Signing this addendum (or its updates) is only an acknowledgement of the receipt of the addendum (or its updates) and is not necessarily in agreement with the hospice provider's determinations.

Beneficiary/Representative Signature (Date signed)

The beneficiary is unable to sign (reason):

Witness Signature (Date signed)

Partnership HealthPlan of California

Application to be a Contracted Hospice Provider

Please submit the following to contracting@partnershiphp.org

Organization Information

1. **Name of Organization**

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

   Title

   Phone

   e-mail

   Billing Department
   Name

   Title

   Phone

   e-mail

   Hospice Program Director

   Name

   Title

   Phone

   e-mail

   Hospice Medical Director (Hospice Medical Director should go through the Partnership Credentialing process)
   Name

   Title

   Phone

   e-mail

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

   Yes ☐ No ☐

4. Medi-Cal provider number:

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

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

   Medicare:

   Medi-Medi:

   Medi-Cal only:

   Uninsured:

   Total:

   Not applicable ☐

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

   Medicare:

   Medi-Medi:

   Medi-Cal only:

   Uninsured:

   Total:

   Not applicable ☐

8. Does your organization provide hospice services to children? ☐ Yes ☐ No

   If Yes, please describe level of experience and training in pediatric hospice/palliative care:

Program Information

9. What strategies will your organization use to identify patients who may be eligible for hospice services?

10. What geographic areas/counties will your hospice program serve? Please note any distance requirements.

11. Describe how your organization will partner with local palliative care providers and/or home health agencies.

12. Attachments:

    a. Medicare Hospice Certification: Please attach evidence

    b. California Department of Public Health Hospice License: Please attach evidence

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3114</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Physical, Occupational and Speech Therapies</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 06/20/2012</td><td colspan="3">Next Review Date:
~~08/12/2027~~11/04/2027 Last Review Date: ~~08/12/2026~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~08/12/2026~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCCP2024 – Whole Child Model for California Children's Services (CCS)
C. MCUP3125 – Gender Dysphoria/ Surgical Treatment
D. MPUG3011 – Criteria for Home Health Services
E. MCUP3113 – Telehealth Services

II. IMPACTED DEPTS:

~~A. Health Services~~
~~B.~~A. Claims
~~C.~~B. Member Services

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
B. 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.
C. Occupational Therapy (OT) provides task-oriented therapeutic activities and exercises designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease or injury; or to help an individual relearn daily living skills or compensatory techniques to improve the level of independence in the activities of daily living.
D. Physical Therapy (PT) is a service with an established theoretical and scientific base and widespread clinical applications in the restoration and promotion of optimal physical function. Physical therapists diagnose and manage movement dysfunction and enhance physical and functional abilities.
E. Physical and Occupational therapy services are designed to:
   1. Assess the existence or extent of a medical condition;
   2. Assess the impact of a medical condition, injury or surgery upon function and role performance;
   3. Restore deterioration in physical function and physical performance of activities of daily living from previous function, due to medical condition, injury, or surgery.
   4. Treat physical limitations or physical dysfunctions in physical activities or activities of daily living, due to a medical condition, surgery or procedure.
   5. Restore deterioration in cognitive skills that impact the ability to perform activities of daily living from previous function, due to medical condition, injury or surgery and treat sensory dysfunctions

due to a medical condition, injury or surgery that impact oral/pharyngeal intake or lead to bodily damage.

F. Speech Therapy (ST): The treatment of speech, swallowing and communication disorders. The approach used depends on the disorder. It may include physical exercises to strengthen the muscles used in speech and swallowing (oral-motor work), speech drills to improve clarity, or sound production practice to improve articulation.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the treatment authorization process for physical, occupational and speech therapies in the outpatient setting.

VI. POLICY / PROCEDURE:

A. Criteria for Remote PT, OT, and ST:
PT, OT, and ST services may be provided virtually, if the service provided does not require in-person or manual examination, manipulation or therapeutic techniques (see CMS and DHCS policies and Partnership policy MCUP3113 Telehealth Services).

B. General Guidelines for Authorization of PT, OT and ST.
1. No Referral Authorization Form (RAF) is required for PT, OT, or ST services, but services must be ordered through a written prescription of a licensed physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, Nurse Practitioner or Dentist).
2. For all Members, no TAR or RAF is required for the initial evaluation.

C. Services That Do NOT Require a TAR
~~1.~~ For members ages 21 and older, Partnership does *not* require Treatment Authorization Requests (TARs) from contracted providers for the first twelve (12) PT, OT, or ST visits per member, within a rolling twelve (12) month period, limited to one (1) visit per day. ~~PT, OT, or ST for:~~
~~2. Members age 21 and over: No TAR required for up to 12 visits for a specific diagnosis (limit one visit per day) in a rolling 12-month period of time.~~
~~3.~~1. ~~A TAR will be required for services in excess of 12 visits for a specific diagnosis.~~

D. Services That Require a TAR
1. After an initial evaluation, Partnership does require a TAR for PT, OT, or ST services for the following circumstances:
   a. Members under age 21
   ~~a.~~b. Members age 21 or over ~~the age of 21~~, when additional therapy services beyond twelve (12) visits are being requested
   ~~b.~~c. Non-contracted Providers
   ~~c.~~d. Home Health Services (A TAR is required for all ages for all PT, OT, or ST services provided through a home health agency. Refer to policy MPUG3011 Criteria for Home Health Services.)
2. Submission Guidelines When a TAR is Required
   a. Partnership Members can be referred by a physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, Nurse Practitioner or Dentist) for one consultation visit, through written prescription, for services to be rendered by a qualified Medi-Cal provider acting within the scope of their practice. As noted above, no TAR or RAF is required for the initial consultation/ evaluation.
   b. Following the initial evaluation, the service provider must submit a TAR for the requested services. The TAR should document, at a minimum, the following information:
      1) Medical diagnosis necessitating the service with a summary of medical condition

2) Related medical conditions

~~2)~~3) Current functional status and measurable deficits

~~3)~~4)Functional limitations
~~4)~~5)Dates and length of treatment
~~5)~~6)Therapeutic goals of treatment and current functional status of the patient with respect to these goals
~~6)~~7)Dates of planned progress review
~~7)~~8)Specific services to be rendered (e.g. evaluation, treatment, modalities)

c. Partnership authorizes ancillary services on a case-by-case basis, provided that medical necessity has been demonstrated in the submitted documentation.

d. The Nurse Coordinators/ Utilization Management (UM) staff review each TAR and consult with the referring physician or ancillary provider as needed to determine the medical necessity of the requested services. If the Nurse Coordinator is unable to approve the requested service based upon information available, the case is submitted to one of Partnership's reviewing physicians for consideration. Determination that a requested service is not medically necessary may only be rendered by a physician.

1) Occupational and physical therapy may be considered medically necessary when:
   a) There is a reasonable expectation, determined by a physical or occupational therapist and the attending physician, that in a predictable period of time the therapy will achieve measurable improvement in the patient's mobility or activities of daily living.
   b) Measurable reversal of deterioration from previous levels of cognitive or communication functions.
   c) The services are used to assess the existence or extent of impairment due to a medical condition.
   d) A "reasonable expectation" referenced above shall be based upon evidence-based medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate and benefit from the therapy process.
   e) Any episode of physical or occupational therapy is not medically necessary and will not be approved when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.

2) Speech Therapy services for Members age 21 or over may be considered medically necessary based upon the receipt of appropriate medical documentation demonstrating that the Member and services meet the following criteria:
   a) Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.
   b) Appropriate adult candidates for speech therapy must be able to participate in and/or benefit from the therapy process, have adequate attention span, cooperation and endurance to participate, and demonstrate behavior conductive to engaging in the process.
   c) Speech therapy as conversational therapy/ voice training should be considered prior to any pitch changing surgery for transgender or gender nonconforming beneficiaries as discussed in policy MCUP3125 Gender Dysphoria/Surgical Treatment.
   d) Speech therapy services are reviewed in accordance with clinical guidelines when considered medically necessary only when there is reasonable expectation that they will achieve significant, measurable improvement in the Member's communication, cognition or swallowing in a reasonable and predictable period of time as determined by the treating therapist and referring provider.
   e) A "reasonable expectation" referenced above shall be based upon evidence-based medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate in and benefit from the therapy process.

f) A course of speech therapy shall be determined to be no longer medically necessary when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.

3) The following are examples of conditions where therapy may be considered medically necessary based upon the receipt of appropriate medical documentation:
   a) Musculoskeletal Pathology or Dysfunction, including limitations in joint range of motion and/or mobility, deterioration from previous function of muscle strength and/or decreased endurance, soft tissue dysfunction, alterations in postural control and alignment.
   b) Neuromuscular Pathology or Dysfunction, including deterioration from previous function of gross and/or fine motor coordination, alterations in tone- increased or decreased, deterioration from previous function of motor planning skills, deterioration from previous function of balance, loss of selective motor control, decrease in bilateral integration.
   c) Neurocognitive Pathology or Dysfunction, including sensory dysfunctions regarding food textures and oral tactile defensiveness when impacting overall health; deterioration from previous function in cognitive, self-care or adaptive skills.
   d) Pathology or Dysfunction of the Vascular System, including primary or secondary lymphedema, edema and venous stasis.
   e) Pathology or Injury to Skin, including burns and/or sores following injury or surgery, open wounds.
   f) Assessments of Impairment Related to Medical Condition, including appropriate assessments as part of a multidisciplinary or interdisciplinary team of motor skills disorders and physical functions; appropriate individual assessments of post therapy functions and periodic review of appropriate maintenance activities for the patient and family
   g) Design of Maintenance Activities, including physical exercise, drills, techniques that a patient performs outside of therapy or after any therapy has concluded.

4) The following services are generally not considered “medically” necessary or are not covered:
   a) Recreational therapy
   b) Activities that provide diversion or general motivation
   c) Exercise programs for healthy individuals, including development and delivery of exercise programs; assisted walking
   d) Programs for communication/cognitive deficits from developmental disorders - where deficits do not impact overall health
   e) Maintenance physical or occupational therapy to preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of the treatment plan have been achieved and when no further functional progress is apparent or expected to occur. Maintenance does not require the skills of a qualified provider of physical or occupational therapy services. The patient is responsible for practicing learned drills, techniques and exercises to preserve his or her present level of function and prevent regression of that function. Maintenance includes ongoing supervision of independent exercise programs, supervision/ observation of activities of daily living, and supervision of independent transfer activities.
      i. For Members residing in a skilled nursing facility, the facility must provide maintenance therapy that is included in the room and board fee and not separately reimbursable.

e. If therapy is required beyond the visits initially approved, a new TAR must be submitted.
f. The approval of continuation of therapy will be based on documentation of measurable improvement in the patient's condition in a reasonable and predictable period of time, based on the written care plan and the clinical judgment of the treating physical or occupational therapist with the patient's referring physician. Regular evaluation of the patient is required to determine that continuation of therapy is medically appropriate. The medical need for continuation must be documented on the TAR submitted to Partnership.
    1) Continued therapy will not be approved once a Member has met established treatment goals, or has stabilized and is not expected to continue to make significant gains, based on the written care plan and the clinical judgment of the treating PT or OT in conjunction with the patient's referring physician.

3. Speech Therapy Related to Hearing Loss for Members Under 21 Years of Age:
    a. Partnership Members who have a California Children's Services (CCS)-eligible condition are enrolled in the Whole Child Model (WCM) program. The WCM program integrates CCS program-covered services with Members' regular Medi-Cal benefits to provide seamless care for children and youth.
        1) Partnership covers the medical condition of hearing loss for hearing tests, evaluations by audiologists, and medical evaluations by head and neck surgeons and physicians in other clinical specialties.
        2) Under the WCM program, Partnership also covers speech and language therapy for hearing impaired children who have hearing aids or need to use sign language, but do not have physical impairment of the articulators. For these conditions, the Member should be referred to CCS in the county of residence to determine program eligibility. Once CCS program eligibility is established, all medically necessary covered services, including case management and authorization of services, for CCS-eligible conditions will be provided by Partnership under the WCM program. See policy MCCP2024 Whole Child Model for California Children's Services (CCS).
    b. Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.
    c. A Member may receive services through the Local Educational Agency (LEA) but is not required to do so prior to receiving therapy benefits under Partnership. If a Member is receiving medically necessary services through the LEA, Partnership will coordinate with the LEA to provide additional services to the extent determined to be medically necessary. For example, if it is determined that the Member medically requires speech therapy three times per week, and he/she receives speech services by the LEA one time per week, Partnership will approve the additional two visits per week if criteria are met.

VII. REFERENCES:

A. Social Security Act Section 1905(r)
B. Medi-Cal Provider Manual/ Guidelines: Physical Therapy (*phys*); Occupational Therapy *(occu)*; Speech Therapy *(speech)*; Medicine: Telehealth (*medne tele*), Home Health Agencies *(home hlth)*
C. California Children's Services (CCS) Medical Eligibility
D. Consolidated Appropriations Act, 2026 (*extends Medicare telehealth flexibilities through 2027*)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

Policy/Procedure Number: MCUP3114	**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Physical, Occupational and Speech Therapies	☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/20/2012	**Next Review Date:** ~~08/12/2027~~11/04/2027 **Last Review Date:** ~~08/12/2026~~11/04/2026

X. REVISION DATES: 01/20/16; 11/16/16; 11/15/17; *02/13/19; 03/11/20; 06/10/20; 01/13/21; 02/09/22; 02/08/23; 03/13/24; 08/14/24; 09/10/25, 08/12/26; 11/04/26

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

PREVIOUSLY APPLIED TO: N/A

****

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

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

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCUP3128				**Lead Department: Health Services** **Business Unit:** Utilization Management	
Policy/Procedure Title: Cardiac Rehabilitation				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 02/18/2015 Effective Date: 08/01/2015			**Next Review Date:** ~~11/11/2026~~11/04/2027 **Last Review Date:** ~~11/12/2025~~11/04/2026		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☐ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~11/12/2025~~11/04/2026	

I. RELATED POLICIES:

A. MCUP3052 – Medical Nutrition Therapy (MNT) Services
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Cardiac rehabilitation is a medically supervised program that helps improve the health and well-being of people who have heart problems.
   1. Phase I cardiac rehabilitation takes place during the acute hospitalization or in an acute rehabilitation setting, of the index diagnosis.
   2. Phase II cardiac rehabilitation takes place in a monitored, supervised outpatient setting.
   3. Phase III cardiac rehab takes place in an outpatient setting, in a supervised environment without cardiac monitoring, including organized group classes.
   4. Phase IV cardiac rehab is a lifetime maintenance of physical conditioning, fitness and wellness, either at home, or other community-based setting.
B. Cardiac rehabilitation programs provide cardiac rehabilitation, including exercise training, education on heart healthy living, and counseling to reduce stress and help Members return to an active life.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

This policy defines covered services and medical necessity criteria for cardiac rehabilitation services. Cardiac rehabilitation services have been found to reduce morbidity and mortality from cardiovascular disease.

VI. POLICY / PROCEDURE:

A. Eligibility
   1. Appropriately identified adults with full-scope Medi-Cal are eligible for Phase II Cardiac Rehabilitation services, with the following diagnoses:

a. Myocardial infarction within the past 12 months
b. Coronary artery bypass surgery in the past 12 months
c. Current stable angina pectoris
d. Heart valve repair or replacement in the past 12 months
e. Coronary angioplasty performed or coronary stent placed in the last 12 months
f. A heart or heart-lung transplant in the last 12 months
g. Intermittent claudication due to atherosclerotic disease, with current symptoms.
h. Stable chronic heart failure with an ejection fraction of less than 35% and New York Heart Association (NYHA) class II to IV symptoms in spite of optimal therapy for at least 6 weeks.
i. Other cardiac or major pulmonary surgery, in the past 12 months
j. Sustained Ventricular Tachycardia, Ventricular Fibrillation or survivor of sudden cardiac death.

2. Partnership HealthPlan of California considers cardiac rehabilitation experimental and investigational for all other indications including:
   a. Atrial Fibrillation (other than post Maze procedure)
   b. Atrial Fibrillation with ablation (other than post Maze procedure)
   c. Takotsubo (stress) Cardiomyopathy
   d. Uncompensated congestive heart failure
   e. Uncontrolled arrhythmias (other than PVCs and PACs)
3. Phase II services are only covered when ordered by a licensed physician and when performed in a facility/program meeting Medicare's standards for cardiac rehabilitation programs. These standards include:
   a. The facility meets the definition of a hospital outpatient department or a physician-directed facility.
   b. The facility has available for immediate use all the necessary cardio-pulmonary emergency and therapeutic life-saving equipment to perform defibrillation, administer oxygen and perform cardiopulmonary resuscitation.
   c. The program is conducted in an area set aside for the exclusive use of the program while it is in session.
   d. The program is staffed by personnel necessary to conduct the program safely and effectively, who are trained in both basic and advanced life support techniques and in exercise therapy for coronary disease.
   e. Services of non-physician personnel must be furnished under the direct supervision of a physician. Direct supervision means that a physician must be in the exercise program area or immediately available and accessible for an emergency at all times the exercise program is conducted. It does not require that a physician be physically present in the exercise room itself, provided the contractor does not determine that the physician is too remote from the patients' exercise area to be considered immediately available and accessible. The examples below are for illustration purposes only. They are not meant to limit the discretion of the contractor to make determinations in this regard.
   f. The non-physician personnel are employees of either the physician, hospital, or facility conducting the program and their services are "incident-to" a physician's professional services.
4. Prior to referral for Phase II cardiac rehabilitation services, a cardiologist or primary care physician with experience and training in evaluation and assessment of cardiovascular disease must complete a diagnostic evaluation of the prospective~~ed~~ cardiac rehabilitation participant. This will include:
   a. Evaluation of chest pain and atypical chest pain. This may include performance of a cardiac stress test or review of a recent stress test
   b. Pre or post-operative evaluation of cardiac operations (if applicable)

c. Review and reconciliation of all medications
d. Review of medical history, including social history, medical history, surgical history
e. Specific recommendations for the exercise regimen to be used in the cardiac rehabilitation program. This can lead to either a prescription or a referral to cardiac rehabilitation. Partnership does not require submission of a Referral Authorization Form (RAF), but Phase II cardiac rehabilitation services do require a TAR as detailed in VI.A.5. below. Partnership may audit the clinical documents to ensure the criteria required in a. – e. have been met.

5. Requests for pediatric cardiac rehabilitation are reviewed on a case-by-case basis in accordance with our Treatment Authorization Request (TAR) Review Process described in policy MCUP3041. Pediatric cases require consultation with an appropriate specialist (e.g. pediatric cardiologist) and must take place at an appropriate facility for pediatric rehabilitation.
6. **A Treatment Authorization Request (TAR) is required for Phase II cardiac rehabilitation services.**
   a. Current Procedural Terminology (CPT)-4 codes 93797 and 93798 may not be reimbursed in the same calendar month as Healthcare Common Procedure Coding System (HCPCS) codes G0422 and G0423, for any provider. Similarly, HCPCS codes G0422 and G0423 may not be reimbursed in the same calendar month as CPT-4 codes 93797 and 93798, for any provider.
   b. Modifiers SA, U7, 24, 25 and 99 are all allowable for CPT-4 codes 93797 and 93798, as well as HCPCS codes G0422 and G0423.
   c. Qualified Practitioners
      1) Licensed practitioners who are eligible for reimbursement of CPT-4 codes 93797 and 93798 include physicians, physician assistants, nurse practitioners and physical therapists.
      2) Licensed practitioners who are eligible for reimbursement of HCPCS codes G0422 and G0423 include physicians, physician assistants, nurse practitioners, psychologists, licensed clinical social workers, marriage and family therapists and physical therapists.
7. For all other indications (individuals who are too debilitated to exercise, and secondary prevention after transient ischemic attack or mild, non-disabling stroke), because of insufficient evidence in the peer-reviewed information, Partnership considers cardiac rehabilitation experimental and investigational and therefore not a benefit.

B. Covered Services
1. Phase I cardiac rehabilitation services are performed while the Partnership Member is in the acute hospital or acute rehab setting. They are integral to the inpatient care provided to Partnership Members for appropriate indications.
2. Phase II cardiac rehabilitation services are performed in an outpatient setting. Services may include:
   a. Medically-supervised exercise program
   b. Nutritional counseling
   c. Stress management
   d. Smoking cessation counseling and support services
3. Phases III and IV cardiac rehabilitation, by themselves, are not covered.
4. Phase II cardiac rehabilitation services do not include the diagnostic evaluation that is required prior to referral to cardiac rehabilitation, which is covered separately.
5. The medically necessary frequency and duration of cardiac rehabilitation is determined by the Member's level of cardiac risk stratification:
   a. High-risk Members have any of the following:
      1) Decrease in systolic blood pressure of 15 mm Hg or more with exercise; or
      2) Exercise test limited to less than or equal to 5 metabolic equivalents (METS); or
      3) Marked exercise-induced ischemia, as indicated by either anginal pain or 2 mm or more

ST depression by electrocardiography (ECG); or
4) Recent myocardial infarction (less than 6 months) which was complicated by serious ventricular arrhythmia, cardiogenic shock or congestive heart failure; or
5) Resting complex ventricular arrhythmia; or
6) Severely depressed left ventricular function (ejection fraction less than 30 %); or
7) Survivor of sudden cardiac arrest; or
8) Ventricular arrhythmia appearing or increasing with exercise or occurring in the recovery phase of stress testing.

b. Program Description for High-Risk Members:
1) 36 one-hour sessions (e.g., 3 times per week for 12 weeks) of supervised exercise with continuous telemetry monitoring
2) Create an individual out-patient exercise program that can be self-monitored and maintained
3) Educational program for risk factor/stress reduction; classes listed below covered for up to 3 months.
4) If no clinically significant arrhythmia is documented during the first 3 weeks of the program, the provider may have the Member complete the remaining portion without telemetry monitoring.

c. Intermediate-risk Members have any of the following:
1) Exercise test limited to 6-9 METS; or
2) Ischemic ECG response to exercise of less than 2 mm of ST depression

d. Program Description for Intermediate-Risk Members:
1) 24 one-hour sessions or less of exercise training with or without continuous ECG monitoring
2) Geared to define an ongoing exercise program that is "self-administered."
3) Educational program for risk factor/stress reduction; classes listed below in VI.B.6. c. – f. covered for up to 3 months.

e. Low-risk Members have exercise test limited to greater than 9 METS

f. Program Description for Low-Risk Members:
1) Six 1-hour sessions involving risk factor reduction education and supervised exercise to show safety and define a home program (e.g., 3 times per week for a total of 2 weeks or 2 sessions per week for 3 weeks).
2) Educational program for risk factor/stress reduction; classes listed below covered for up to 3 months.

g. Intensive Cardiac Rehabilitation (ICR)
1) ICR is a Centers for Medicare & Medicaid Services (CMS) designation (through the National Coverage Determination [NCD] process) for certain programs demonstrated to have:
a) Accomplished one or more of the following for its patients:
i. Positively affected the progression of coronary heart disease
ii. Reduced the need for coronary bypass surgery, OR
iii. Reduced the need for percutaneous coronary interventions; AND
b) Accomplished a statistically significant reduction in five or more of the following measures for patients from their levels before CR services to after CR services:
i. Low density lipoprotein
ii. Triglycerides
iii. Body mass index
iv. Systolic blood pressure

v. Diastolic blood pressure
vi. The need for cholesterol, blood pressure, and diabetes medications

2) Proof of CMS designation should accompany the TAR
3) ICR sessions are limited to 72 one-hour sessions, up to 6 sessions per day, over a period of up to 18 weeks.

6. Procedure codes covered:
   a. 93797 – Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG Monitoring (For intermediate-risk and low-risk Members)
   b. 93798 – Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG Monitoring (for high-risk Members)
   c. G0422 – Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session (This code will only be paid to programs approved by CMS, as described above).
   d. G0423 – Intensive cardiac rehabilitation; with or without continuous ECG monitoring without exercise, per session (This code will only be paid to programs approved by CMS, as described above.)
   e. Nutrition Therapy services are also covered, as defined in policy MCUP3052 Medical Nutrition Therapy (MNT) Services.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Rehabilitative Services *(rehab)*
B. Up-To-Date: Lynne T Braun, PhD, RN, CNP, Nanette K Wenger, MD, Robert S Rosenson, MD, "Cardiac Rehabilitation Programs" updated 5/15/2024.

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

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

X. REVISION DATES: 06/17/15; 05/18/16; 05/17/17; *08/08/18; 09/11/19; 09/09/20; 09/08/21; 09/14/22; 10/11/23; 10/09/2; 11/12/25; 11/04/26

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

PREVIOUSLY APPLIED TO: N/A

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3130</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Osteopathic Manipulation Treatment</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 06/17/2015
Effective Date: 10/01/2015</td><td colspan="4">Next Review Date: ~~11/12/2026~~11/04/2027
Last Review Date: ~~11/12/2025~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 11/12/2025</td></tr>
</table>

I. RELATED POLICIES:
MPCR13C - Osteopathic Manipulation Treatment Credentialing

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

III. DEFINITIONS:
A. Osteopathic medicine is a branch of the medical profession in the United States, whose physicians are known as Doctors of Osteopathy (DO).
B. Osteopathic physicians are trained in Osteopathic Manipulative Treatment (OMT), also known as Osteopathic Manipulative Medicine (OMM), a core set of manual manipulative techniques used to treat somatic dysfunction.
C. Somatic dysfunction means an impaired or altered function of related components of the somatic system, which is the part of the peripheral nervous system associated with the voluntary control of body movements via skeletal muscles.

IV. ATTACHMENTS:
A. N/A

V. PURPOSE:
This policy describes the conditions under which osteopathic manipulation treatment (OMT) services are a covered benefit.

VI. POLICY / PROCEDURE:
Osteopathic Manipulation Therapy (OMT) Coverage
A. OMT services should only be provided by physicians skilled, trained and experienced in providing these services. This includes Doctors of Osteopathic Medicine (DOs)~~,~~ but may include other medical doctors (MDs) who have completed supplementary training and are certified by the Osteopathic Medical Board of California.
B. Authorization:
1. No treatment authorization is required to perform OMT if it is performed by a primary care clinician or a Doctor of Osteopathic Medicine credentialed by Partnership HealthPlan of California

(Partnership) AND with documentation of skill, training and experience in providing OMT services. Non-credentialed providers will not be eligible for payment for OMT.

2. Only one OMT service should be billed per day. A maximum of 12 treatments may be billed per rolling 12-month period. Reimbursement for OMT services beyond 12 treatments per rolling 12-month period requires a Treatment Authorization Request (TAR) for medical necessity.
3. ~~Codes covered.~~ The following CPT® codes are covered under this OMT policy when billed in conjunction with ICD-10 diagnosis codes M99.01, M99.02, M99.03, M99.04, or M99.05:
   a. 98925 Osteopathic manipulative treatment (OMT); 1-2 body regions involved
   b. 98926 Osteopathic manipulative treatment (OMT); 3-4 body regions involved
4. Evaluation and Management (E&M) services may be billed on the same day as OMT services, when medically necessary, using modifier 25 in the following conditions:
   a. If the patient's condition requires a separately identifiable E&M service above and beyond the usual pre- and post-service work associated with the procedure
   b. If a new condition occurs or the patient's condition has changed substantially, necessitating an overall assessment

C. OMT is a proven medical therapeutic option for treatment of musculoskeletal disorders, including acute and chronic lower back pain.

D. OMT is unproven and not medically necessary in the following circumstances/diagnoses:
1. The patient's condition has returned to the pre-symptom state.
2. Little or no improvement is demonstrated within 30 days of the initial visit despite modification of the treatment plan.
3. Concurrent chiropractic manipulative therapy, for the same or similar condition, provided by another health professional whether or not the healthcare professional is in the same professional discipline.
4. When documentation of somatic dysfunction is absent from the patient's medical record
5. Manipulative therapy under anesthesia.
6. Non-musculoskeletal disorders (e.g. asthma, otitis media, infantile colic, etc.)
7. Prevention/maintenance/custodial care
8. Internal organ disorders (e.g., gallbladder, spleen, intestinal, kidney, heart or lung disorders)
9. Scoliosis correction
10. Craniosacral therapy (cranial manipulation)
11. Manipulative services that utilize nonstandard techniques

E. All OMT services conducted should be documented in the medical record, including the diagnosis, any disability that is present, the treatment used, the length of the treatment, and the effectiveness of the treatment.

VII. REFERENCES:

A. Spinal Manipulative therapy for chronic low-back pain. Cochrane abstract. February 13, 2011
B. Spinal Manipulative therapy for acute low-back pain. Cochrane abstract. September 12, 2012
C. Medi-Cal Provider Manual/ Guidelines: Osteopathic Manipulation Treatment (*osteo)*
D. American Osteopathic Association
E. Christopher L Knight, MD et al. Treatment of acute low back pain; UpToDate. Accessed 05/01/2023
F. Roger Chou, MD et al. Subacute and chronic low back pain: Nonpharmacologic and pharmacologic treatment; UpToDate. Accessed 05/01/2023

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

Policy/Procedure Number: MCUP3130		**Lead Department: Health Services** **Business Unit: Utilization Management**
Policy/Procedure Title: Osteopathic Manipulation Treatment		☒ **External Policy** ☐ **Internal Policy**
Original Date: 06/17/2015 **Effective Date:** 10/01/2015	**Next Review Date: 11/0412/20276** **Last Review Date: 11/0412/20265**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

X. REVISION DATES: 05/18/16; 05/17/17; *09/12/18; 05/08/19; 05/13/20; 05/12/21; 05/11/22; 08/09/23; 09/11/24; 11/12/25; 11/04/26

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PREVIOUSLY APPLIED TO: N/A

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPUP3116</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Positron Emission Tomography Scans (PET Scans)</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 09/19/2012
Effective 01/01/2013</td><td colspan="4">Next Review Date: ~~11/12/2026~~11/04/2027
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/12/2025~~11/04/2026</td></tr>
</table>

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 address the use of PET Scans in other areas besides oncology.

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. 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).
D. When a PET Scan is paired with another imaging modality, such as Three-~~-~~d~~D~~imensional Computerized Tomography (CT) or Magnetic Resonance Imaging (MRI), the associated modality will be reviewed along with the PET Scan.

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)*

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

*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

Policy/Procedure Number: MPUP3116		Lead Department: Health Services Business Unit: Utilization Management
Policy/Procedure Title: Positron Emission Tomography Scans (PET Scans)		☒ **External Policy** ☐ **Internal Policy**
Original Date: 09/19/2012 Effective 01/01/2013	**Next Review Date: 11/12/202611/04/2027** **Last Review Date: 11/12/202511/04/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

PartnershipAdvantage
MPUP3116 – 09/19/2012 to 01/01/2015

Healthy Families
MPUP3116– 09/19/2012 to 03/01/2013

****

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

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

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: MP316				**Lead Department: Member Services**	
Policy/Procedure Title: Provider Request to ~~Discharge~~Reassign Member & Assistance with Inappropriate Member Behavior				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 7/27/1994			**Next Review Date: 11/4/2027~~09/10/2026~~** **Last Review Date: 11/4/2026~~09/10/2025~~**		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☐~~☒~~ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date: 11/4/2026~~09/10/2025~~**	

I. RELATED POLICIES:

A. MP301— Assisting Providers with Missed Appointments
B. MP312— Processing PCP/MH Selections and Transfers Requests

II. IMPACTED DEPTS:

A. Provider Relations ~~(PR)~~
B. Care Coordination ~~(CC)~~

III. DEFINITIONS:

A. Provider Request to ~~Discharge~~Reassign: A provider's request to ~~discharge~~ reassign a ~~M~~M~~m~~ember from ~~his/her~~their practice.
B. Re-assignment: The process in which a~~A~~ ~~M~~M~~m~~ember is transferred to the care of another Primary Care Provider or into a -Direct Member category, if applicable.
C. Member Type U: For the purpose of this policy, M~~m~~embers are defined as "Type U Members" if they have been ~~discharged~~ reassigned for reasons other than fraud, sexual comments, and threats of violence and/or violent behavior.
D. Member Type V: For the purpose of this policy, M~~m~~embers are defined as "Type V Members" if they have been ~~discharged~~ reassigned for fraud, sexual comments, and threats of violence and/or violent behavior. ~~Threats of violence includes menacing body language, sexual advances, and/or verbal threats of physical violence.~~
E. 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.
~~E. A model of care that provides the main functions of primary health care. This includes comprehensive care, patient-centered, coordinated care, accessible services, and quality and safety. The provider identified as the member's medical home or PCP who is responsible for managing the member's primary care needs.~~
F. Wellness & Recovery (W&R): Partnership's ~~regional~~ Drug Medi-Cal Organized Delivery System that administers substance use benefits for Partnership and other Medi-Cal beneficiaries in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties. ~~Waiver program in seven counties within Partnership's service area.~~
G. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.

Policy/Procedure Number: MP316			Lead Department: Member Services
Policy/Procedure Title: Provider Request to ~~Discharge~~ Reassign Member & Assistance with Inappropriate Member Behavior			☒ **External Policy** ☐ **Internal Policy**
Original Date: 7/27/1994		**Next Review Date: 11/4/2027~~09/10/2026~~** **Last Review Date: 11/4/2026~~09/10/2025~~**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

~~F.~~H. Community Supports (CS) Provider: A contracted provider experienced and/or trained in providing one or more of the Community Supports

IV. ATTACHMENTS:

A. ~~Form #6 (Provider Request for Discharge~~Reassignment~~/Assistance with Inappropriate Behavior)~~Form #6 Provider Request for Reassignment/Assistance with Inappropriate Behavior

B. ~~Letter #MS10a (Member~~~~Member Services Notifies PCP of Decision)~~Letter #10a Member Services Notifies PCP of Decision

~~B.~~C. Letter #10b Notification of PCP Reassignment Request Approved

~~C.~~D. ~~Letter #MS10c (Assistance with Inappropriate Behavior at Provider's Office)~~Letter #10c Assistance with Inappropriate Behavior at Provider's Office

~~D. Letter #MS10b (Notification of PCP Discharge Reassignment Request Approved)~~

V. PURPOSE:

To ~~establishd~~~~efine~~outline the criteria and process for ~~under which a~~~~in which a medical~~ provider to ~~may~~ request assistance with inappropriate behavior or ~~assistance for members that display inappropriate behavior and/or request~~ the ~~discharge~~ reassignment of a ~~Partnership member~~Member~~. from his/her practice and the requirements for~~~~process of member~~Member ~~and provider notification.~~

from their practice

~~.~~

VI. POLICY / PROCEDURE:

A. Assistance with Inappropriate Behavior

1. Criteria for Assistance:

Providers may request ~~contact Partnership for~~ assistance from Partnership when ~~in addressing situations involving~~ a Member and/or the Member's representative exhibits ~~whose conduct is inappropriate,~~ disruptive, verbally abusive, threatening~~,~~ or other inappropriate behavior, or otherwise interferes with the maintenance of a safe, respectful, and professional care environment.

~~Prior to requesting discharge~~reassignment~~, providers may request assistance from Partnership when a member~~Member ~~and/or member~~Member~~'s representative engages in~~displays ~~verbally abusive and/or disruptive behavior in a provider's office.~~

~~1.~~ Examples of inappropriate behavior include but are not limited to the following:

a. Yelling and/or screaming
b. Ethnic slurs or foul language
c. Physical or verbal threats of violence
d. Sexual comments, innuendoes, or advances

2. Provider ~~r~~Request ~~s~~for ~~Partnership a~~Assistance:

~~a. ,~~ The Provider must complete and submit~~ting :~~

~~b.~~a. ~~Completes Partnership's Form #6 titled~~ "Provider Request for ~~Discharge~~Reassignment/Assistance with Inappropriate Behavior" form (Attachment A) ~~(Attachment A), and~~to ~~faxes it to~~ Partnership's ~~Member~~Member Services Department.

3. Plan Review and Determination:

a. Upon receipt of the request, ~~Member~~Member Services will review~~s~~ the submitted form ~~request~~ to determine whether the criteria for assistance are met.

1) If the form is incomplete or additional information is needed, Partnership's Provider Relation's (PR) Department will contact the provider to request the necessary information.

2) If the requested information is not received within five (5) business days, the request will be denied, and the provider will be notified.

~~2.~~ If the request is approved, Member Services will send notice #10c, Assistance with Inappropriate Behavior at Provider's Office ~~and~~ :

4. ~~Sends~~ ~~sends~~ ~~Mails~~ ~~letter #10c (Attachment C)~~ to the M~~m~~ember and ~~the~~ ~~faxes~~ a copy ~~is sent~~ to the requesting provider.

~~3. If provider, is copied.~~

~~4. If the form is I~~Incomplete ~~forms or additional information is needed, notifies are referred to Partnership's Provider Relation's~~ (PR) D~~d~~epartment ~~and pends the request for~~ Provider ~~Relations contacts the provider to request information to complete the request. and are pended for f~~five ~~(5) business days.~~

~~PR contacts the provider to request information needed to complete the request.~~

5. ~~If information is not received within five (5) business days,~~ the request is denied, ~~and~~ the provider is notified.

~~Provider Relations contacts the provider to request information to complete the request.~~

B. ~~Discharge~~ Reassignment Requests

Partnership's best effort is used to provide ~~member~~Members the opportunity to be cared for by medical providers with whom a collaborative provider/patient relationship can be developed. ~~Because the relationship is personal in nature, circumstances may arise under which the relationship between a member~~Member ~~and a provider becomes non-collaborative.~~If that relationship becomes non-collaborative, a provider may request reassignment of the Member. ~~Medical providers are permitted to request that a member~~Member ~~be discharged~~ reassigned ~~from his/her practice in certain circumstances, but i~~It is the sole responsibility of Partnership to determine if the request meets Partnership's ~~discharge~~ reassignment criteria. Providers are expected to have procedures in place that provide guidance to practitioners and staff when dealing with challenging patients.

C. ~~Discharge~~ Reassignment Criteria

1. Upon receipt of a provider's request and supporting documentation, Partnership shall determine if the request meets~~sing the written documentation provided by the provider and the discharge reassignment criteria listed below, appropriate Partnership staff determines if the request for discharge reassignment meets~~ Partnership's ~~discharge~~ reassignment criteria. Designated Member Services staff may consult~~s~~ with ~~the~~ Care Coordination (CC) designees and/or~~,~~ Partnership's Chief Medical Officer (CMO) or designee, as needed. ~~as needed.~~
2. The following behaviors are generally considered appropriate criteria for ~~discharge~~reassignment:
   a. Fraudulently receiving benefits under a health plan contract.
   b. Fraudulently receiving and/or altering prescriptions, theft of prescription pads, or photocopying prescriptions.
   c. Physically or sexually abusive behavior exhibited to the provider or office personnel.
   d. Threatening behavior exhibited in the course of needing or receiving care.
   e. Credible threat of the ~~member~~Member's intent to initiate or pursue legal action (not including a state hearing) against the provider and/or their associates.
   f. Refusal by the ~~member~~Member to follow recommended medical treatment where the provider believes there is no alternative treatment, and that refusal will severely endanger the health of the ~~member~~Member. This situation cannot be improved by repeated attempts by Partnership's CC designee to intervene, and in the judgment of the CMO or designee, a change in provider would clearly benefit the ~~member~~Member's health status.
   g. A determination by Partnership's CC designee and the CMO or designee that deterioration in the provider/patient relationship has occurred to the point where continuation might result in adverse consequences to the ~~member~~Member's health or to the safety of the provider or

provider's staff.

h. If a ~~member~~Member has been previously ~~discharged~~ reassigned from a practice, it is the responsibility of the practice to notify Partnership within sixty (60) days of the ~~member~~Member's initial assignment.

1) ~~.~~Documented evidence that the ~~member~~Member had been ~~discharged~~ reassigned from the practice site before the ~~member~~Member became Partnership eligible is required. Exceptions to the sixty (60) day period can be made at the discretion of Partnership on a case-by-case basis.

~~h.~~i. Disruptive or verbally inappropriate behavior to the provider, office staff, or other patients if counseling and corrective action by the provider has been ineffective. For assistance with inappropriate behavior, refer to section VI.A. Assistance with Inappropriate Behavior.

j. Three (3) or more missed appointments within the previous six (6) month period or four (4) or more missed appointments within the previous twelve (12) month period, if the provider has made a good faith effort to correct the ~~member~~Member's behavior.

1) ~~-~~Good faith effort is defined as at least one verbal and one written warning or at least two written warnings. All verbal and/or written warnings must inform the ~~member~~Member that continued missed appointments will result in ~~discharge~~reassignment.

~~1)~~2) ~~-~~Provider offices must provide documentation of the verbal warning and one written warning or two (2) or more written warnings. The verbal and/or written warnings must be within the specified timeframes of the missed appointments.

~~2)~~3)Exceptions: Missed appointments due to an inpatient hospital stay or appointments cancelled 24 hours in advance are not considered missed appointments for the purpose of this policy.

~~If the provider has multiple locations and/or practices, the provider must specify on the Discharge Form #6 titled "Provider Request for Reassignment/Assistance with Inappropriate Behavior" (Attachment A), Reassignment Request Form if the discharge reassignment applies to all locations and/or practices or specific locations and/or practices.~~

D. Requesting ~~Discharge~~ Reassignment Process

1. The provider must notify Partnership's Member Services D~~d~~epartment in writing to request a ~~member~~Member ~~discharge~~reassignment. The provider must provide complete documentation outlining the nature of the problem, including ~~Form #6 titled~~ "Provider Request for ~~Discharge~~Reassignment/Assistance with Inappropriate Behavior" (Attachment A) and supporting documentation for each ~~member~~Member included in the ~~discharge~~ reassignment request.

a. The request must indicate whether~~if~~ the ~~member~~Member is receiving~~or is not in~~ active care for an acute medical condition and/or if the ~~member~~Member has any diagnostic testing or surgical procedures pending~~eries scheduled~~. ~~If additional information is needed from the provider, the Member Services department will request the additional information through Partnership's PR department.~~

If the provider has multiple locations and/or practices, the provider must specify if the reassignment applies to all locations and/or practices or specific locations.

~~a.~~b.

2. By the end of the second business day from the date of receipt, the designated Member Services staff documents the date the ~~discharge~~ reassignment request was received~~ using the DE Remark Code.~~

3. If additional information is required from the Provider, Member Services shall coordinate with the PR Department to obtain the necessary information.

~~b. In this case,~~

a. ~~When the provider does not provide the required supporting documentation, MS requests assistance from PR to request the additional information from the provider.~~ t~~The request is~~

~~pended~~is ~~pended for five (5) business days.~~ If the requested information is not received within five (5) business days, the request is denied.

E. Provider Notification of ~~-~~Decisions
1. Member Services sends written notification of the ~~ed providers in writing L~~letter ~~#MS10a (Attachment B) to notify providers of the discharge~~ reassignment decision to the provider.~~.~~
2. The provider can call the Member Services D~~d~~epartment at (800) 863-4155 to check the status of a request.

F. Approved Requests
1. ~~Member~~Member Type V:~~ –~~ ~~Discharged~~ Reassigned for fraud, sexual comments, threatening and/or violent behavior.
   a. A~~The~~ copy of the provider's ~~discharge~~ reassignment request~~submission~~ and supporting documentation is sent to the CC designee.
   b. The CC designee determines if the relationship between the provider and ~~member~~Member can be repaired. If the relationship cannot be repaired, CC designee assists the ~~member~~Member in selecting a new ~~medical home or~~ PCP/Medical Home. If the CC designee and/or the ~~member~~Member ~~needs~~need more time to select a new PCP/Medical Home~~medical home or PCP~~, the ~~member~~Member is placed in a limited Direct ~~Member~~Member status for a minimum of thirty (30) to a maximum of sixty (60) days. During this time, the ~~member~~Member can be seen by any Medi-Cal provider willing to see the ~~member~~Member and bill Partnership. If at the end of the limited period, the ~~member~~Member has not informed Partnership of their new PCP/Medical Home~~medical home or PCP~~, Partnership assigns the ~~member~~Member to the next closest open PCP.
2. ~~Member~~Member Type U: ~~–~~ ~~Discharged~~ Reassigned for reasons other than fraud, sexual comment, threats of violence and/or violent behavior.
   a. ~~Member~~Members are placed in a limited Direct ~~Member~~Member status for a minimum of thirty (30) days to a maximum of sixty (60) days.
   b. Referrals are sent to CC if ~~Form #6~~the "Provider Request for ~~Discharge~~Reassignment/Assistance with Inappropriate Behavior" form ~~form,~~ (Attachment A), indicates any current treatments and/or if the ~~member~~Member has any open Treatment Authorizations Requests/Referral Authorization Forms.
3. ~~Member~~Member N~~n~~otifications – Letter #~~MS~~10b (Attachment D) is sent to the ~~member~~Member within ten (10) business days from the date the request was received. The notification includes Nondiscrimination and Language Assistance notices. ~~-~~The letter provides the following information ~~explains~~:
   a. ~~-T~~the reason for the ~~discharge~~ reassignment and the effective date of the new PCP/Medical Home~~medical home or PCP~~.
   b. How to ~~The letter advises the member~~Member ~~how to~~ choose ~~e~~ a new PCP/Medical Home~~medical home or PCP~~
   c. T~~,~~ to contact Partnership's Member Services De~~de~~partment if they need assistance or have questions.
   d. ~~-H and, if applicable, h~~ow to receive care during the Direct ~~Member~~Member period. ~~Enclosures include, Nondiscrimination and Language Assistance notices.~~

G. Transition of Care
1. If the ~~member~~Member has diagnostic testing, specialty referrals and/or surgical procedures~~eries~~ scheduled for conditions that could adversely affect the ~~member~~Member's health if delayed,

designated Member Services s~~S~~taff requests that the CC D~~d~~epartment work with the ~~member~~Member and appropriate providers to ensure that needed medical care is provided. The ~~member~~Member may be assigned to Direct ~~Member~~Member status, depending on the timing of the ~~discharge~~reassignment.

2. If the ~~member~~Member is medically unstable, the PCP will continue to provide care to the ~~member~~Member until Partnership is able to change the ~~member~~Member's PCP for a period not to exceed two (2) months.

H. Process Approved Request to block system relinking, auto assignment and alert ~~member~~Member facing departments

1. To prevent ~~discharged~~ reassigned ~~member~~Members from relinking or auto assignment, blocks and alerts are added to the appropriate ~~member~~Membership systems.

I. ~~Discharge~~ Reassignment of Direct ~~Member~~Members and W&R "only" ~~member~~Members

1. A provider can terminate care of a Direct ~~Member~~Member or W&R "only" ~~member~~Members, when the provider/patient relationship becomes non-collaborative, by notifying the ~~member~~Member in writing that they will no longer be able to provide care for that ~~member~~Member. If the ~~member~~Member is unstable, the provider should care for the ~~member~~Member until the ~~member~~Member selects another provider, and the provider provides emergency care for at least 30 days.
2. Primary Care Providers should notify Partnership of their intent to ~~discharge~~ reassign a Direct ~~Member~~Member from their practice so that Partnership can document the reason for ~~discharge~~ reassignment and assist with transition of care, as described above in section VI.G Transition of Care.

J. ~~Discharge~~ Reassignment Requests from Specialists, ECM, Community Support and W&R Providers

~~1. A~~ Sspecialty~~ist~~, ECM, Community Support, ~~provider~~ or W&R providers ~~can cease~~may discontinue ~~providing~~ care for ~~any~~ a ~~member~~Member when the provider~~-~~/patient relationship becomes non-collaborative. In these cases,~~, the specialist physician or W&R~~ providers must notify both the PCP and the ~~patient~~ Member that they will no longer provide care to the ~~patient~~Member. The PCP should refer the member to another specialist for treatment, if specialist care is still necessary.

1.

2. In all cases, the provider ~~discharging~~ reassigning a member should assist with continuity of care by transferring appropriate medical records to the new provider.

K. Request for Grievance

1. Members may request a grievance.

L. Reporting Violent and/or Fraudulent Behavior

1. Providers are encouraged to report violent and/or fraudulent behavior to the appropriate authorities.
2. Member Services notifies Partnership's Regulatory Affairs and Compliance department of suspected fraudulent behavior in accordance with CMP 09~~.~~

VII. REFERENCES:

N/A~~N/A~~

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director of Member Services & Grievance

X. REVISION DATES:

Medi-Cal

04/27/95; 10/13/99; 06/20/01; 08/15/01; 06/19/02 (Hlth Srvcs Policy); 06/18/03 (Mbr Srvcs Policy); 03/05/04; 05/19/04;11/17/04; 11/16/05; 03/07/08; 08/12/08; 01/21/09; 08/19/09; 12/16/09; 03/23/10; 05/11/11; 01/07/2014; 07/14/14; 11/08/17; 02/13/19; 05/13/20; 08/11/21; 09/14/22; 09/13/23; 09/11/24; 09/10/25; 11/04/26

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

N/A

PREVIOUSLY APPLIED TO: Partnership *Advantage*: MP316 – 01/01/2007 to 01/01/2015; Healthy Kids: MP 316 12/01/2005 to 12/31/2016

Provider Request for Reassignment~~Discharge~~/Assistance with Inappropriate Behavior

Section 1 - What would you like Partnership to do?

- ☐ Would you like Partnership to reach out to the member to counsel them on improving their behavior?
- ☐ Do you want to request that the member be reassigned~~disenrolled~~ from your office(s)? **Must attached required documentation**.

Section 2 - Member Information: **Partnership ID (CIN)** #_____

Name: _____ DOB: _____ Phone #_____

Section 3 - Member Care Information:

1. Is the member in treatment for an active medical condition? ☐ No ☐ Yes - attach description of medical condition
2. Are there any diagnostic testing or surgeries scheduled? ☐ No ☐ Yes - attach list of scheduled procedures and any active TARs and/or RAFs. Please include TAR & RAF #s:

   _____

Section 4 - Provider Submitting Request:

1. PCP/Med Grp Name: _____ PCP/Group's Partnership PCP#: _____
   Does ~~reassignement~~reassignment~~discharge~~ apply to all facilities and/or locations affiliated with the group? ☐ Yes ☐ No
   If yes, list all the Partnership providers or locations that apply:

2. Have you already communicated with the member regarding your concerns? ☐ Yes ☐ No ☐ N/A If yes, what did you advise the member:

   _____

3. Who do we contact if we have questions regarding the member's care or the reason for reassignment~~disenrollment~~:

   Print Name: _____ Phone # _____

4. Who and where do we fax our decision to:

   Print Name: _____ Phone # _____ Fax#: _____

Section 5 - Reason for your request:

Please check all applicable boxes. **If you are requesting to reassign~~disenroll~~ the patient, attach documentation outlined in the policy**. If the action of the member is not specified in the policy, provide documentation outlining the incident or reason for request.

☐ Missed Aa~~a~~ppointments ☐ Disruptive/Vv~~e~~rbally Ii~~n~~appropriate Bb~~e~~havior ☐ Suspected Ff~~r~~aud

☐ Failure to Oo~~b~~tain/Mm~~a~~intain a Cc~~o~~llaborative Rr~~e~~lationship ☐ Non-Compliance/Rr~~e~~fusal to Ff~~o~~llow Tt~~r~~eatment Pp~~l~~an.*

☐ Inappropriate Ss~~e~~xual Cc~~o~~mments or Aa~~d~~vances

☐ Threats of Vv~~i~~olence and/or Vv~~i~~olent Bb~~e~~havior ~~,~~; Hh~~a~~s behavior been reported to police? ☐ Yes ☐ No If "No" please explain why:

_____

☐ Other: _____

**Note: All requests for reassignment~~discharge~~ for non-compliance are reviewed by a Partnership Medical Director. Presence of a Substance Abuse Disorder alone is not sufficient grounds for reassignment~~discharge~~. Please refer to specialty care or address treatment as necessary.*

Signature of Provider: _____ Date: _____

Print name of Provider: _____

Section 6 - Fax to (707) 420-7580 attention Partnership's **Enrollment Unit:**
Partnership has ten (10) business days to process your request from the date received. Forms that are incomplete or missing the required documentation may be denied.

******************************PARTNERSHIP INTERNAL USE*********************************

Member #: _____

DECISION:

☐ Pended Sent to Dept./Name: _____ Date Ssent: _____ Due Bback By: _____
☐ Approved Effective: _____ New Assignment: _____ Date Aapproved: _____
☐ Request Denied Reason: _____ Date Ddenied: _____

Referral to Case Management: ☐ Yes; date: _____ ☐ No

Letter #_____; Date notice sent to provider: _____

Letter #_____; Date notice sent to member: _____

☐ Call Center/AmisysSystem entries completed on date: _____

COMMENTS:

Member Services:S _____

Care Coordination:CC

_____

Provider Relations:R _____

Member Services Designeeirector Signature: _____ Date: _____

PARTNERSHIP HEALTHPLAN of CALIFORNIA

4665 Business Center Drive
Fairfield, California 94534

Attachment B – Letter 10a
Member Services Notifies PCP of Decision

<DATE>

FAX: **<Fax #>**
<Provider Office>
<Provider's Address>
<Provider's City, State and Zip>

Re: Request to discharge: **<mbr>** Partnership~~PHC~~ **ID #**

Dear **<Provider Name>**~~<Name>~~:

Partnership HealthPlan of California has received your request to reassign~~discharge~~ the above member. The documentation submitted by your office has been reviewed by Partnership. Based on the reassignment~~discharge~~ ~~disenrollment~~ guidelines outlined in Partnership's Policy MP 316, your request has been:

☐ Approved. The member will be transferred from your practice, effective **<Date>**.

☐ Denied. It was determined that your request did not meet the reassignment~~ment~~~~discharge~~ guidelines outlined in Partnership's Policy MP 316. You must continue providing services to this member.

☐ Denied. It was determined that your request did not meet the reassignment~~ment~~~~discharge~~ guidelines outlined in Partnership's Policy MP 316. However, the member has requested to be transferred to another primary care provider. The effective date of the transfer is **<Date>**.

☐ Denied. Not enough information has been provided to approve your request. Please provide additional information that specifically details your reason for requesting ~~the~~ to reassign~~discharge~~ the member(s) and resubmit your disenrollment request. See enclosed Provider reassignment Tool to help determine the type of documentation needed. At this time, you must continue to provide services to this member.

☐ Other:

☐ Special message or instructions

If you have questions or concerns regarding this reassignment~~discharge~~ ~~disnerollment~~ request or if you would like to appeal this decision, please contact your Provider Relations Representative at **(707) 863-4100**.

Thank you for the excellent care you provide to our members and your continued support of Partnership~~PHC~~.

Sincerely,
Provider Relations Department
Partnership HealthPlan of California

4665 Business Center Drive
Fairfield, California 94534

Attachment C – Letter 10C
Assistance with Inappropriate Behavior at Provider's Office

<Date>

<Member Name>
<Member's Address>
<Member's City, State Zip>

Re: <Member's Name only if minor>

Dear <Member Name or Parent/Legal Guardian>:

This letter is to let you know that Partnership HealthPlan of California was told by <PCP's name and/or name of office>; that <members' name> <enter behavior or reason provider is requesting assistance> <if reporting inappropriate behavior; **add:** may have been inappropriate during a recent medical visit>.

There may be times when something happens at the provider's office that you may not like. It is best to try to solve the issue calmly.

If you are not able to solve problems at your provider's office, call us for help at **(800) 863-4155**.

Visit our website at PartnershipHP.org to use the Member Portal or look at the Member Handbook, Provider Directory, and your Rights and Responsibilities.

We are here to help. If you have any questions or concerns, please call us at **(800) 863-4155**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call the California Relay Service at **(800) 735-2929** or call **711**.

The Department of Health Care Services Managed Care Ombudsman's office can help with any questions or complaints about your health care. You can call them at **(888) 452-8609**, Monday – Friday, 8 a.m. to 5 p.m.

This notice does not change your Partnership benefits or keep you from getting the care you need.

Sincerely,

Member Services Department

Enclosures: Nondiscrimination and Language Assistance Notice, Member Rights and Responsibilities

4665 Business Center Drive
Fairfield, California 94534

Attachment D – Letter 10B
Notification of PCP Reassignment Request Approved

<DATE>

<Member's Name>
<Member's Address>
<Member's City, State and Zip>

Re: Provider Discharge

Dear <Member Name or Parent/Legal Guardian>

<Current PCP> {insert if provider is requesting discharge from multiple sites} <and all affiliated sites> has asked that **<names of reassigned patients>** be removed from their care. Partnership has approved this request.

You have been removed from your primary care provider (PCP) because <insert appropriate reason(s):> you missed 3 or more appointments in the last 6 months; you have used unkind, upsetting or abusive words; you did not follow your medical treatment plan and put your health at risk; your relationship with your PCP or office staff is not working well; you have given false information to get or change your medication(s); you have been removed from care by a specialist; <other reason>>

{Insert appropriate paragraphs and remove all paragraphs not applicable}

[Member needs to pick a PCP or medical home]
To give you time to pick a new PCP, you have from **<date>** to **<date>** to choose a new PCP. During this time, you may see any Medi-Cal provider willing to bill Partnership for Medi-Cal covered services.

Please pick a new PCP and let us know who you picked by **<date>.** If you do not pick a new PCP by this date, Partnership will choose one for you.

To pick a new PCP, you can look at our Provider Directory on our website at PartnershipHP.org. Pick a PCP that says they are taking new patients. You can tell us the PCP you picked by changing your PCP using our Member Portal on our website. You can also tell us by calling Member Services at **(800) 863-4155**.

[Member has Other Health Coverage (OHC)]
Our records show you have other health coverage. Generally, that means your other health coverage is billed first for your care and Partnership is billed last. Because you have other health coverage and Medi-Cal, you have Direct Member status. This means you can be seen by any Medi-Cal provider that takes your other health coverage and is willing to bill Partnership for Medi-Cal services.

[Members with Medicare]

You have Medicare and Medi-Cal, which means you can be seen by any provider who takes both Medicare and Medi-Cal. The provider must agree to see you and bill Medicare and Partnership for Medi-Cal covered services. Medicare is billed first and Partnership is billed last. This is called Direct Member Status.

[Out of the service area or approved for continuity of care or any other direct member status]
You have Direct Member status, which means you can be seen by any Medi-Cal provider that is willing to bill Partnership for Medi-Cal covered services.

[Insert in addition to any of the above paragraph's anytime a member is an American Indian/Alaska Native]
As an American Indian/Alaska Native, you have the right to get healthcare services from any Indian Health Care Provider. You can also pick an Indian HealthCare Provider for your PCP or any PCP listed in our directory that accepts new members.

[Member is already assigned to a new PCP]
Because you have already changed your PCP, you do not need to pick a new PCP. You can continue to see the PCP that you have selected.

[Closing statement]
Visit our website at PartnershipHP.org to use the Member Portal or look at the Member Handbook, Provider Directory, and your Rights and Responsibilities.

We are here to help. If you have any questions or concerns, please call us at **(800) 863-4155**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call the California Relay Service at **(800) 735-2929** or call **711**.

The Department of Health Care Services Managed Care Ombudsman's office can help with any questions or complaints about your health care. You can call them at **(888) 452-8609**, Monday – Friday, 8 a.m. to 5 p.m.

This notice does not change your Partnership benefits or keep you from getting the care you need.

Sincerely,

Member Services Department
Partnership HealthPlan of California

Enclosures: Nondiscrimination and Language Assistance Notice, Members Rights and Responsibilities Statement

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MP316</td><td colspan="3">Lead Department: Member Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Provider Request to Reassign Member & Assistance with Inappropriate Member Behavior</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 7/27/1994</td><td colspan="3">Next Review Date: 11/4/2027
Last Review Date: 11/4/20266</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td>☒ Medi-Cal</td><td colspan="2">☐ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 11/4/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MP301 Assisting Providers with Missed Appointments
B. MP312 Processing PCP/MH Selections and Transfers Requests

II. IMPACTED DEPTS:

A. Provider Relations
B. Care Coordination

III. DEFINITIONS:

A. Provider Request to Reassign: A provider's request to reassign a Member from their practice.
B. Reassignment: The process in which a Member is transferred to the care of another Primary Care Provider or into a Direct Member category, if applicable.
C. Member Type U: For the purpose of this policy, Members are defined as "Type U Members" if they have been reassigned for reasons other than fraud, sexual comments, and threats of violence and/or violent behavior.
D. Member Type V: For the purpose of this policy, Members are defined as "Type V Members" if they have been reassigned for fraud, sexual comments, and threats of violence and/or violent behavior.
E. 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.
F. Wellness & Recovery (W&R): Partnership's Drug Medi-Cal Organized Delivery System that administers substance use benefits for Partnership and other Medi-Cal beneficiaries in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano counties.
G. Enhanced Care Management (ECM) Provider: A Provider of ECM. ECM Providers are community-based entities with experience and expertise providing intensive, in-person care management services to individuals in one or more of the Populations of Focus for ECM.
H. Community Supports (CS) Provider: A contracted provider experienced and/or trained in providing one or more of the Community Supports

IV. ATTACHMENTS:

A. Form #6 Provider Request for Reassignment/Assistance with Inappropriate Behavior
B. Letter #10a Member Services Notifies PCP of Decision
C. Letter #10b Notification of PCP Reassignment Request Approved
D. Letter #10c Assistance with Inappropriate Behavior at Provider's Office

Policy/Procedure Number: MP316			Lead Department: Member Services
Policy/Procedure Title: Provider Request to Reassign Member & Assistance with Inappropriate Member Behavior			☒ **External Policy** ☐ **Internal Policy**
Original Date: 7/27/1994		**Next Review Date: 11/4/2027** **Last Review Date: 11/4/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

V. PURPOSE:

To outline the criteria and process for a provider to request assistance with inappropriate behavior or the reassignment of a Member from their practice**.**

VI. POLICY / PROCEDURE:

A. Assistance with Inappropriate Behavior

1. Criteria for Assistance:
   Providers may request assistance from Partnership when a Member and/or the Member's representative exhibits disruptive, verbally abusive, threatening or other inappropriate behavior, or otherwise interferes with the maintenance of a safe, respectful, and professional care environment. Examples of inappropriate behavior include but are not limited to the following:
   a. Yelling and/or screaming
   b. Ethnic slurs or foul language
   c. Physical or verbal threats of violence
   d. Sexual comments, innuendoes, or advances
2. Provider Request for Assistance:
   a. The Provider must complete and submit "Provider Request for Reassignment/Assistance with Inappropriate Behavior" form (Attachment A) to Partnership's Member Services Department.
3. Plan Review and Determination:
   a. Upon receipt of the request, Member Services will review the submitted form to determine whether the criteria for assistance are met.
      1) If the form is incomplete or additional information is needed, Partnership's Provider Relation's (PR) Department will contact the provider to request the necessary information.
      2) If the requested information is not received within five (5) business days, the request will be denied, and the provider will be notified.
4. If the request is approved, Member Services will send notice #10c, Assistance with Inappropriate Behavior at Provider's Office to the Member and a copy to the requesting provider.
5. If the request is denied, the provider is notified.

B. Reassignment Requests

Partnership's best effort is used to provide Members the opportunity to be cared for by medical providers with whom a collaborative provider/patient relationship can be developed. If that relationship becomes non-collaborative, a provider may request reassignment of the Member. It is the sole responsibility of Partnership to determine if the request meets Partnership's reassignment criteria. Providers are expected to have procedures in place that provide guidance to practitioners and staff when dealing with challenging patients.

C. Reassignment Criteria

1. Upon receipt of a provider's request and supporting documentation, Partnership shall determine if the request meets Partnership's reassignment criteria. Designated Member Services staff may consult with Care Coordination (CC) designees and/or Partnership's Chief Medical Officer (CMO) or designee, as needed.
2. The following behaviors are generally considered appropriate criteria for reassignment:
   a. Fraudulently receiving benefits under a health plan contract.
   b. Fraudulently receiving and/or altering prescriptions, theft of prescription pads, or photocopying prescriptions.
   c. Physically or sexually abusive behavior exhibited to the provider or office personnel.
   d. Threatening behavior exhibited in the course of needing or receiving care.
   e. Credible threat of the Member's intent to initiate or pursue legal action (not including a state hearing) against the provider and/or their associates.

f. Refusal by the Member to follow recommended medical treatment where the provider believes there is no alternative treatment, and that refusal will severely endanger the health of the Member. This situation cannot be improved by repeated attempts by Partnership's CC designee to intervene, and in the judgment of the CMO or designee, a change in provider would clearly benefit the Member's health status.

g. A determination by Partnership's CC designee and the CMO or designee that deterioration in the provider/patient relationship has occurred to the point where continuation might result in adverse consequences to the Member's health or to the safety of the provider or provider's staff.

h. If a Member has been previously reassigned from a practice, it is the responsibility of the practice to notify Partnership within sixty (60) days of the Member's initial assignment.
   1) Documented evidence that the Member had been reassigned from the practice site before the Member became Partnership eligible is required. Exceptions to the sixty (60) day period can be made at the discretion of Partnership on a case-by-case basis.

i. Disruptive or verbally inappropriate behavior to the provider, office staff, or other patients if counseling and corrective action by the provider has been ineffective. For assistance with inappropriate behavior, refer to section VI.A. Assistance with Inappropriate Behavior.

j. Three (3) or more missed appointments within the previous six (6) month period or four (4) or more missed appointments within the previous twelve (12) month period, if the provider has made a good faith effort to correct the Member's behavior.
   1) Good faith effort is defined as at least one verbal and one written warning or at least two written warnings. All verbal and/or written warnings must inform the Member that continued missed appointments will result in reassignment.
   2) Provider offices must provide documentation of the verbal warning and one written warning or two (2) or more written warnings. The verbal and/or written warnings must be within the specified timeframes of the missed appointments.
   3) Exceptions: Missed appointments due to an inpatient hospital stay or appointments cancelled 24 hours in advance are not considered missed appointments for the purpose of this policy.

D. Requesting Reassignment Process
   1. The provider must notify Partnership's Member Services Department in writing to request a Member reassignment. The provider must provide complete documentation outlining the nature of the problem, including "Provider Request for Reassignment/Assistance with Inappropriate Behavior" (Attachment A) and supporting documentation for each Member included in the reassignment request.
      a. The request must indicate whether the Member is receiving active care for an acute medical condition and/or if the Member has any diagnostic testing or surgical procedures pending.
      b. If the provider has multiple locations and/or practices, the provider must specify if the reassignment applies to all locations and/or practices or specific locations.
   2. By the end of the second business day from the date of receipt, the designated Member Services staff documents the date the reassignment request was received.
   3. If additional information is required from the Provider, Member Services shall coordinate with the PR Department to obtain the necessary information.
      a. If the requested information is not received within five (5) business days, the request is denied.

E. Provider Notification of Decisions
   1. Member Services sends written notification of the reassignment decision to the provider.
   2. The provider can call the Member Services Department at (800) 863-4155 to check the status of a request.

F. Approved Requests
   1. Member Type V: Reassigned for fraud, sexual comments, threatening and/or violent behavior.

a. A copy of the provider's reassignment request and supporting documentation is sent to the CC designee.
b. The CC designee determines if the relationship between the provider and Member can be repaired. If the relationship cannot be repaired, CC designee assists the Member in selecting a new PCP/Medical Home. If the CC designee and/or the Member need more time to select a new PCP/Medical Home, the Member is placed in a limited Direct Member status for a minimum of thirty (30) to a maximum of sixty (60) days. During this time, the Member can be seen by any Medi-Cal provider willing to see the Member and bill Partnership. If at the end of the limited period, the Member has not informed Partnership of their new PCP/Medical Home, Partnership assigns the Member to the next closest open PCP.

2. Member Type U: Reassigned for reasons other than fraud, sexual comment, threats of violence and/or violent behavior.
   a. Members are placed in a limited Direct Member status for a minimum of thirty (30) days to a maximum of sixty (60) days.
   b. Referrals are sent to CC if "Provider Request for Reassignment/Assistance with Inappropriate Behavior" form (Attachment A), indicates any current treatments and/or if the Member has any open Treatment Authorizations Requests/Referral Authorization Forms.
3. Member Notifications – Letter #10b (Attachment D) is sent to the Member within ten (10) business days from the date the request was received. The notification includes Nondiscrimination and Language Assistance notices. The letter provides the following information:
   a. The reason for the reassignment and the effective date of the new PCP/Medical Home.
   b. How to choose a new PCP/Medical Home
   c. To contact Partnership's Member Services Department if they need assistance or have questions,
   d. How to receive care during the Direct Member period.

G. Transition of Care
1. If the Member has diagnostic testing, specialty referrals and/or surgical procedures scheduled for conditions that could adversely affect the Member's health if delayed, designated Member Services staff requests that the CC Department work with the Member and appropriate providers to ensure that needed medical care is provided. The Member may be assigned to Direct Member status, depending on the timing of the reassignment.
2. If the Member is medically unstable, the PCP will continue to provide care to the Member until Partnership is able to change the Member's PCP for a period not to exceed two (2) months.

H. Process Approved Request to block system relinking, auto assignment and alert Member facing departments
1. To prevent reassigned Members from relinking or auto assignment, blocks and alerts are added to the appropriate Membership systems.

I. Reassignment of Direct Members and W&R "only" Members
1. A provider can terminate care of a Direct Member or W&R "only" Members, when the provider/patient relationship becomes non-collaborative, by notifying the Member in writing that they will no longer be able to provide care for that Member. If the Member is unstable, the provider should care for the Member until the Member selects another provider, and the provider provides emergency care for at least 30 days.
2. Primary Care Providers should notify Partnership of their intent to reassign a Direct Member from their practice so that Partnership can document the reason for reassignment and assist with transition of care, as described above in section VI.G Transition of Care.

J. Reassignment Requests from Specialists, ECM, Community Support and W&R Providers
1. Specialty, ECM, Community Support, or W&R providers may discontinue care for a Member when the provider-patient relationship becomes non-collaborative. In these cases, providers must notify both the PCP and the Member that they will no longer provide care to the Member. The PCP should

refer the member to another specialist for treatment, if specialist care is still necessary.

2. In all cases, the provider reassigning a member should assist with continuity of care by transferring appropriate medical records to the new provider.

K. Request for Grievance
1. Members may request a grievance.

L. Reporting Violent and/or Fraudulent Behavior
1. Providers are encouraged to report violent and/or fraudulent behavior to the appropriate authorities.
2. Member Services notifies Partnership's Regulatory Affairs and Compliance department of suspected fraudulent behavior in accordance with CMP 09

VII. REFERENCES:
N/A

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director of Member Services & Grievance

X. REVISION DATES:
Medi-Cal
04/27/95; 10/13/99; 06/20/01; 08/15/01; 06/19/02 (Hlth Srvcs Policy); 06/18/03 (Mbr Srvcs Policy); 03/05/04; 05/19/04;11/17/04; 11/16/05; 03/07/08; 08/12/08; 01/21/09; 08/19/09; 12/16/09; 03/23/10; 05/11/11; 01/07/2014; 07/14/14; 11/08/17; 02/13/19; 05/13/20; 08/11/21; 09/14/22; 09/13/23; 09/11/24; 09/10/25; 11/04/26

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

PREVIOUSLY APPLIED TO: Partnership *Advantage*: MP316 – 01/01/2007 to 01/01/2015; Healthy Kids: MP 316 12/01/2005 to 12/31/2016

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Synopsis of Changes to Discussion Policies

Below is a summary of revisions to the policies that will be discussed at the Oct. 21, 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]

MPQG1005 Adult Preventive Health Guidelines		Pages 247 - 264
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	

Summary of Revisions (why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
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). **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.	Health Services Claims Provider Relations Configuration

1

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

Synopsis of Changes to Discussion Policies

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		Pages 265 – 280
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	

Summary of Revisions (why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
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.	Claims Configuration Provider Education

MCUG3118 Prenatal & Perinatal Care		Pages 281 – 299
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.):*		

Synopsis of Changes to Discussion Policies

☐ 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	

Summary of Revisions (why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
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 <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."	Provider Education Claims Configuration Member Services Provider Contracting

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.	

MCUP3133 Wheelchair Mobility, Seating and Positional Components		Pages 301 – 312
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	

Summary of Revisions (why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
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." **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."	Claims Configuration Provider Relations Member Services

Synopsis of Changes to Discussion Policies

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 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.	

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MPQG1005 (previously MCQG1005 & QG1001050)				**Lead Department: Health Services** Business Unit: Quality Improvement	
Guideline/Procedure Title: Adult Preventive Health Guidelines				☒ **External Guideline** ☐ **Internal Guideline**	
Original Date: 04/25/1994			**Next Review Date:** ~~04/14/2027~~11/04/2027 **Last Review Date:** ~~04/08/2026~~11/04/2026		
Applies to:	☐ **Employees**		☒ **Medi-Cal**	☒ **Partnership Advantage**	
Reviewing Entities:	☒ **IQI**		☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**		☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**		☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO**	☐ **COO**	☐ **CREDENTIALS**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*				**Approval Date:** ~~04/08/2026~~11/04/2026	

I. RELATED POLICIES:

A. MCQP1021 – Initial Health Appointment
B. MCQP1022 – Site Review Requirements and Guidelines
C. MPUP3047 – Tuberculosis Related Treatment
D. MCUP3052 – Medical Nutrition Therapy (MNT) Services
E. ~~MCUP3101~~ MPBP8007 – Screening and Treatment for Substance Use Disorders
F. MPCP2026 – Diabetes Prevention Services

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Provider Relations
~~C.~~D. Configuration

III. DEFINITIONS:

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

IV. ATTACHMENTS:

A. Adult Preventive Health Screening Guidelines
B. TB Screening Recommendations (Flowcharts)

V. PURPOSE:

To specify and define Partnership Health Plan of California (Partnership) guidelines for adult health screening and preventive services provided by primary care providers to adults aged 18 and over, as recommended by the United States Preventive Services Task Force (USPSTF) and other nationally recognized standards of practice. These include the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Physicians (ACP). These guidelines address periodic health and behavioral risk screening and preventive services for average risk asymptomatic adults.

Individuals identified as being at high risk for a given condition may require screening at intervals that are more frequent or the performance of additional screening tests specific to the condition. High-risk individuals are defined as those individuals whose risk behaviors, family history, socioeconomic status, or lifestyle is associated with a higher tendency towards a specific disease. "Required" and "recommended" screening interventions for various conditions as adapted from the USPSTF guidelines and other resources are listed in Attachment A. (See VI.C below for Preventive Care for Medicare recipients.) Required interventions are an integral component of primary care. Partnership audits the compliance of each primary care provider (PCP) performing these services at least once every three years during Medical Record Review (MRR). Recommended interventions are considered to constitute good clinical care but are not required by Partnership and are not considered as audit criteria.

VI. GUIDELINE / PROCEDURE:

A. Initial Health Appointment (IHA)

~~A.~~1. ~~An Initial Health Appointment (~~IHA~~)~~ must be completed for all Members within 120 days of assignment to Partnership and periodically re-administered per Department of Health Care Services' Contract and CalAIM: Population Health Management (PHM) Policy Guide requirements.

~~1.~~2. An IHA must be performed by a provider within the primary care medical setting.

~~2.~~3. An IHA is not necessary if the Member's PCP determines that the Member's medical record contains complete information that was updated within the previous 12 months.

a. If a Member is new to a PCP's practice and received health-screening services from another provider within the past 12 months, the new PCP should request those medical records from the former provider.

~~3.~~4. If a Member has not been seen for an IHA or for a periodic health-screening visit, the PCP should perform the indicated screening, behavioral risk assessment, and preventive interventions during episodic visits or recommend that the Member schedule a health-screening appointment.

~~4.~~5. An IHA must be provided in a manner culturally and linguistically appropriate to the Member.

~~5.~~6. An IHA must be documented in the Member's medical record and include all of the following:

a. A history of the Member's physical and mental health;
b. An identification of risks;
c. An assessment of need for preventive screenings or services;
d. Health education offered, and
e. The diagnosis of and plan for treatment of any diseases.

7. A subsequent risk assessment should be completed annually or as indicated by the Member's needs and according to the provider's clinical judgment.

~~6.~~8. 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.

B. Documentation

1. Preventive services offered and/or performed, as well as health education provided either verbally or in writing, must be documented in the Member's medical record. Completed and outstanding preventive services should be easily identifiable.
2. Providers must ensure timely provision of immunizations to adult Members in accordance with a recommendation from the CDC/ACIP ~~the most recent schedule and recommendations published by the~~ (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 ~~ACIP-recommended~~ immunizations as part of all regular health visits. All provided immunizations must be documented in the California Immunization Registry (CAIR2).
3. PCPs are required to provide annual cognitive assessments for Members who are 65 years of age or older

and who do not have Medicare coverage. (Reference ~~APL 22-025~~APL 22-025 APL 26-014.) ~~Partnership verifies whether providers have completed the required DHCS Dementia Care Aware cognitive health assessment training, using the list of providers who have completed the training provided by DHCS. Providers must complete the required training to bill and receive reimbursement from Partnership~~. As part of new provider training, Partnership educates its providers to bill appropriately for an annual cognitive health assessment according to the Provider billing requirements outlined in APL ~~22-025~~26-014.

~~a. To receive reimbursement for this assessment, providers must complete the DHCS Dementia Care Aware cognitive health assessment training **prior to** billing for the annual cognitive assessments.~~

a. 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.

b. ~~Once certified, P~~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.) ~~and have~~Providers must have readily available documentation based on APL 26-014 guidelines in the Member's medical record. Approved assessment screening tools include the General Practitioner assessment of Cognition (GPCOG) and the Mini-Cog. Informant tools for family members and close friends, which include the Eight-item Informant Interview to Differentiate Aging and Dementia, the GPCOG, and the Short Informant Questionnaire on Cognitive Decline in the Elderly.

c. Providers who bill for the annual cognitive health assessment must provide appropriate follow-up care based on assessment scores including, but not limited to, additional assessments or specialist referrals.

d. ~~Certified P~~providers should use the CPT code 1494F for billing. ~~**Partnership is not required to reimburse non-certified providers.**~~

C. Medicare Preventive Care
1. All recommendations described in Attachment A apply to Medicare recipients, provided age and other individual specific criteria are met.
2. All adult vaccinations recommended by the current CDC's Advisory Committee on Immunization Practices apply.
3. The following services are available to both Medicare and Medi-Cal recipients:
   a. Medical Nutrition Services (MNT) as outlined in Partnership policy MCUP3052 – Medical Nutrition Services.
   b. Diabetes Prevention Services (DPP) as outlined in Partnership policy MPCP2026 – Diabetes Prevention Services.
4. Medicare-specific preventive care visits as outlined on the Medicare website at http://www.medicare.gov/coverage/preventive-screening-services including, but not limited to
   a. A "Welcome to Medicare" visit
   b. An annual "adult wellness visit" (AWV)
   c. A cardiovascular behavioral therapy visit (performed by the PCP)
   d. An obesity behavioral therapy visit (performed by the PCP).

D. Monitoring and Quality Improvement
1. Documentation of adult preventive health services is reviewed as a component of the Medical Record Review.

VII. REFERENCES:

A. Department of Managed Health Care All Plan Letter 26-014 Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older (July 1, 2026 *supersedes* APL 22-025)

~~A.~~B. DHCS (APL) 25-015 Assembly Bill 144 and Coverage of Preventive Care Services (Sept. 18, 2025)

~~B.~~C. ~~California Department of Health Care Services' (~~DHCS~~)~~ CalAIM: Population Health Management (PHM) Policy Guide (updated ~~July 2025~~January 2026) https://www.dhcs.ca.gov/CalAIM/Documents/PHM- Policy-Guide.pdf

~~C.~~D. DHCS All Plan Letter (APL) ~~24-008~~ 26-015 Immunization Requirements (July 14, 2026 ~~June 21, 2024~~, *supersedes* APL ~~18-004~~24-008)

~~D.~~E. DHCS APL ~~22-030~~ 26-001, Initial Health Appointment (~~Dec. 22, 2022~~Jan. 7, 2026, *supersedes* APL ~~13-017~~22-030)

~~E. DHCS APL 22-025, Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older (Nov. 28, 2022)~~

F. DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (Oct. 11, 2021 supersedes APL 18-014)

G. American Cancer Society Screening Guidelines: https://www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines.html

H. American Academy of Family Physicians (AAFP) 2023 list of assessments that differ from USPSTF: Clinical Preventive Services Recommendations https://www.aafp.org/family-physician/patient-care/clinical-recommendations/aafp-cps.html

D. American College of Obstetricians & Gynecologists (ACOG): http://www.acog.org/ (requires subscription)

E. American College of Physicians (ACP): https://www.acponline.org/clinical-information/clinical-guidelines-recommendations

F. Centers for Disease Control, Vaccines and Immunizations https://www.cdc.gov/vaccines/?CDC_AAref_Val=https://www.cdc.gov/vaccines/schedules/index.html

G. American Society for Colposcopy and Cervical Pathology: https://www.asccp.org/guidelines/screening-guidelines/

H. Adult Vaccination Schedule; https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf

K. United States Preventive Services Task Force (USPSTF) https://uspreventiveservicestaskforce.org/uspstf/home

L. California Welfare and Institutions Code 14132.171, Annual cognitive health assessment

M. Medicare Preventive & Screening Services – https://www.medicare.gov/coverage/preventive-screening-services

N. California Assembly Bill 2132 Health Care Services: Tuberculosis (Sept. 29, 2024) https://leginfo.legislature.ca.gov/

~~O. Department of Health Care Services vaccine schedules pending guidance.~~

VIII. DISTRIBUTION:

A. Partnership Department Directors

B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal

HS-4 - 12/27/95; 08/05/97; 10/10/97 [name change only]; 02/10/99; 06/21/00, 06/20/01; 06/19/02; 10/30/02; 10/20/04; 05/17/06; 09/19/07; 03/18/09; 10/20/10; 03/21/12; 04/17/13; 04/16/14; 04/15/15; 05/18/16; 4/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 02/09/22; 09/14/22; 03/08/23; 04/10/24; 03/12/25; ~~03/11/26~~04/14/26; 11/04/26

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*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 meeting date.

PREVIOUSLY APPLIED TO:

Partnership Advantage
MPQG1005 - 09/19/2007 to 01/01/2015

Healthy Families
MPQG1005 - 10/20/2010 to 03/01/2013

Healthy Kids
MPQG1005 - 09/19/2007 to 04/17/2013

ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

These guidelines for adult health screening and preventive services are derived from the most recent United States Preventive Services Task Force (USPSTF) and other nationally recognized standards of practice from organizations such as American Academy of Family Physicians (AAFP), American College of Obstetricians and Gynecologists (ACOG), American Cancer Society (ACS), American College of Physicians (ACP), and others. Age, sex and risk factor specific USPSTF recommendations can be found using the ePSS app found on the USPSTF website.

~~Required interventions are italicized and considered to be an integral component of primary care. Consequently,~~ Partnership HealthPlan of California (Partnership) audits the compliance of each PCP performing these services at least once every three years during the Medical Record Review (MRR).

*The USPSTF recommends clinicians discuss these preventive services with eligible patients and offer them as a priority. All these services have received an "A" (strongly recommended) or a "B" (recommended) grade from the Task Force.

PREVENTIVE CARE	FREQUENCY/DETAILS
Aspirin for the Primary Prevention of Cardiovascular Events *	A meta-analysis in the Jan. 22, 2019 issue of JAMA concluded that there was no net benefit for use of aspirin for primary prevention of cardiovascular disease. The USPSTF (April 2022) recommends for adults aged 40 to 59 years with a 10% or greater 10-year cardiovascular disease (CVD) risk, the decision to initiate low-dose aspirin for the primary prevention of CVD should be an individual one. Evidence indicates that the net benefit of aspirin use in this group is small. Persons who are not at increased risk for bleeding and are willing to take low-dose aspirin daily are more likely to benefit. (Grade C) For adults 60 years or older, the USPSTF recommends against initiating low-dose aspirin use for the primary prevention of CVD. (Grade D) Cardiovascular risk can be calculated by the heart risk calculator found at PREVENT Online Calculator – Professional Heart Daily / American Heart Association or the ASCVD Risk Calculator Plus for mobile devices.
Assessment for Hearing Impairment	Age 65+ at the time of the periodic health examination. For individuals likely to take action based on abnormal testing results, consider a three-question screening: 1. Do you have difficulty with your hearing? 2. How bothered are you by your hearing loss? 3. How motivated are you to do something about it? (Affirmative responses to all three warrants referral for diagnostic evaluation and possible treatment.) Reference: *JAMA March 23/30, 2021, pp. 1162-1163.* The USPSTF concludes current evidence is insufficient re: screening for hearing loss in older adults.
High Blood Pressure Screening *	Upon initial entry into PCP practice, then at least every two years. If elevated, the USPSTF (April 2021) recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment, when feasible.
Hypertensive Disorders of Pregnancy Screening	The USPSTF (September 2023) recommends screening for hypertensive disorders in pregnant persons with blood pressure measurements at each prenatal visit. This includes all pregnant persons without a known diagnosis of a hypertensive disorder of pregnancy or chronic hypertension. (Grade B)

ADULT PREVENTIVE HEALTH SCREENING GUIDELINES

PREVENTIVE CARE	FREQUENCY/DETAILS
Colorectal Cancer Screening *	The USPSTF (May 2021) recommends performing screening for colorectal cancer in adults aged 50 to 75 (Grade A) and ages 45 to 49. (Grade B) • Modalities include Fecal Occult Blood Test (FOBT) or Fecal Immunochemical Test (FIT) annually, OR colonoscopy every 10 years; OR flexible sigmoidoscopy every five years OR FIT_DNA test every three years. (See USPSTF for other variations.) CT colonoscopy is technically difficult and Partnership requires a Treatment Authorization Request (TAR). • Recommendations for adults aged 50 to 75 (Grade A) differ from those aged 76 to 85. For adults aged 76 to 85 years, the decision to screen for colorectal cancer is an individual one, taking into account patient's overall health and prior screening for colorectal cancer are more likely to benefit. • The USPSTF does not comment on screening for colorectal cancer in adults older than 85 years of age.
Height & Weight	• Initial entry into PCP practice. • Age 18 to 64: weight at least every two years. • Age 65+: weight at least annually.
HIV Screening and Pre-exposure Prophylaxis to Prevent Acquisition of HIV *	The USPSTF (June 2018 – currently under review) recommends that each adolescent and adult ages 15 to 65 without risk factors be tested for HIV once in their lifetime. In addition, all individuals at increased risk for HIV, regardless of age, should be tested every year. Pregnant persons should be tested with each pregnancy, including those presenting in labor oat at delivery whose HIV status is unknown. The Centers for Disease Control and Prevention (CDC) recommends prenatal testing for syphilis and HIV during a pregnant person's first prenatal visit and repeat testing for "high-risk" pregnant persons during the third trimester (preferably 28-32 weeks). (CDC, April 19, 2022) The USPSTF (August 2023) also recommends that clinicians prescribe preexposure prophylaxis using effective antiretroviral therapy to persons who are at increased risk of HIV acquisition to decrease the risk of acquiring HIV.
Hepatitis C Screening*	The USPSTF (March 2020) recommends a one-time screening for average risk adults ages 18 to 79. In addition, adults at increased risk of contracting Hepatitis C (e.g., those using injectable drugs of abuse), should be screened periodically (ungraded recommendation). There is limited evidence to determine how often to screen persons at increased risk.
Lung Cancer Screening *	The USPSTF (March 2021) recommends annual screening for lung cancer with low-dose computed tomography (LCDT; CPT code 71211) in adults ages 50 to 80 years who have a 20+ pack-year smoking history and IN ADDITION currently smoke or have quit within the past 15 years or develop a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery. (Grade B) Full-dose CT scans are not approved for screening.
Syphilis Infection, Screening – Non-pregnant and Pregnant Persons *	The USPST (September 2022) recommends screening persons at increased risk for syphilis. (Grade A) At highest risk are men who have sex with men and persons living with HIV. Other risk factors ae history of incarceration, history of commercial sex work, male younger than 29 years old, and (in Partnership regions) current homelessness and current use of methamphetamines.

	The USPSTF (September 2018) recommends early screening for syphilis infection in all pregnant persons. Those presenting in labor or at delivery whose syphilis status is unknown should be tested at that time. (Grade A) The Centers for Disease Control and Prevention (CDC) recommends prenatal testing for syphilis and HIV during a pregnant person's first prenatal visit and repeat testing for "high-risk" pregnant persons during the third trimester (preferably 28-32 weeks). (CDC April 19, 2022) Screen and confirm - Options for testing include traditional screening algorithm: Screen with an initial nontreponemal test (e.g., Venereal Disease Research Laboratory (VDRL) or rapid plasma regain [RPR] test). If positive, confirm with a treponemal antibody detection test (e.g., *T pallidum* particle automated treponemal test (e.g., enzyme-linked or chemiluminescence immunoassay). If positive, confirm with a nontreponemal test.
Latent Tuberculosis Infection (LTBI) Screening	The USPSTF (May 2023) recommends screening for latent tuberculosis infection (LTBI) in populations at increased risk. (Grade B) (See MPQG1004 Attachment B – TB Screening Overview for more specifics.) This recommendation meets the requirements of California's new Tuberculosis screening law, Assembly Bill 2132, which was signed into law Sept. 29, 2024, and took effect Jan. 1, 2025.
Glaucoma Screening	AAFP and USPSTF (May 2022) find insufficient evidence for or against. (Grade I) Medicare recommends screening for those in these high-risk categories: 1. Persons with diabetes, 2. Family history of glaucoma, 3. African American and age 50 or older, or 4. Hispanic and age 65 or older.
Hyperlipidemia Screening (needed for full cardiovascular risk factor evaluation)	The USPSTF recommendations covering lipid screening in adults are archived. UpToDate® ("Screening for lipid disorders in adults" Aug. 2, 2021) recommends obtaining a fasting or non-fasting lipid profile when an adult enters care at a new practice to screen for familial hypercholesterolemia and for cardiovascular risk assessment, with rescreening as part of a cardiovascular risk analysis every five years. Earlier rescreening may be indicated depending on patient-specific factors.
Statin Use for Primary Prevention of Cardiovascular Disease (CVD)	The USPSTF (August 2022) recommends prescribing statins for the primary prevention of CVD for adults ages 40 to 75 years with one or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension or smoking), AND a 10-year cardiovascular risk of ≥10% (Grade B) or 7.5% to <10%. (Grade C) Current evidence is insufficient to assess benefits versus harms in adults > 75 years of age. (Grade I) Cardiovascular risk can be calculated by the heart risk calculator found at PREVENT Online Calculator – Professional Heart Daily / American Heart Association or the ASCVD Risk Calculator Plus for mobile devices.
Vaccination	Based on age and risk factors. For updated schedule, reference the CDC guidelines. https://www.cdc.gov/vaccines/schedules/
Diabetes Mellitus in Adults, Screening for Type 2 and Prediabetes *	The USPSTF (August 2021) recommends screening all adults ages 35 to 70 years who are overweight or obese. (Grade B) The screening interval is uncertain, but every three years "may be reasonable." 2023 Standards of the American Diabetes Association: 1. Testing for prediabetes and DM2 in asymptomatic people should be considered in any overweight adult (BMI >25)[1] with one or more risk factors. Risk factors include a first-degree relative with diabetes, high-risk race/ethnicity (e.g., African American, Latino, Native American, Asian American, Pacific Islander), history of

	CVD, hypertension, HDL cholesterol level < 35 mg/dL (0.90 mmol/L) and triglyceride level > 250 mg/dL (2.82 mmol/L), polycystic ovary syndrome, physical inactivity, and/or other clinical conditions associated with insulin resistance (e.g., severe obesity, acanthosis nigricans). 2. Screen all adults beginning at age 35 years. 3. If test results are normal, screen every three years. 4. Acceptable screening tests include fasting plasma glucose, 2-h plasma glucose during a 75-g GTT, and HgbA1c. 5. Persons with HIV should be screened using a fasting glucose test before starting antiretroviral therapy, when switching therapies, and 3-6 months after starting therapy, and then annually, if screening results are normal. [1] *The ADA suggests different BMI parameters for Asian Americans; however, Partnership does not endorse this differentiation.*
Dental Disease and referral to dental provider	The USPSTF (November 2023) concludes that the current evidence is insufficient to assess the balance of benefits and harms of routine screening performed by primary care clinicians for oral health conditions, including dental caries or periodontal-related disease, in adults. The AAFP recognizes the PCP may act as a first line of defense by promoting good oral health during patient visits. Their recommendation is to assess for and promote oral health. Ask about brushing and flossing, use of tobacco and other smoked products, consumption of sugary drinks and advocating and assisting with identifying a primary dental office. Frequency includes entry into PCP practice, then yearly or as indicated by the PCP and/or dental care provider.
Alcohol and Drug Misuse and Behavioral Counseling Interventions *	The USPSTF (November 2018 currently under review) recommends screening for unhealthy alcohol use in primary care settings in adults 18 years and older, including pregnant persons. Screen all adults annually; if present, offer behavioral interventions to reduce unhealth alcohol use. (Grade B) The USPSTF (June 2020) recommends asking about unhealthy drug use in adults aged 18 years or older. When screening is positive, offer or refer for appropriate treatment. California Department of Health Care Services (DHCS) All Plan Letter (APL) 21-014 – Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment – Oct. 11, 2021)
Diet, Behavioral Counseling in Primary Care to Promote a Healthy Lifestyle – Recommendations for adults with and without known CVD risks *	The USPSTF (July 2022 - currently under review) recommends for adults **without** known CVD risk factors individualizing the decision to offer to refer to behavioral counseling interventions to promote a healthy diet and physical activity. The USPSTF (November 2020 – currently under review) recommends offering or referring adults **with** one of the following: 1. Hypertension 2. Dyslipidemia 3. Mixed multiple risk factors such as metabolic syndrome or a ≥ 7.5% estimated 10-year CVD risk to intensive behavioral/counseling interventions to promote a healthy diet and physical activity for CVD prevention. This recommendation no longer includes adults with other known modifiable CVD risk factors such as abnormal blood glucose levels, obesity, and smoking, as these populations are covered by other USPSTF recommendations. Individuals with a diagnosis of prediabetes should be referred to participate in a Diabetes Prevention Program, if available.

Screening for Depression and Suicide Risks * in Adults and Perinatal Depression	The USPSTF (June 2023) recommends screening for depression on the general adult population, including pregnant persons and post-partum persons. (Grade B) Screening should be implemented with adequate systems in place to ensure accurate diagnoses, effective treatment, and appropriate follow up. There is little evidence regarding optimal timing for screening. The USPSTF (October 2022) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for suicide risk in the adult population, including pregnant and post-partum persons, as well as older adults. (Grade I) The USPSTF (February 2019) also recommends that pregnant persons at risk of depression should be referred for counseling even if not currently depressed. (Grade B) Risk factors include low socio-economic status. Consequently, all pregnant Partnership members should be referred for at least one counseling session. The Partnership HealthpPlan Perinatal Services (PHPS) Program includes provision of counseling services. If a PHPS program is available, all eligible Partnership members should be referred to a PHPS program for counseling and other services.
BEHAVIORAL CONDITIONS	**DETAILS**
Anxiety *	The USPSTF (June 2023) recommends screening for anxiety disorders in adults 64 years or younger, including pregnant and post-partum persons who have no recognized signs of symptoms of anxiety. (Grade B) The USPSTF (June 2023) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for anxiety disorders in older adults 65 years or older. (Grade I)
Cognitive Health Assessment (for members 65 years and older)	PCPs are required to provide annual cognitive assessments for Members who are 65 years of age or older and who do not have Medicare coverage. (Reference APL 26-014.). 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.
Obesity *	The AAFP recommends screening all adults for obesity (using BMI >30).. The current USPSTF (September 2018) recommendation is that clinicians should offer or refer patients with a BMI of 30 or more to intensive, multicomponent behavioral interventions. (Grade B) $BMI = \left(\frac{\text{Weight in Pounds}}{(\text{Height in inches}) \times (\text{Height in inches})} \right) \times 703$
Tobacco Use and Tobacco Caused Disease Counseling, including for Pregnant Persons *	For all adults who are not pregnant, the USPSTF (January 2021) recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and USDA- (FDA-) approved pharmacotherapy for cessation. (Grade A) For all pregnant persons, the USPSTF recommends that clinicians ask all pregnant persons about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant persons who use tobacco. (Grade A)

Unintended Pregnancy *	Screen all reproductive aged persons at risk for unintended pregnancy (and males who may cause unintended pregnancy); offer counseling and access to contraceptives, including emergency contraception. (ACOG 2019) Recommended screening question with a modified "One Key Question" method: "Do you, or any of your sensual or sexual partners, want to become pregnant in the coming year?" (AAFP 2021)
OTHER SCREENINGS	**DETAILS**
Abdominal Aortic Aneurysm Screening*	The USPSTF (December 2019) recommends one-time screening for abdominal aortic aneurysm by ultrasound in persons aged 65 to 75 who have ever smoked (≥100 cigarettes smoked) and were assigned as male at birth. (Grade B)
Prostate Cancer Screening (Prostate Specific Antigen blood test) *	USPSTF recommendations (December 2023 – currently under review): • Asymptomatic average risk persons with a prostate aged 55 to 69 years should have shared decision making with their clinician about the pros and cons of screening. (Grade C) • Persons with a prostate aged 70 and older should not be screened. (Grade D) • Persons with a prostate with prostate symptoms may have a PSA as part of their diagnostic evaluation.
Screening for Intimate Partner Violence *	Adapted from USPSTF (June 2025) recommendations: Screen all patients of childbearing age for intimate partner violence when a routine health maintenance exam is performed, including those who are pregnant and postpartum. (Grade B) Providers should refer patients who screen positive to ongoing support services.
Breast Cancer Screening by Mammography *	The USPSTF (April 2024) recommends biennial mammography for persons aged 40 to 74 years with breasts and assigned as female at birth who are asymptomatic. (Grade B) Transgender and Gender Diverse persons: The "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8" from the World Professional Association for Transgender Health (WPATH) recommends "… health care professionals follow local breast cancer screening guidelines developed for cisgender women in their care of transgender and gender diverse people who have received estrogens, taking into consideration length of time of hormone use, dosing, current age, and the age at which hormones were initiated." Shared decision making is recommended.
Breast Cancer, Chemoprevention *	The USPSTF (September 2019) recommends clinicians offer to prescribe risk reducing medications, such as tamoxifen, raloxifene or aromatase inhibitors, to persons at high risk for breast cancer and at low risk for adverse effects of chemoprevention. (Grade B) A breast cancer risk assessment toll is available at www.cancer.gov/bcrisktool
Breast and Ovarian Cancer Susceptibility, Genetic Risk Assessment and BRCA Mutation Testing *	Adapted* the USPSTF (August 2019) recommends assessment with an appropriate brief family risk assessment tool for persons at high risk of breast and ovarian cancer. Persons with a positive result should be offered genetic counseling and, if indicated after counseling, genetic testing. (Grade B) See MCUP3131 – Genetic Testing policy for details.

Breastfeeding, Behavioral Interventions to Promote *	The USPSTF (April 2025) recommends interventions or referrals during pregnancy and after birth to promote and support breastfeeding. (Grade B)
Cervical Cancer Screening *	USPSTF recommendations (December 2024 – currently under review) • Persons with a cervix aged 21 to 29 should have cervical cytology screening alone every three years. Persons with a cervix aged 30 to 65 may have cervical cytology screening every three years, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or may have high-risk HPV testing every five years. (Grade A) • Persons with a cervix under aged 21 should not be screened. (Grade D) • Persons with a cervix over age 65 should only be screened if they have never been previously screened, or if one of their last three screenings had any type of cervical atypia. (Grade D) • Routine cervical cytology testing should be discontinued (regardless of age) in persons with a history of a total hysterectomy (removal of the cervix along with the uterus) for noncancerous reasons, as long as they have no history of high-grade CIN. (Grade D) • The USPSTF recommends against screening for cervical cancer in women who have had a hysterectomy with removal of the cervix and do not have a history of a high-grade precancerous lesion (ie, cervical intraepithelial neoplasia [CIN] grade 2 or 3) or cervical cancer. (Grade D) • The USPSTF recommends against screening for cervical cancer in women older than 65 years who have had adequate prior screening and are not otherwise at high risk for cervical cancer. (Grade D) • Note: although the American Cancer Society changed its recommendations in 2020 to recommend later initiation of screening, less frequent screening, and use of HPC screening only under age 30, Partnership continues to recommend following the recommendations of USPSTF / ACOG. Additional Notes: The American Society for Colposcopy and Cervical Pathology (ASCCP) recommends the use of vaginal swab collection for high-risk HPV testing in cervical cancer (April 2025), American Cancer Society (December 2025) • Clinician-collected specimens are preferred and self-collected vaginal specimens are acceptable • Vaginal swab collection is recommended for primary HPV screening in asymptomatic, average-risk people with a cervix ages 25-65 years • Following a negative HPV test, self-collected vaginal specimens require repeat testing in 3 years, while clinician-collected vaginal specimens require repeat testing in 5 years • Self-collected vaginal specimens resulting in HPV positive results require a follow-up visit for a clinician-collected cervical specimen • Self-collection is not recommended for high-risk individuals, including those with immunosuppression • Use only FDA-approved collection devices and HPV assays
Chlamydia and Gonorrhea Screening *	USPSTF recommendations (September 2021): Annual screening recommended for sexually active women 24 years or younger and for women aged 25 years or older at increased risk for infection. Risks include previous or current STI, a sex partner with a STI, inconsistent condom use when indicated, a history of exchanging sex for money or drugs, and a history of incarceration. (Grade B) Transgender and gender-diverse persons – Gonorrhea and chlamydia screening recommendations should be adapted based on anatomy (i.e., screening

	recommendations for cisgender females should be extended to all transgender males and gender-diverse persons with a cervix.) Screening at the pharyngeal and rectal site for gonorrhea and chlamydia should be considered based on reported sexual behaviors and exposure. (UpToDate®, March 2024)
Osteoporosis in Postmenopausal Persons Assigned as Female at Birth Screening *	USPSTF recommendation (January 2025): Screen persons assigned as female at birth age 65 and older with bone measurement testing to prevent osteoporotic fractures. (Grade B) For post-menopausal persons assigned as female at birth younger than 65 years, apply a formal clinical risk assessment tool such as the FRAX tool, found at https://www.sheffield.ac.uk/FRAX/tool.aspx?country=9 to determine the appropriate need for bone measurement testing. (Grade B) The USPSTF does not speak to the frequency of interval between testing. ACOG (September 2021) recommends repeat testing no earlier than two years after initial screening in those with a borderline result of a change in risk factors. A one-year follow-up test is recommended for patients on chronic glucocorticoid treatment. WPATH's "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8" provides osteoporosis screening recommendations based on surgical and hormonal histories of transgender and gender diverse individuals.
Vitamin D, Calcium or Combined Supplementation for the Primary Prevention of Fractures in Postmenopausal Persons Assigned as Female at Birth	The USPSTF (April 2018 – currently under review) recommends against daily supplementals with 400 IU or les of Vitamin D and 1000 mg or les of Calcium for the primary prevention of fractures in postmenopausal persons assigned as female at birth. (Grade D) The USPSTF (April 2018) finds inconclusive evidence that the benefits outweigh the risks for daily Calcium doses greater than 1000 mg of Vitamin D supplementation greater than 400 IU to prevent fractures. (Grade I) WPATH's "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8" provides osteoporosis prevention recommendations based on surgical and hormonal histories of transgender and gender diverse individuals.

Resources: United States Preventive Services Task Force recommendations, American Academy of Family Physicians (AAFP), American College of Obstetricians & Gynecologists (ACOG), American College of Physicians (ACP), UpToDate®, the American Diabetes Association, "Standards of Care for the Health of Transgender and Gender Diverse People, Version 8," Centers for Disease Control and Prevention (CDC).

Distribution: Partnership Provider Manual, Department Heads

* Language updated to be non-gender specific.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MPQG1005 (previously MCQG1005 & QG1001050)</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Adult Preventive Health Guidelines</td><td colspan="3">☒ External Guideline
☐ Internal Guideline</td></tr>
<tr><td colspan="2">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: 11/04/2027
Last Review Date: 11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="2">☐ Employees</td><td colspan="2">☒ Medi-Cal</td><td>☒ Partnership Advantage</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td>☒ QUAC</td></tr>
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<tr><td>☐ CEO ☐ COO</td><td colspan="2">☐ CREDENTIALS</td><td>☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: 11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCQP1021 – Initial Health Appointment
B. MCQP1022 – Site Review Requirements and Guidelines
C. MPUP3047 – Tuberculosis Related Treatment
D. MCUP3052 – Medical Nutrition Therapy (MNT) Services
E. MPBP8007 – Screening and Treatment for Substance Use Disorders
F. MPCP2026 – Diabetes Prevention Services

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. 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 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.

IV. ATTACHMENTS:

A. Adult Preventive Health Screening Guidelines
B. TB Screening Recommendations (Flowcharts)

V. PURPOSE:

To specify and define Partnership Health Plan of California (Partnership) guidelines for adult health screening and preventive services provided by primary care providers to adults aged 18 and over, as recommended by the United States Preventive Services Task Force (USPSTF) and other nationally recognized standards of practice. These include the American Academy of Family Physicians (AAFP), the American College of Obstetricians and Gynecologists (ACOG), and the American College of Physicians (ACP). These guidelines address periodic health and behavioral risk screening and preventive services for average risk asymptomatic adults.

Individuals identified as being at high risk for a given condition may require screening at intervals that are more frequent or the performance of additional screening tests specific to the condition. High-risk individuals are defined as those individuals whose risk behaviors, family history, socioeconomic status, or lifestyle is associated with a higher tendency towards a specific disease. "Required" and "recommended" screening interventions for various conditions as adapted from the USPSTF guidelines and other resources are listed in Attachment A. (See VI.C below for Preventive Care for Medicare recipients.) Required interventions are an integral component of primary care. Partnership audits the compliance of each primary care provider (PCP) performing these services at least once every three years during Medical Record Review (MRR). Recommended interventions are considered to constitute good clinical care but are not required by Partnership and are not considered as audit criteria.

VI. GUIDELINE / PROCEDURE:

A. Initial Health Appointment (IHA)
   1. IHA must be completed for all Members within 120 days of assignment to Partnership and periodically re-administered per Department of Health Care Services' Contract and CalAIM: Population Health Management (PHM) Policy Guide requirements.
   2. An IHA must be performed by a provider within the primary care medical setting.
   3. An IHA is not necessary if the Member's PCP determines that the Member's medical record contains complete information that was updated within the previous 12 months.
      a. If a Member is new to a PCP's practice and received health-screening services from another provider within the past 12 months, the new PCP should request those medical records from the former provider.
   4. If a Member has not been seen for an IHA or for a periodic health-screening visit, the PCP should perform the indicated screening, behavioral risk assessment, and preventive interventions during episodic visits or recommend that the Member schedule a health-screening appointment.
   5. An IHA must be provided in a manner culturally and linguistically appropriate to the Member.
   6. An IHA must be documented in the Member's medical record and include all of the following:
      a. A history of the Member's physical and mental health;
      b. An identification of risks;
      c. An assessment of need for preventive screenings or services;
      d. Health education offered, and
      e. The diagnosis of and plan for treatment of any diseases.
   7. A subsequent risk assessment should be completed annually or as indicated by the Member's needs and according to the provider's clinical judgment.
   8. 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.

B. Documentation
   1. Preventive services offered and/or performed, as well as health education provided either verbally or in writing, must be documented in the Member's medical record. Completed and outstanding preventive services should be easily identifiable.
   2. 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).

3. PCPs are required to provide annual cognitive assessments for Members who are 65 years of age or older and who do not have Medicare coverage. (Reference APL 26-014.). As part of new provider training, Partnership educates its providers to bill appropriately for an annual cognitive health assessment according to the Provider billing requirements outlined in APL 26-014.
    a. 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.
    b. 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. Approved assessment screening tools include the General Practitioner assessment of Cognition (GPCOG) and the Mini-Cog. Informant tools for family members and close friends, which include the Eight-item Informant Interview to Differentiate Aging and Dementia, the GPCOG, and the Short Informant Questionnaire on Cognitive Decline in the Elderly.
    c. Providers who bill for the annual cognitive health assessment must provide appropriate follow-up care based on assessment scores including, but not limited to, additional assessments or specialist referrals.
    d. Providers should use the CPT code 1494F for billing.

C. Medicare Preventive Care
1. All recommendations described in Attachment A apply to Medicare recipients, provided age and other individual specific criteria are met.
2. All adult vaccinations recommended by the current CDC's Advisory Committee on Immunization Practices apply.
3. The following services are available to both Medicare and Medi-Cal recipients:
    a. Medical nutrition services as outlined in Partnership policy MCUP3052 – Medical Nutrition Therapy (MNT) Services.
    b. Diabetes Prevention Services (DPP) as outlined in Partnership policy MPCP2026 – Diabetes Prevention Services.
4. Medicare-specific preventive care visits as outlined on the Medicare website at http://www.medicare.gov/coverage/preventive-screening-services including, but not limited to
    a. A "Welcome to Medicare" visit
    b. An annual "adult wellness visit" (AWV)
    c. A cardiovascular behavioral therapy visit (performed by the PCP)
    d. An obesity behavioral therapy visit (performed by the PCP).

D. Monitoring and Quality Improvement
1. Documentation of adult preventive health services is reviewed as a component of the Medical Record Review.

VII. REFERENCES:

A. Department of Managed Health Care All Plan Letter 26-014 Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older (July 1, 2026 *supersedes* APL 22-025)
B. DHCS (APL) 25-015 Assembly Bill 144 and Coverage of Preventive Care Services (Sept. 18, 2025)
C. DHCS CalAIM: Population Health Management (PHM) Policy Guide (updated January 2026) https://www.dhcs.ca.gov/CalAIM/Documents/PHM- Policy-Guide.pdf
D. DHCS All Plan Letter (APL) 26-015 Immunization Requirements (July 14, 2026, *supersedes* APL 24-008)

E. DHCS APL 26-001, Initial Health Appointment (Jan. 7, 2026, *supersedes* APL 22-030)
F. DHCS APL 21-014 Alcohol and Drug Screening, Assessment, Brief Intervention and Referral to Treatment (Oct. 11, 2021 supersedes APL 18-014)
G. American Cancer Society Screening Guidelines: https://www.cancer.org/health-care-professionals/american-cancer-society-prevention-early-detection-guidelines.html
H. American Academy of Family Physicians (AAFP) 2023 list of assessments that differ from USPSTF: Clinical Preventive Services Recommendations https://www.aafp.org/family-physician/patient-care/clinical-recommendations/aafp-cps.html
D. American College of Obstetricians & Gynecologists (ACOG): http://www.acog.org/ (requires subscription)
E. American College of Physicians (ACP): https://www.acponline.org/clinical-information/clinical-guidelines-recommendations
F. Centers for Disease Control, Vaccines and Immunizations https://www.cdc.gov/vaccines/?CDC_AAref_Val=https://www.cdc.gov/vaccines/schedules/index.html
G. American Society for Colposcopy and Cervical Pathology: https://www.asccp.org/guidelines/screening-guidelines/
H. Adult Vaccination Schedule; https://www.cdc.gov/vaccines/schedules/downloads/adult/adult-combined-schedule-bw.pdf
K. United States Preventive Services Task Force (USPSTF) https://uspreventiveservicestaskforce.org/uspstf/home
L. California Welfare and Institutions Code 14132.171, Annual cognitive health assessment
M. Medicare Preventive & Screening Services – https://www.medicare.gov/coverage/preventive-screening-services
N. California Assembly Bill 2132 Health Care Services: Tuberculosis (Sept. 29, 2024) https://leginfo.legislature.ca.gov/

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:
Medi-Cal HS-4 - 12/27/95; 08/05/97; 10/10/97 [name change only]; 02/10/99; 06/21/00, 06/20/01; 06/19/02; 10/30/02; 10/20/04; 05/17/06; 09/19/07; 03/18/09; 10/20/10; 03/21/12; 04/17/13; 04/16/14; 04/15/15; 05/18/16; 4/19/17; *06/13/18; 06/12/19; 06/10/20; 06/09/21; 02/09/22; 09/14/22; 03/08/23; 04/10/24; 03/12/25; 04/14/26; 11/04/26

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

PREVIOUSLY APPLIED TO:
Partnership Advantage: MPQG1005 - 09/19/2007 to 01/01/2015

Healthy Families: MPQG1005 - 10/20/2010 to 03/01/2013

Healthy Kids: MPQG1005 - 09/19/2007 to 04/17/2013

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3013 (previously UP100313)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Durable Medical Equipment (DME) Authorization</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: ~~10/08/2026~~11/04/2027
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~10/08/2025~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3124 – Referral to Specialists (RAF) Policy
C. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
D. MCUG3134 – Hospital Bed/ Specialty Mattress Guidelines
E. MPUP3039 – Direct Members
~~E.~~F. MPUP3139 – Criteria and Guidelines for Utilization Management

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would ~~be inappropriate~~not meet their care needs. Assignment to Direct Member status is based on the Member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP. When a PCP is not assigned, Partnership supports coordination of care among providers.
B. ~~DME:~~ Durable Medical Equipment (DME): According the Department of Health Care Services, DME is a broad term that refers to medical devices and equipment that are durable (i.e. can withstand repeated use, which under the federal definition means that it is expected to last at least three years), used for a medical purpose (i.e. prescribed by a provider) and is necessary to support a member in performing activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs).
C. Medical Necessity: Reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
D. MTU: Medical Therapy Unit - Outpatient clinics located in designated public schools where Medical Therapy Program (MTP) services are provided.
E. MTP: Medical Therapy Program – A special program within California Children's Services (CCS) that provides physical therapy (PT), occupational therapy (OT) and medical therapy conference (MTC) services for children who have disabling conditions, generally due to neurological or musculoskeletal disorders. Services are provided at Medical Therapy Units (MTUs).

F. RAF: Referral Authorization Form
G. TAR: Treatment Authorization Request

IV. ATTACHMENTS:

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

V. PURPOSE:

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

VI. POLICY / PROCEDURE:

A. Partnership covers certain durable medical equipment when prescribed by a physician, physician assistant, or advanced practice registered nurse (which includes nurse practitioner, nurse anesthetist, nurse midwife, and clinical nurse specialist).
   1. When the need for new or modified equipment is identified, the patient's treating provider must confirm the medical necessity of the DME. A written prescription (or electronic equivalent) for rental or purchase must clearly contain the following information:
      a. Full name, address and telephone number of the prescribing provider
      b. Date of prescription (must be current - written within one year of today's date)
      c. Item(s) being prescribed. If multiple or custom items are prescribed, they must be separately specified. Specific billing codes and modifiers MUST be requested.
      d. Medical condition necessitating the particular DME item
      e. Duration of medical necessity stated as precisely as possible (i.e. "3 months" or "permanent")
   2. Partnership will authorize items of DME in accordance with this policy and other criteria listed below ~~Partnership's MCUP3124 Referral to Specialists (RAF) Policy and MCUP3041 Treatment Authorization Request (TAR) Review Process policy, as well as Title 22, Medi-Cal Provider Bulletins and InterQual® Criteria~~ to meet the Member's needs for medically necessary equipment. These needs are limited to services or devices necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain. Other authorization criteria include, but are not limited to:
      a. Title 22 of the California Code of Regulations
      b. Medi-Cal Guidelines
      c. Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process
      d. Partnership policy MCUP3124 Referral to Specialists (RAF) Policy
      ~~a.~~e. Partnership policy MPUP3139 Criteria and Guidelines for Utilization Management.
   ~~2.~~3. Partnership covers durable medical equipment that is the lowest cost to meet the patient's medical needs.

~~B. When the need for new or modified equipment is identified, the patient's treating provider must confirm the medical necessity of the DME. A written prescription for rental or purchase must clearly contain the following information:~~

~~C.~~B. ~~Full name, address and telephone number of the prescribing provider~~
~~D.~~B. ~~Date of prescription (must be current - written within one year of today's date)~~
~~E.~~B. ~~Item(s) being prescribed. If multiple or custom items are prescribed, they must be separately specified. Specific billing codes and modifiers MUST be requested.~~
~~F.~~B. ~~Medical condition necessitating the particular DME item~~
~~G.~~B. ~~Duration of medical necessity stated as precisely as possible (i.e. "3 months" or "permanent")~~

~~C.~~B. Partnership Health Services Department will refer to DHCS Medi-Cal Guidelines sections for Durable Medical Equipment including DME: Billing Codes *(dura cd)* and DME: Other DME Equipment (*dura other*) to determine which items may be rented and/or purchased.

1. "DME Rental Only" items are summarized in Attachment A. ~~summarizes "DME Rental Only" items.~~
    a. Partnership follows the guidelines as set forth in Title 22 Div 3 Sub 1 Chap 3 Article 3 51224.5 that when previously paid rental charges equal the maximum allowable purchase price of the rented item, the item is considered to have been purchased and NO FURTHER reimbursement to the provider shall be made for the beneficiary's use of the item UNLESS repair and maintenance is separately authorized.
    b. Ten months of rental is equal to purchase unless otherwise noted in DHCS guidelines/ Attachment A.
    c. Unless otherwise noted, DME rental is based on a rental period of one calendar month, with the beginning date of rental as the date of service.
    d. For codes that are available for both purchase and rental, if the rental costs exceed purchase, then the provider should be purchasing rather than renting

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

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

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

F. Specific Equipment Requirements
    1. Augmentative and Alternative Communication Devices – Partnership considers authorization for Augmentative and Alternative Communication (AAC) Devices as a benefit for eligible Members with speech, language and hearing disorders if the following conditions have been met:
        a. The request must be accompanied by an assessment acceptable to Partnership, conducted by a licensed speech and language pathologist.
        b. Additional assessments will be considered from other appropriately licensed providers, such as physical or occupational therapists, if the Member has physical limitations which could impact his/her ability to use the AAC device.
        c. A signed prescription from the Member's physician must accompany the request.
        d. The Partnership Chief Medical Officer or physician designee will apply current Medi-Cal criteria when making a determination.
    2. Bathroom Equipment must be ordered by the Member's PCP or specialist treating the Member

through a referral from the PCP. For Direct Members, the bathroom equipment must be ordered by the physician currently managing the medical care for the Member.

a. The following types of bathroom equipment are covered by Partnership provided that medical necessity has been demonstrated. (Note that DME items are covered as medically necessary only to preserve bodily functions essential to activities of daily living or to prevent significant physical disability, but not necessarily to restore the Member to previous function.)
   1) Toilet rail or armrest
   2) Raised toilet seat
   3) Tub stool, bench or bath seat
   4) Bathtub safety rail or grab bars
   5) Transfer tub bench
   6) Commode (bedside)

b. When a ~~The~~ TAR is required for bathroom equipment, it must include documentation of medical necessity for use of the device that includes the following information related to the condition:
   1) Length of time Member has been or will be needing the equipment
   2) Assessment of mental status
   3) Evaluation of functional abilities including assessment of body strength/mobility
   4) Information concerning the Member's ability to properly use the bathroom equipment

~~3. Compression Garments – Effective October 1, 2024, Partnership covers Over the Counter (OTC) compression garments as follows:~~

~~a. Procedure code A6593 may be billed for OTC compression garments and will be limited to two units (per limb) every six months.~~

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

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

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

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

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

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

6. Infant Monitor Guidelines
   a. The monitor must be ordered by the PCP or by a specialist who is treating the Member through a referral from the PCP. For Direct Members, the monitor must be ordered by the physician who is currently managing the medical care for the Member.
   b. A monitor can be ordered for a Member who has a history of bradycardia or apnea.
   c. The TAR must include documentation of medical necessity for use of the monitor that includes the following information related to the condition:
      1) Length of time Member needs the monitor
      2) Description of the history of the condition
   d. Infant monitors are generally authorized until the baby reaches 46 weeks post-conceptual age. Extension beyond this age requires submission of clinical justification.
   e. For all requests, the individual needs of the Member and the characteristics of the delivery system are considered in the authorization process. The general criteria for authorization of monitors are as follows:
      1) Documented apneic spells defined as a cessation of breathing for 20 seconds or longer or a

shorter pause accompanied by bradycardia (<100 beats per minute), cyanosis, or pallor
2) Significant apnea or bradycardia requiring infant stimulation
3) Frequent periods of apnea and/or bradycardia

f. The TAR for an infant monitor should include information concerning the caretaker's ability to properly use the monitor.
g. TARs are typically authorized for rental only. If medical necessity is demonstrated, authorization for purchase may be approved.

7. Knee Scooters require a TAR and may be billed with code E0118 under the following guidelines:
   a. Knee scooters may be billed when a Member is expected to be non-weight bearing for 3 weeks or longer and one of the following criteria are met:
      1) Member has fracture, dislocation, tendon rupture or surgery which requires absolute non-weight bearing to maximize chances for optimal healing and recovery. The Member is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches.
      2) Member has an ulcer or infection which requires absolute non-weight bearing to maximize chances for optimal healing and recovery. This patient is unable to utilize crutches effectively, or is unable to perform tasks of daily living with crutches.
      3) Member has a neurologic or musculoskeletal condition which makes him/her unable to effectively or safely bear weight on one foot. The knee scooter will greatly increase this person's ability to function independently.
   b. Wheelchairs will not be authorized in conjunction with knee scooters.
   c. The resale of the knee scooter is prohibited. Partnership recommends the equipment be donated to a charitable organization when no longer in use.
8. Pediatric Adaptive Equipment – Requests for pediatric adaptive equipment (e.g. specialty strollers, adaptive car seats, floor sitters/activity chairs, stair climbers, etc.) will be reviewed on a case by case basis using criteria described in CCS Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) *08/08/2003*. For Members enrolled in the Medical Therapy Program, medical appropriateness of devices and/or equipment will be determined and recommended by the Medical Therapy Unit providing services. The MTU must submit a TAR with an MTU DME form and all required information as per the process described in Attachment E - MTU DME Review Process and Example Form.
9. Portable ramps are a covered benefit under Partnership. Prior authorization is required.
   a. Portable ramps are those that meet the following conditions:
      1) Foldable or collapsible
      2) Not attached
      3) Suitcase types, which can be easily and readily carried and transported by the recipient for use in multiple locations.
   b. Ramps are not considered portable when they are fixed or modular or in any way attached. Non-portable ramps are not a Medi-Cal benefit.
   c. Criteria for authorization are as follows:
      1) The Member utilizes a manual or power wheelchair for home and/or community access (see policy MCUP3133 Wheelchair Mobility, Seating and Positional Components).
      2) Access to variable height surfaces at home, to a vehicle, and in the community is needed.
      3) The weight of the Member and wheelchair does not exceed the manufacturer's recommended weight limit for the ramp.
      4) Caretaker / Member must demonstrate the ability to safely use the ramp.
      5) Based on the Member's needs, the portable ramp is safer and more efficacious than permanent structural modifications to the Member's residence.

a) Partnership reimburses for a maximum of one vehicle ramp and one home access ramp. If the ramp is needed for employment, the benefit is to be provided through the Department of Rehabilitation.

d. If the Treatment Authorization Request (TAR) includes all information required, the request is reviewed by a Partnership Nurse Coordinator (and the Chief Medical Officer or physician designee if needed.) If the medical necessity of the request is uncertain or questionable, all information is sent to an independent consultant with expertise in the area of the equipment requested. The consultant evaluates all information and may schedule an appointment with the Member, perform an independent evaluation of the request and submit a report to Partnership with recommendations as to the medical appropriateness of the request.

10. Tumor Treating Field Devices – Partnership reviews authorization requests for tumor treating field devices (electrical stimulation devices used for cancer treatment) on a case-by-case basis based on Medi-Cal criteria. Initial TARs are approved for 3 months rental. Re-authorization may be granted when all of the following criteria are met:
    a. A magnetic resonance imaging (MRI) scan has been performed not more than 2 months prior to date of renewal request and documents no evidence of disease progression, and
    b. The Karnofsky Performance Status score is 60 or higher, and
    c. The patient has been wearing the device at least 18 hours daily.
10. Ventilators – Partnership reviews authorization requests for non-invasive ventilators on a case-by-case basis based on InterQual criteria. Initial TARs are approved for 3 months rental. Reauthorizations can be approved in up to 12-month increments. Authorization requests for invasive ventilators are reviewed on a case-by-case basis based on Medi-Cal criteria.
11. Dynamic Splinting
    a. Partnership reviews authorization requests for dynamic splints for the knee (E1810) on a case-by-case basis. Authorizations may be approved as follows:
        1) Pre-operatively: As an adjunct to physical therapy for a Member having surgery to correct knee joint stillness or a contracture due to a previous injury or surgery to the knee.
        2) Post-operatively: As an adjunct to physical therapy if there is documentation of joint stiffness or contracture causing functional limitation of range of motion in the subacute post-operative period defined as > 3 weeks and up to 4 months after surgery.
    b. Dynamic splinting is not considered medically necessary for the following:
        1) Pre-operative request unless the surgery is to correct knee joint stiffness or contraction due to previous injury or surgery
        2) No evidence of knee contracture or stiffness in the subacute post-operative period
        3) Chronic joint stiffness or fixed contractures
        4) No significant improvement to the joint after 4 months of use

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

H. Non-Covered Items - The following DME items are not included as Medi-Cal or Partnership benefits:
    1. Books or other items of a primarily educational nature
    2. Air conditioners/air filters or heaters
    3. Food blenders
    4. Reading lamps or other lighting equipment
    5. Bicycles, tricycles or other exercise equipment
    6. Television sets
    7. Orthopedic mattresses, recliners, recliners with lift system, rockers, seat lift chairs or other furniture

items
8. Waterbeds
9. Household items
10. Modifications of automobile or other highway motor vehicles
11. Other items not used primarily for health-care and which are regularly and primarily used by persons who do not have a specific medical need for them

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

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

VII. REFERENCES:

A. Medi-Cal Provider Manual/Guidelines: Durable Medical Equipment (DME): Overview (*dura*), Billing Codes *(dura cd),* Billing Codes: Frequency Limits *(dura cd fre),* Other DME Equipment (*dura other*) and Oxygen and Respiratory Equipment (*dura oxy*); Orthotic and Prosthetic Appliances and Services: Criteria for Authorization and Reimbursement – Orthotics (*ortho auth ortho*)
B. DHCS All Plan Letter (APL) 15-018 Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components (07/09/2015)
C. Title 22 California Code of Regulations (CCR) Div 3 Sub 1 Chap 3 Article 3 51224.5
D. InterQual Criteria®
E. CCS Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) (08/08/2003)
F. CCS Numbered Letter (N.L.) 02-0107 Authorization of Rental of Portable Home Ventilators (01/05/2007)
~~G. Partnership Benefits Review and Evaluation Workgroup (BREW) Form #24 OTC/Off-the-Shelf Compression Garments. (07/25/2024)~~

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

03/23/95; 10/10/97 (name change only); 02/09/00; 05/17/00; 09/19/01; 09/18/02; 10/15/03; 02/18/04; 10/20/04; 10/19/05; 08/16/06; 04/16/08; 07/15/09; 07/21/10; 06/20/12; 02/18/15; 02/17/16; 02/15/17; *03/14/18; 09/12/18; 04/10/19; 05/13/20; 09/09/20; 08/11/21; 08/10/22; 01/11/23; 04/10/24; 08/14/24; 10/08/25; 11/04/26

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting

date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

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

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

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

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

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

DME RENTAL ONLY

Decubitus Care Equipment

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

Oxygen and Related Equipment

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

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

DME RENTAL ONLY

Traction and Trapeze Equipment

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

Miscellaneous

E0604	Breast Pump, heavy duty, hospital grade, electric (AC and/or DC), any type. This is also known as a hospital grade (multi-user) electric breast pump.
E0720	TENS device, two lead, localized stimulation [+]
E0730	TENS device, four or more leads, for multiple nerve stimulation [+]
E0766	Electrical stimulation device used for cancer treatment, includes all accessories, any type must be billed with modifier RR (rental) and KF
E2402	Negative pressure wound therapy electrical pump, stationary or portable (daily rental)
K0606	Automatic external defibrillator, with integrated electrocardiogram analysis, garment type
K0743	Suction pump, home model, portable, for use on wounds (modifier RR)

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

Rental Period

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

DME LIMITED TO SPECIAL CIRCUMSTANCES

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

HCPCS codes E0650, E0651, E0652, E0655, E0656,- E0657, E0658, E0659, E0660, E0665, E0666, E0667, E0668, E0669, E0670, E0671, E0672, -E0673, E0675, E0676, E0678, E0679, E0680, E0681, -E0682

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

Cervical Traction Device

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

Limited to CCS ONLY

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

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Oxygen (O_2) REQUEST VERIFICATION FORM

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

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

Date of Birth: _____ Physician: _____

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

2. Date of O_2 Saturation test: _____

3. Is the O_2 request

Continuous use? _____

Supplemental use with activity? _____

Nocturnal use? _____

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

I have reviewed and concur with this information._____

Requesting Physician Signature/Please Also Print Name

State of California - Health and Human Services Agency

Department of Health Care Services

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

(EXCEPT WHEELCHAIRS AND SCOOTERS)

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

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

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

REQUIRES THE ATTENDING CLINICIAN TO COMPLETE AND SIGN

SECTION 1—Clinician's Information:

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

Address Street	City	State	ZIP

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

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

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

Address Street	City	State	ZIP

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

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

Equipment required for:

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

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

SECTION 2A—For Renewal:

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

SECTION 3—Equipment Requested:

a) _____

b) STANDARD: _____ BARIATRIC: _____

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

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

e) Other DME the beneficiary has: _____

f) How many hours per day of usage? _____

g) Accessories requested and why: _____

h) Custom features requested and why: _____

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

j) Patient currently using the following equipment: _____

k) When/How often: _____

l) State specific reason for accessories requested: _____

SECTION 4—Diagnosis Information

Diagnoses: _____ Date of onset: _____

Prognosis: _____

SECTION 5—Pertinent History:

_____

_____

SECTION 6—Functional Status:

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

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

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

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

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

Cognitive status: _____ Vision: Impaired ❒ Normal ❒

Contractures:

SECTION 7—Living Environment:

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

Other: _____

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

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

Transportation:

SECTION 8—Hospital Bed:

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

_____

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

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

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

If no, explain why: _____

_____

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

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

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

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

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

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

SECTION 10—Clinician attestation and signature/date:

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

Clinician's Signature:

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

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

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

When quote is agreed upon,

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

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

Notes:

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

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

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

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

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

☐ Signed prescription attached

☐ Therapist assessment complete

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

☐ Quote reviewed

☐ The following codes/items are not approved:

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

MTU Approval Date:

Sample Form

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3118 (previously MCQG1017 & QG100117)			**Lead Department: Health Services** **Business Unit:** Utilization Management	
Guideline/Procedure Title: Prenatal & Perinatal Care			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/22/1994 (Policy HS-1)		**Next Review Date:** ~~10/08/2026~~11/04/2027 **Last Review Date:** ~~10/08/2025~~11/04/2026		
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:** ~~10/08/2025~~11/04/2026	

I. RELATED POLICIES:

A. MCUP3141 – Delegation of Inpatient Utilization Management
B. MPQP1022 – Site Review Requirements and Guidelines
C. MPBP8003 – Mental Health Services
D. ~~MPCP2017~~ MPBP8011 – Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines
E. MP~~C~~NP~~D~~9006 – Doula Services Benefit
F. MPCR15 – Doula Credentialing
G. MCUP3124 – Referral to ~~a~~ Specialists (RAF) Policy
H. MCUP3052 – ~~-~~Medical Nutrition Therapy (MNT) Services
I. ~~MCCP2020~~ MPNP9007 – Lactation Policy and Guidelines
J. MCUP3113 – Telehealth Services
K. ~~MCQG1015 – Pediatric Preventive Health Guidelines~~CLPM31 – Obstetrical Services

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

D. Doula: A trained birth worker credentialed by Partnership who provides health education, advocacy, and physical, emotional, and non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support before, during, and after miscarriage, stillbirth, and abortion. Doulas are not licensed and they do not require clinical supervision.
E. Licensed Midwife is licensed as a Midwife by the Medical Board of California.
F. Partnership HealthPlan Perinatal Services (PHPS): CPSP-like services that are equivalent to, or substantially similar to, the services defined by the CDPH-defined CPSP program. *(see also the Comprehensive Perinatal Services Program (CPSP) definition above)*
G. Perinatal Case Manager: Provides ~~services of health education and case management~~health education and case management services in a perinatal program using CPSP or other protocols and under the supervision of the Clinical Director.
    1. A Perinatal Case Manager is equivalent to a Comprehensive Perinatal Health Worker (CPHW) in a CPSP program
H. Perinatal services are defined as pregnancy-~~-~~related services ~~given~~ provided before and during delivery and for a period of 12 months following delivery
I. Professional Organizations: The primary professional organizations representing Obstetricians/Gynecologists, Family Physicians, Nurse Midwives, and Licensed Midwives in the United States are listed below. These organizations develop clinical guidance, provide educational resources, advocates for health care, and set standards of care for obstetric and gynecologic practices.
    1. American College of Obstetricians and Gynecologists (ACOG)
    2. American Academy of Family Physicians (AAFP)
    3. American College of Nurse-Midwives (ACNM)
    ~~2.~~4. National Association of Certified Professional Midwives (NACPM)

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IV. ATTACHMENTS:

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

V. PURPOSE:

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

VI. GUIDELINE / PROCEDURE:

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

b. Health Education Learning Needs/ Risks/ Concerns (prenatal tool / postpartum tool)
c. Nutrition (prenatal tool / postpartum tool)

8. To increase provider awareness of comprehensive perinatal services and the potential benefits for pregnant Members.

B. 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.

~~B.~~C. Partnership HealthPlan Perinatal Services (PHPS)

1. All pregnant Members are eligible to receive perinatal case management services.
   a. Partnership encourages universal participation in the CPSP and CPSP-like programs, collectively called Partnership HealthPlan Perinatal Services (PHPS). Members are eligible for PHPS services from the time they believe they may be pregnant through 12 months post-partum.
   b. PHC offers a perinatal program called the Growing Together Program, open to all pregnant and post-partum individuals.
   c. For patients with additional needs and risks, Partnership shall refer Members to Partnership Care Coordination and local resources for programs (e.g. Enhanced Care Management (ECM), home visiting programs, Black infant health, targeted case management, etc.).
2. Program materials for PHPS are subject to audit and review during the Site Review process at least every three years for prenatal care providers and Perinatal Case Managers.
   a. A PHPS program may submit claims for services using Z-codes for any affiliated practice site.
   b. PHPS services may be performed in the home, office or via telemedicine, using the appropriate modifiers and place of service codes.
   c. Partnership allows all practices sites of a provider organization that has a CDPH-approved CPSP program to submit claims for perinatal services using applicable CPSP billing codes for the services provided.
3. Modular Approach: All organizations/ Perinatal Services Pro~~-~~grams with or without a CDPH-certified CPSP program are expected to follow the statutory standards. To meet Member needs, PHPS/CPSP providers may provide and bill for a subset of perinatal support services. If a Perinatal Services ~~CPSP~~ program is unable to provide comprehensive services, they are expected to partner with other providers to ensure all Member needs and program requirements are fulfilled. In the event that PHPS or CDPH-certified programs experience a temporary challenge with providing a subset of CPSP/PHPS services due to staffing or capacity challenges, they are also expected to solicit partner organization(s) to fill any gaps. To accomplish this, perinatal providers may submit claims for any CPSP service, whether or not they are providing case management services. For example, “CPSP-like Program A” may provide case management for a member but needs to use a Registered Dietician (RD) at “CPSP-like Program B” to provide nutrition education services. Each program will bill for the services that they provide and ensure that any services and assessments are centralized in the care plan of the program providing primary case management responsibilities (in the example, “CPSP-like Program A”).
4. Partnership Tracking of Perinatal Services Providers: ~~-~~To ensure Partnership oversight of Perinatal Case Management Services, all PHPS providers (including both CPSP programs and providers offering CPSP-like services) need to complete an application (see Attachment A).
   a. All components of the PHPS program relying on outside providers (including delivering providers) require a written letter of agreement from the outside provider.
   b. Providers that may have a PHPS program include: physicians specializing in OB/GYN, Pediatrics, Family Physician; a physician group; a health center, including Federally Qualified Health Centers, Rural Health Centers and Tribal Health Centers; an alternative birthing center; a county run health clinic; a hospital outpatient clinic; a Certified Nurse Midwife run practice; a Licensed Midwife practice.

c. Quality Monitoring of PHPS providers will be completed as follows:
   1) At the time of the Site Review of all PHPS and perinatal providers which occurs at least every three years
   2) Monitoring of grievances
   3) Reviewing administrative data to evaluate quality outcomes and utilization. Specific measures to be evaluated include:
      a) The percentage of all deliveries in which a patient has at least one PHPS service
      b) The percentage of pregnant members with at least one PHPS service who complete at least:
         i. Tthree antenatal and one postpartum PHPS case management -visits/ ~~(~~? Comprehensives~~ Assessments)~~
         ii. Oone mental health service (either PHPS service or other)
         iii. Ffour nutrition services (either PHPS or other)
         iv. Oone doula visit

5. In areas with a hospital capitation agreement, perinatal services including antenatal care, labor and delivery services, should be provided by perinatal providers who deliver at or collaborate with delivery teams at the contracted hospital nearest the Member or a hospital associated with capitation agreements that pertain as related to Member's primary care or other capitation factors.
   a. Exceptions to this include emergency deliveries and out-of-area hospital admissions authorized according to policy MCUP3141 Delegation of Inpatient Utilization Management, Members determined to be high risk who require the services of a perinatologist, and pregnant Members who are not assigned to a primary care provider because they are in a Direct Member category.
   ~~d.~~b. Members may choose a midwifery provider outside of their capitated facility ~~i~~of that facility does not offer midwifery services for delivery.

~~5.~~6. Obstetrics providers and Perinatal Services Providers are encouraged to refer Partnership Members who are pregnant to Partnership's Growing Together Program for support and to assist Members with connections to community resources when and where appropriate.

~~6.~~7. Obstetrics providers are encouraged to refer Partnership Members who are pregnant that may have clinical, behavioral and/or psycho-social risk, or those who have intensive case management and/or care coordination needs to Partnership's Care Coordination department for support.

~~7.~~8. All providers of perinatal services must deliver services in conformance with the following:
   ~~a.~~ Current ACOG Standards for Obstetric-Gynecologic Services~~,~~ (available at this website): https://www.acog.org/clinical~~https://www.acog.org/clinical-information/physician-faqs/-/media/3a22e153b67446a6b31fb051e469187e.ashx~~
   a.
   b. DHCS All Plan Letter (APL) 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members.
   c. ~~Perinatal Services care should generally follow the~~ CPSP Provider ~~Handbook rogram~~ guidelines
      1) Provider Resource Documents https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/Provider-Resource-Document.aspx
      2) CPSP Program page https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx#
      3) CPSP Provider Handbook https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/CDPH%20Document%20Library/Archive/CPSP-Provider-Handbook.pdf

   ~~and fulfill screening ns as outlined in DHCS . which can be found in the CPSP Provider Handbook. Updated s to these practice based guidelines may be made, but these should be standardized and memorialized in written clinical policies, procedures and protocols. SpecifPHPS program protocals~~

~~should include the following ic recommendations for addition are:~~

~~1) Screening for Perinatal Mood Disorder with evidenced based tool such as Edinburgh or PHQ 2 or 9 in the first trimester and throughout pregnancy and post-partum~~

~~2) Screening for Adverse Childhood Events (ACES). See Partnership policy MCQG1015 Pediatric Preventive Health Guidelines~~

~~3) Universal Substance Use Screening using the 4Ps Plus or other evidenced based standardized screening tool to screen for substance use~~

~~4) Screening for Anxiety with the GAD 2, with reflex follow up and referrals for positive result to the GAD7~~

~~b. Screening for Intimate Partner Violence~~

~~APL 26 0005~~

~~c. Claims for PHPS services should be submitted using the codes defined by DHCS for CPSP services. These Z-codes should be used by all PHPS programs, both CDPH-recognized CPSP programs and by CPSP-like programs.~~

d. Newborn Screening Regulations as set forth in Title 17, California Code of Regulations, Section 6500 et seq.

e. Hemolytic disease of the Newborn Requirements as set forth in Title 17, California Code of Regulations, Section 6510 et seq.

f. Title 22 regulations; Title 17 regulations and all applicable sections of the Health and Safety Code.

g. The California Prenatal Screening Program https://www.cdph.ca.gov/Programs/CFH/DGDS/pages/pns/default.aspx~~.~~

9. Updates to individual practice-based guidelines should be standardized and memorialized in written clinical policies, procedures and protocols. PHPS program protocols should include the following screenings:
   a. Screening for Perinatal Mood Disorders at the first prenatal visit, throughout pregnancy, and in postpartum visits using an evidence-based tool such as Edinburgh or PHQ-2 or PHQ-9
   b. Screening for Adverse Childhood Events (ACES)
   c. Universal Substance Use Screening using the 4Ps Plus or other evidenced-based standardized screening tool to screen for substance use
   d. Screening for Anxiety with the GAD 2, with reflex follow up and referrals for positive result to the GAD7
   e. Screening for Intimate Partner Violence (IPV)

~~Pregnant and post-partum patients must be screened for perinatal mood disorders using a standardized tool~~

~~g. 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.~~

10. 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.

~~h.~~ Patients who meet diagnostic criteria or have risk factors for perinatal mood disorders should be referred to a behavioral health specialist for further treatment (see policy MPBP8003 Mental Health Services and/or policy ~~MPCP2017~~ MPBP8011 Scope of Primary Care – Behavioral Health and Indications for Referral Guidelines).

a.

~~8.~~11. ~~Perinatal service providers include all of the following~~ Ppractitioners who~~for~~ ~~the purpose of~~ provide~~ing~~ perinatal services include:

a. Physicians who are general practitioners, family medicine physicians, pediatricians, or obstetrician-gynecologists
b. Certified Nurse Midwives
c. Licensed Midwives
d. Nurse Practitioners
e. Physician Assistants
f. Registered Nurses, Licensed Vocational Nurses, Social Workers, Health Educators, Childbirth Educators, Registered Dietitians, Comprehensive Perinatal Health Workers or Perinatal Case Managers

~~9.~~12. Doulas can provide non-medical support for pregnant and postpartum persons before, during, and after childbirth, including support during miscarriage, stillbirth, and abortion ~~in accordance with Doula policy : XXXX~~ as described in policy MPNP9006 Doula Services Benefit.

~~C.~~D. PHPS Standards of Perinatal Case Management

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

1) Perinatal Case managers are expected to provide core educational messages related to nutrition and nutritional risk assessment. These services would be included in their case management services and not billed separately. Targeted nutrition education services may be billed with the nutrition-specific Z-codes, when provided by one of the following:
   a) Nutritionist or Nutrition Coach: General information on healthy diet in pregnancy, which may include motivational interviewing techniques, may be provided by a health educator, a community health worker, or other staff person who has completed at least 6 months of training in nutrition and health coaching. Complex dietary needs or issues would be referred to a Registered Dietician
   b) Certified Registered Dietician: May perform general nutrition education, but also has the expertise to handle more complex issues, such as diet modifications for obesity, gestational diabetes, celiac disease, hyperemesis, food allergies, restrictive diets (such as those with no dairy products or no meat), etc. In addition, many Rregistered Ddieticians (RD) are Ceertified Ddiabetes Care and Eeducationors Specialists (CDCES), and the usual nutritional Z-codes can be used when billing for these services by a Registered Dietician.
   c) Pregnant individuals can be more motivated to make changes, and obesity is usually very difficult to treat with little nutrition services available to non-pregnant individuals; we highly recommend that all individuals with a pre-pregnancy BMI greater than 25 have at least one visit with a Nutritionist or Nutrition coach, with additional visits if the patient needs them to reinforce changed behavior.

c. Mental Health Services
   1) Perinatal Case Managers
      a) Perinatal Case Managers are expected to screen for depression and anxiety as part of their initial, ongoing and post-partum assessments and to recommend and arrange for referrals for birthing individuals who screen positive.
         i. 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.
      b) Additionally, Perinatal Case Managers / CPHWs are expected to offer support and encouragement and to encourage social activities to build mental health resilience.
      a)c) These services would be included as part of their case management services, but they are encouraged to bill separately for depression screening so such screening can be captured using claims data, using one of the following codes:
         i. Preferred:
            a. HCPCS: G8431 for a positive screen with a plan
            b. HCPCS: G8510 for a negative screen
         ii. Other option:
            a. CPT: 96127 used for each screening tool used (can bill two units if G codes above not used and both the PHQ2 ≥ 9 (for depression) and the GAD 2 ≥ 7 (for anxiety) are used). If the depression screening is reported using the G-codes above, if a GAD is also done, it can be reported using one unit of 96127.
            b. ICD10: use Z13.31 if screening is done on patient without symptoms concerning for depression or anxiety; use a more specific code if a screening is done in response to signs or symptoms.
   2) Mental Health Counselors (including counseling for substance use disorders):
      The United State Preventive Services Task Force (USPSTF) recommends that ALL low-income pregnant individuals receive preventive counseling on building resilience and detecting early signs of depression and anxiety that would require evaluation. Such

preventive counseling, and counseling for mild dysphoria, can be provided by a community health worker (CHW) or health educator with special training on such preventive mental health counseling, under the supervision of a licensed mental health clinician. The mental health Z-codes may be used.

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

d. Perinatal Health Education services may be provided by staff with the qualifications outlined in the CPSP program or by educators or health workers with specific training competencies related to one or more aspects of wellness for birthing individuals. Education conducted in the course of routine prenatal/post-partum/peripartum care provided by clinicians or doulas is not separately reimbursable; it is considered a part of their professional services. Separate and stand-alone educational services, whether individual or in a group setting, may be billed by a CPSP program or a CPSP-like program using the education Z-codes. CHW provided education may be billed as a CHW service or a perinatal education service, but not both.

~~D.~~E. CPSP/Perinatal Services Case Management Responsibilities

1. The Perinatal Case Manager/CPHW is expected to plan and ensure the provision of comprehensive perinatal services, including nutrition, health education, and psychosocial assessments and reassessments, individualized care plan development, coordination of services, and referrals. At a minimum, for low-risk individuals, four case management visits are recommended: one in each trimester and one in the post-partum period.
2. The Perinatal Services case manager must assure that the following has been provided to the Member and documented in the medical record:
   a. An orientation about the purpose of the Perinatal program and the guidelines about the services which have been offered
   b. Identify the location/ provider of medical prenatal care, with planned location of delivery.
   c. Review the warning signs and symptoms that warrant urgent attention and office procedures for the perinatal services.
   d. Information about the available adjunctive referral services available to the Member.
   e. Advise the Member about their rights and responsibilities in accepting or refusing the services offered.
   f. Notification regarding Partnership appeal and grievance policies.
   g. ~~An offering~~ Complete ~~of~~ the initial nutrition, health education and psychosocial assessments~~,~~; ~~and~~ develop an individualized care plan~~, development,~~; and offer ~~including~~ both individual and group interventions for each service as recommended in the individualized care plan~~s~~.
   h. Documentation of referrals to services which are not specifically included in the definition of comprehensive perinatal services, but which are appropriate for the medical and/or psychosocial health of the Member, should be noted in the record by the Perinatal case manager.
3. The Perinatal Services case manager must use orientation, assessments, re-assessments, individual and group process interventions and family support participation as methods for the provision of comprehensive perinatal services.
   a. Standardized assessment and reassessment tools, and the individualized care plan must be updated and revised as necessary ~~at least~~ each trimester and at the post-partum visit, more frequently as needed.

1) The CDPH standardized tool or a modification of this tool may be used, but it should be standardized and documented in the provider's organizational policies and procedures and, where feasible, integrated into the shared medical record.

b. Each component of the individualized care plan should identify risk conditions; prioritize the Member's needs, referrals, and proposed interventions including methods, time frames and outcome objectives for psychosocial, health education, and nutrition services.

c. The perinatal provider must document the assessment of the member's obstetrical status at each visit.

4. A Member has the right to decline to participate in any part of the Comprehensive Perinatal Services Program. This should be documented clearly in the medical record.
   a. Members who initially declined should be offered services throughout pregnancy and postpartum period
5. Within 3 business days of completion of an initial problem list and care plan, and upon update of this care plan each trimester, a copy must be transmitted to the prenatal care provider in a manner agreed upon by the PHPS provider and the prenatal care provider. Any urgent changes or developments should be additionally communicated via phone, secure text, a centralized health information exchange, or secure email (as requested by the prenatal care provider).
6. Providers of PHPS must submit a TAR to Partnership for the provision of services in excess of the Partnership maximum frequency allowance for nutrition, psychosocial and health education services.
7. Perinatal Services providers must maintain an updated list of staff working in their program, with their job titles and training/licensure. These will be reviewed at Site Reviews of the perinatal provider at least every 3 years.
   a. These will be provided to Partnership upon request and submitted with PHPS applications and updates.

~~E.~~F. Perinatal Services Health Education Roles

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

~~F.~~G. Diabetes Care in Pregnancy (formerly known as "Sweet Success" programs)

1. Birthing people with diabetes are at risk of a variety of serious complications for both the birthing person and their baby. A large body of research shows that intensive education, case management and obstetrical support reduces the incidence of complications and improves outcomes (summarized by the American Diabetes Association in the references).
2. To optimize outcomes for pregnant persons with diabetes, the PHPS program allows for the following services:
   a. Diabetes education (including the use of continuous glucose monitoring) may be provided by any Certified Diabetes Care and Education~~or~~ Specialist (CDCES), whether through a PHPS provider or through any other Partnership contracted CDCES. When a Registered Dietitian (RD) performs CDCES services in a PHPS program, the nutrition Z-codes may be used. When a contracted RD performs CDCES services outside of a PHPS program, the codes listed in policy MCUP3052 Medical Nutrition Therapy (MNT) Services may be used. If a nurse within a PHPS program conducts CDCES services, the education Z-codes may be used.
   b. Extra perinatal case management services are required for optimal outcomes in patients with pregnancy and diabetes. Any TARS for increased visit frequencies for diabetes in pregnancy will be evaluated with this in mind.
   c. Diabetes education for pregnant individuals may be done either in-person or through video

telemedicine visits.

d. While any licensed prescriber may adjust medications for diabetes in pregnancy, expertise and experience in this area is associated with tighter control and improved outcomes. Ideally there is a hierarchy of expertise in such prescribing, with all levels thoroughly educated on and in alignment of the goal of excellent blood sugar control in a pregnant individual. The details of the hierarchy can vary, but may include a CDCES-RN adjusting medication via a written protocol under supervision of a physician with expertise in more complex cases. Such medication titration by an RN is typically associated with additional diabetes education and thus can be billed through PHPS using the education Z-codes.

e. The decision as to who will provide CDCES services and who will manage medication must account for the geographic location of the patient, their preferences for telemedicine, regional access to technology that supports telemedicine, visits, the availability of staff with expertise in this area, and the language and cultural concordance of different provider options. Requiring all patients to travel long distances on a frequent basis for care that could safely be provided locally or via telemedicine results in inequitable care as patients choose to forgo the care altogether.

1) Where cellular and internet service are unreliable, PHPS programs can consider "hosting" telemedicine visits at their practice sites with non-local consultants to ease access and avoid long distance travel

H. Lactation Counseling and Education

1. 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.
2. Basic lactation education, more formal lactation counseling or lactation consultation may be included as part of PHPS case management services, nutrition service or health education services, depending on the credentials of the person providing the services, using the corresponding Z-codes. Non-PHPS providers may also provide lactation counseling or consultation services as outlined in ~~MCCP2020~~ MPNP9007 Lactation Policy and Guidelines.
3. Women, Infants and Children Supplemental Nutrition (WIC) programs in each county may provide lactation services for Members. PHPS/CPSP programs that do~~es~~ not have Lactation Education, Support or Consultation available should refer to local WIC programs and other community-based l~~L~~actation services.

I. Referral Procedures

1. Specialist care with an obstetrics provider (e.g. Maternal Fetal Medicine or High Risk Obstetrics) does not require an approved Referral Authorization Form (RAF). However, some specialists and practices require a referral and medical records prior to scheduling a consultation.
2. Consultation during pregnancy with a non-Obstetrics specialist (Cardiology, Endocrine) requires that a Referral Authorization Form (RAF) be submitted by the Primary Care Provider (See policy MCUP3124 Referral to Specialists [RAF] Policy)~~.~~
   a. Members requiring a referral to a Medical or Obstetrics specialist should be referred to Partnership's Care Coordination Department for Complex Care Management.

~~2.~~3. It is the responsibility of the perinatal provider to confirm the Member's eligibility and PCP information with Partnership at each visit.

VII. REFERENCES:

A. Guidelines for Perinatal Care –8th Edition by the American College Obstetricians & Gynecologists (ACOG) and the American Academy of Pediatrics (AAP), September 2017.

B. Title 22 regulations; Title 17 regulations and all applicable sections of the Health and Safety Code

C. Medi-Cal Guidelines/ Provider Manual: Pregnancy: Early Care and Diagnostic Services (preg early)

~~C.~~D. Department of Health Care Services (DHCS) All Plan Letter (APL) ~~18-022~~26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members~~ Access Requirements for Freestanding Birth~~

~~Centers and the Provision of Midwife Services~~ (~~12/19/2018~~03/25/2026)

~~D.~~E. DHCS APL 22-024 Population Health Management Policy Guide (11/28/2022)

~~E.~~F. DHCS APL 23-024 *Revised* Doula Services (11/03/2023)

~~F.~~G. California Department of Public Health CPSP Program https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx

H. American Diabetes Association Professional Practice Committee; 15. Management of Diabetes in Pregnancy: Standards of Care in Diabetes—~~2024~~2026. Diabetes Care 1 January 202~~4~~6; 4~~97~~ (Supplement_1): S321~~282~~–S338~~294~~. https://doi.org/10.2337/dc26-S015 ~~https://doi.org/10.2337/dc24-S015~~

I. United States Preventive Services Taskforce (USPSTF): Perinatal Depression: Preventive Interventions. https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/perinatal-depression-preventive-interventions

J. Kroenke, K., Spitzer, R. L., Williams, J. B. W., & Löwe, B. (2003). The Patient Health Questionnaire-2: Validity of a two-item depression screener. *Medical Care*, 41(11), 1284–1292. doi. 10.1097/01.MLR.0000093487.78664.3C

~~G.~~K. Kroenke, K., Spitzer, R. L., & Williams, J. B. W. (2001). The PHQ-9: Validity of a brief depression severity measure. *Journal of General Internal Medicine*, 16(9), 606–613. https://doi.org/10.1046/j.1525-1497.2001.016009606.x

~~H.~~L. Cox, J. L., Holden, J. M., & Sagovsky, R. (1987). Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry*, 150(6), 782–786. https://doi.org/10.1192/bjp.150.6.782

VIII. DISTRIBUTION:

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

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

X. REVISION DATES: (HS-1 - 12/10/96; 10/10/97 [name change only]; 02/17/99; 06/21/00, 10/17/01; 06/19/02; 10/20/04; 04/20/05; 05/18/05; 05/17/06; 08/15/07; 08/20/08; 06/17/09; 01/16/13; 03/19/14; 09/17/14; 02/18/2015; 01/20/16; 01/18/17; *06/13/18; 06/12/19; 06/10/20; 02/10/21; 03/09/22; 03/08/2023; 11/08/23; 09/11/24; 10/08/25; 11/04/26

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

PREVIOUSLY APPLIED TO: N/A

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

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

Guideline/Procedure Number: MCUG3118 (previously MCQG1017 & QG100117)		**Lead Department: Health Services** **Business Unit: Utilization Management**
Guideline/Procedure Title: Prenatal & Perinatal Care		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/22/1994 (Policy HS-1)	**Next Review Date: 10/08/202611/04/2027** **Last Review Date: 10/08/2025**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

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

Partnership HealthPlan of California

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

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

Check one:

_____ Initial (New Perinatal Case Management Service Program)

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

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

Date form completed: _____

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

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

Name of Organization: _____

Organizational NPI Number: _____

Organizational Medi-Cal ID Number: _____

Mailing Address of Organization Headquarters:_____

County where Organizational Headquarters is located: _____

Counties primarily served by PHPS program: _____

Contact Person: _____

Email of Contact Person: _____

Name of CEO or signing authority: _____

Email of CEO or signing authority: _____

Name of Clinical Director of PHPS program: _____

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

Email of Clinical Director: _____

NPI of Clinical Director: _____

Administrative Director of PHPS program: _____

Email of Administrative Director: _____

Primary phone number for program: _____

Type of Perinatal Services:

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

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

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

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

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

(Add more rows if needed)

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

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

Attachments:

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

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

- If your organization performs perinatal case management, please include a copy of the standard assessment that you use or plan to use.
- All ~~L~~licensed 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.

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

_____
Clinical Director's Name and Signature

Submit to: PHPS@partnershiphp.org

For internal use:

Date Perinatal Site Review Last Completed:_____

Date Perinatal Site Review Passed: _____

Date Parent Organization Contract Executed: _____

Parent Organization Provider Number: _____

Other Notes:

MCUG3118 Attachment B
Partnership HealthPlan of California

Frequency Limits for Partnership HealthPlan Perinatal Services (PHPS)

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

Frequency Limits for Partnership HealthPlan Perinatal Services (PHPS)

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

Applying for the CPSP Program

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

Enrollment Requirements:

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

Eligible CPSP Provider Types:

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

To apply for CPSP approval:

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

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

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

New Information for all approved CPSP Providers

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

CPSP Annual Survey

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

Protocol Changes

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

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

Link to program and other handouts.

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3133</td><td colspan="2">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Wheelchair Mobility, Seating and Positional Components</td><td colspan="2">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 11/18/2015</td><td colspan="3">Next Review Date: ~~05/13/2027~~11/04/2027
Last Review Date: ~~05/13/2026~~11/04/2026</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="2">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~05/13/2026~~11/04/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3013 – Durable Medical Equipment (DME) Authorization
C. MCCP2024 – Whole Child Model for California Children's Services (CCS)

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. **Activities of Daily Living (ADL):** The activity of dressing/bathing, eating, ambulating (walking), toileting and hygiene.
B. **Complex Rehabilitation Technology (CRT):** (previously known as Custom Rehabilitation Equipment)~~:~~ Durable medical equipment (DME), ~~Any item, piece of equipment or product system,~~ whether modified or customized, that is individually configured for Members to meet their specific and unique medical, physical and functional needs and capacities for ADLs and IADLs, as medically necessary. CRT is used to increase, maintain or improve functional capabilities with respect to mobility and reduce anatomical degradation and complications of Members~~individuals~~ with disabilities. CRT may only be provided by an accredited CRT supplier. ~~Custom rehabilitation equipment~~CRT includes, but is not limited to, non-standard manual wheelchairs, power wheelchairs and seating systems, power scooters that are specially configured, ordered, and measured based upon patient height, weight and disability, specialized wheelchair electronics and cushions, custom bath equipment, standards, gait trainers and specialized strollers.
C. **CRT Supplier:** Accredited as a Durable Medical Equipment (DME) CRT supplier that specializes in the evaluation, configuration, fitting, adjustment, modification and/or programming of complex rehab technology to meet the specific and unique medical, physical and functional needs of members with disabilities and complex medical conditions.
~~C.~~D. **Durable Medical Equipment (DME):** Devices and equipment, other than prosthetic or orthotic appliances, which have been ordered by a physician, physician assistant, or advanced practice registered nurse (which includes nurse practitioner, nurse anesthetist, nurse midwife, and clinical nurse specialist) in the treatment of a specific medical condition and which have all of the following characteristics:
   1. Can withstand repeated use
   2. Is used to serve a medical purpose
   3. Is not useful to an individual in the absence of an illness, injury, functional impairment or congenital

anomaly; and

4. Is appropriate for use in or out of a patient's home.

~~D.~~E. **Instrumental Activities of Daily Living (IADL):** Activities that allow an individual to live independently in a community and include shopping, housekeeping, accounting, food preparation, taking medications as prescribed, use of a telephone or other form of communication, and accessing transportation within one's community.

~~E.~~F. **Licensed Practitioners:** Clinical professionals furnishing medical care, or any other type or remedial care recognized under State law within their scope of practice as defined by State Law.

~~F.~~G. **Medical Necessity:** For the purposes of this policy, a wheelchair is considered medically necessary if the beneficiary's medical condition and mobility limitation are such that without the use of a wheelchair, the beneficiary's ability to perform one or more mobility related Activities of Daily Living or Instrumental Activities of Daily Living, in or out of the home, including access to the community, is impaired and the beneficiary is not ambulatory or functionally ambulatory without static supports such as a cane, crutches or walker.

~~G.~~H. **Power Mobility Device (PMD):** Base codes include both integral frame and modular construction type power wheelchairs (PWCs) and power operated vehicles (POVs).

~~H.~~I. **Power Operated Vehicle (POV):** Chair-like battery power fed mobility device for people with difficulty walking due to illness or disability, with integrated seating system, tiller steering, and four-wheel non-highway construction.

~~I.~~J. **Power Wheelchair (PWC):** Chair-like battery powered mobility device for people with difficulty walking due to illness or disability, with integrated seating system, electronic steering, and four or more wheel non-highway construction.

~~J.~~K. **Qualified Health Ce~~are Professional (QHCP):** A l~~L~~icensed/certified medical professional such as a physical, occupational, or speech therapist ~~s~~or a practitioner who has specific training and experience in rehabilitation wheelchair evaluations and Member's seating and positioning needs. The QHCP may have no financial relationship with the CRT supplier, QRTP, manufacturer of the recommended CRT product(s) or third-party payor. ~~with competence in analyzing the needs of consumers with disabilities, assisting in the selection of appropriate assistive technology for the consumer's needs, and training in the use of the selected device(s). Specialty certification is required for professionals working in seating, positioning and mobility.~~

~~K.~~L. **Qualified Rehabilitation Technical Professional (QRTP):** A professional with competence in analyzing the needs of Members with disabilities, who has direct, in-person involvement in the selection of appropriate assistive technology for the Member's needs and is directly involved with or closely supervises the final fitting and delivery of the wheelchair to Partnership Members. The QRTP must be a W-2 employee of an accredited CRT supplier; hold the credential of Assistive Technology Professional (ATP) or Seating and Mobility Specialist (SMS) from RESNA; and/or hold the credential of CRT Supplier from the International Registry of Rehabilitation Technology Suppliers. ~~Individuals typically certified as Assistive Technology Professionals who are employed by the vendor providing assistive technology devices to Partnership Members. They may have an additional certification of a Certified Rehabilitation Specialist.~~ The QRTP is responsible for ensuring the equipment provided meets the technical needs of the patient.

~~L.~~M. **SPC:** Seating and provisional components

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe the policy and processes for review of wheelchairs (manual and electric powered) and Power Operated Vehicles (POV) in accordance with the Department of Health Care Services All Plan Letter (APL) 15-018 Criteria For Coverage of Wheelchairs and Applicable Seating and Positioning Component

issued July 9, 2015 as well as the California Children's Services (CCS) Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) issued August 8, 2003 and CCS N.L. 09-0514 Powered Mobility Devices (PMD) issued May 29, 2014.

VI. POLICY / PROCEDURE:

A. An authorization request for rental or purchase of a manual or powered mobility device (wheelchair, POV) requires a written request/prescription from a licensed professional and will be reviewed as follows:

1. Upon receipt of the Treatment Authorization Request (TAR) for complex rehabilitation technology (CRT)~~custom rehabilitation equipment~~ (as per III.B.) and/or powered mobility devices (as per III.H~~G~~.), Partnership HealthPlan of California (Partnership) will arrange for an assessment by an independent Qualified Healthcare Professional (QHCP) who is not employed by or paid by a mobility device vendor/CRT supplier. The purpose of the assessment is to evaluate the appropriateness of the request, document medical necessity for the mobility device, and identify the type of equipment best suited to meet the Member's specific needs. The assessment must be performed in the setting where the Member will use the mobility device. The independent QHCP's written summary of findings and recommendations is required to be submitted to Partnership before a determination decision can be made for the mobility device authorization request. Partnership does not offer incentives or compensation to independent consultants or health plan staff to deny medically appropriate services requested by Members or providers.
2. A prescription for a wheelchair will not be denied on the grounds that it is for use only outside the home.
3. 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.
4. A TAR is required for all wheelchair requests when Partnership is the secondary payer to Medicare.
   a. Partnership will process a TAR for a dually eligible Member in the same manner as it would process a TAR for a Medi-Cal-only Member, regardless of whether Medicare (or any other health coverage) has authorized the equipment or been billed.
   b. A TAR for such requests must include all medical justification and documentation that would normally accompany a Medi-Cal-only TAR and include the message "Medi/Medi: Charpentier/Rates", "Medi/Medi: Charpentier/Benefit Limitation", or "Medi/Medi: Charpentier/Both Rates and Benefit Limitation" in the Medical Justification section.
5. The following sequential questions offer clinical guidance for the ordering of an appropriate device to meet the medical need of treating and restoring the beneficiary's ability to perform one or more mobility related ADLs or IADLs. These guiding principles will be used by Partnership in making a benefit coverage determination.
   a. Does the beneficiary have a mobility limitation that significantly impairs his/her ability to participate in one or more ADLs or IADLs? A mobility limitation is one that:
      1) Prevents the beneficiary from accomplishing the ADLs or IADLs entirely, or,
      2) Places the beneficiary at reasonably determined heightened risk of morbidity or mortality secondary to the attempts to participate in ADLs or IADLs, or
      3) Prevents the beneficiary from completing the ADLs or IADLs within a reasonable time frame
   b. Are there other conditions that limit the beneficiary's ability to participate in ADLs or IADLs?

1) Some examples are impairment of cognition or judgment and/or vision.
2) For these beneficiaries, the provision of a wheelchair and seating and provisional components (SPC) might not enable them to participate in ADLs or IADLs if the comorbidity prevents effective use of the wheelchair or reasonable completion of the tasks even with wheelchair and SPC.

c. If these other limitations exist, can they be ameliorated or compensated such that the additional provision of wheelchair and SPC will be reasonably expected to improve the beneficiary's ability to perform or obtain assistance to participate in ADLs or IADLs?
   1) If the amelioration or compensation requires the beneficiary's compliance with treatment, for example medications or therapy, substantive non-compliance, whether willing or involuntary, can be grounds for denial of wheelchair and SPC coverage if it results in the beneficiary continuing to have a limitation.
   2) It may be determined that partial compliance results in adequate amelioration or compensation for the appropriate use of wheelchair and SPC.
d. Does the beneficiary demonstrate the capability and the willingness to consistently operate the wheelchair and SPC safely and independently?
   1) Safety considerations include personal risk to the beneficiary as well as risk to others. The determination of safety may need to occur several times during the process as the consideration focuses on a specific device.
   2) A history of unsafe behavior may be considered.
   3) Additional information may be requested from the Member's treating medical providers.
e. Can the functional mobility deficit be sufficiently resolved by the prescription of a cane, crutches or walker?
   1) The cane, crutches or walker should be appropriately fitted to the beneficiary for this evaluation.
   2) Assess the beneficiary's ability to safely use a cane, crutches or walker.
f. Does the beneficiary's typical environment support the use of wheelchair and SPC?
   1) Determine whether the beneficiary's environment will support the use of medically necessary types of wheel-chair and SPC.
   2) Keep in mind such factors as physical layout, surfaces, and obstacles, which may render wheelchair and SPC unusable.
g. Does the beneficiary have sufficient upper extremity function to propel a manual wheelchair to participate in ADLs or IADLs during a typical day? The manual wheelchair should be optimally configured (SPC), wheelbase, device weight, and other appropriate accessories) for this determination.
   1) Limitations of strength, endurance, range of motion, coordination, and absence or deformity in one or both upper extremities are relevant.
   2) A beneficiary with sufficient upper extremity function may qualify for a manual wheelchair. The appropriate type of manual wheelchair, i.e. light-weight, etc., should be determined based on the beneficiary's physical characteristics and anticipated intensity of use.
   3) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a manual wheelchair.
   4) Assess the beneficiary's ability and willingness to safely and effectively use a manual wheelchair.
h. Does the beneficiary have sufficient strength and postural stability to operate a POV/scooter?
   1) A covered POV is a 4-wheeled device with tiller steering and limited seat modification capabilities. The beneficiary must be able to maintain stability and position for adequate operation without additional SPC. Three-wheeled devices are not covered.
   2) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a POV.

3) Assess the beneficiary's ability to safely use a POV/scooter.

i. Are the additional features provided by a power wheelchair or powered SPC needed to allow the beneficiary to participate in one or more ADLs or IADLs?

1) The pertinent features of a power wheelchair compared to a POV are typically control by a joystick or alternative input device, lower seat height for slide transfers, and the ability to accommodate a variety of seating needs.
2) The type of wheelchair and options provided should be appropriate for the degree of the beneficiary's functional impairments.
3) The beneficiary's typical environment (in or out of the home) provides adequate access, maneuvering space and surfaces for the operation of a power wheelchair.
4) Assess the beneficiary's ability to safely and independently use a power wheelchair and powered SPC.

4. When a manual or powered mobility device authorization is approved, it is the vendor's/CRT supplier's responsibility to have a Qualified Rehabilitation Technical Professional (QRTP) ensure the equipment provided meets the technical needs of the Member. Any customized additions or added features that are not specifically covered under the approved authorization will require submission of another request (for a "custom wheelchair or device") to authorize these additions. Failure on the part of the CRT supplier~~vendor~~ to do so before building and delivering the customized device could result in denial of requests for payment for the additional features.

B. Medical Necessity

1. Manual wheelchairs are medically necessary when:
   a. Criteria 1), 2), 3), 4) and 5) below are met; and
   b. Criterion 6) or 7) is met, and
   c. Criteria is met for specific devices listed below.
      1) The beneficiary has a mobility limitation that significantly impairs his/her ability to participate in one or more ADLs or IADLs, and
      2) The beneficiary's mobility limitation cannot be sufficiently resolved by the use of an appropriately fitted cane, crutches or walker, and
      3) The manual wheelchair supplied to the beneficiary for use in or out of the home and community settings provides adequate access to these settings (e.g., between rooms, in and out of the home, transportation, over surfaces and a secure storage space), and
      4) Use of a manual wheelchair will improve the beneficiary's ability to participate in ADLs or IADLs.
      5) The beneficiary has expressed a willingness to use the manual wheelchair that is provided, and
      6) The beneficiary has sufficient upper extremity function and other physical and mental capabilities needed to safely self-propel the manual wheelchair during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function.
      7) A standard wheelchair may be medically necessary
         a) When the beneficiary is able to self-propel the wheelchair, or
         b) Propel with assistance
      8) A standard hemi-wheelchair may be medically necessary
         a) For disarticulation of one or both lower extremities, or
         b) Requires a lower seat height because of short stature, or
         c) To enable the beneficiary to place his/her feet on the ground for propulsion
      9) A lightweight wheelchair may be medically necessary
         a) When a beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel, or

b) For a beneficiary with marginal propulsion skills.

10) A high strength lightweight wheelchair may be medically necessary when
   a) The beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel while engaging in frequent ADLs or IADLs that cannot be performed in a standard or lightweight wheelchair, or
   b) The beneficiary requires a seat width, depth, or height that cannot be accommodated in a standard, lightweight or hemi-wheelchair
11) An ultra-lightweight multi-adjustable wheelchair may be medically necessary when
   a) The beneficiary's medical condition and the weight of the wheelchair affects the beneficiary's ability to self-propel while engaging in frequent ADLs or IADLs that cannot be performed in a standard, lightweight or high strength lightweight wheelchairs, and
   b) The beneficiary's medical condition and the position of the push rim in relation to the beneficiary's arms and hands is integral to the ability to self-propel the wheelchair effectively, and
   c) The beneficiary has demonstrated the cognitive and physical ability to independently and functionally self-propel the wheelchair, or
   d) The beneficiary's medical condition requires multi-adjustable features or dimensions that are not available in a less costly wheelchair (e.g., pediatric size and growth options)
12) A heavy--duty wheelchair is medically necessary when
   a) The beneficiary weighs more than 250 pounds, as documented in clinical notes within the past 12 months, or
   b) The beneficiary has severe spasticity, or
   c) Body measurements cannot be accommodated by standard sized wheelchairs.
13) An extra heavy--duty wheelchair is medically necessary when
   a) The beneficiary weighs more than 300 pounds, as documented in clinical notes within the past 12 months, or
   b) Body measurements cannot be accommodated by a heavy--duty wheelchair
14) Manual tilt-in-space wheelchairs are medically necessary when
   a) The beneficiary is dependent for transfers, and
   b) The beneficiary has a plan of care that addresses the medical need for frequent positioning changes (e.g., for pressure reduction or poor/absent trunk control) that do not always include a tilt position.
15) Pediatric sized folding adjustable wheelchairs with seating systems are covered as primary or back-up wheeled mobility when
   a) The beneficiary meets the criteria for wheeled mobility, and
   b) The wheelchair is an appropriate size for the beneficiary, and
   c) The beneficiary meets the criteria for recline and positioning options, and
   d) The wheelchair provides growth capability in width and length

2. Powered Mobility Devices are medically necessary when:
   a. Criteria 1), 2), and 3) below are met, and
   b. Criteria is met for specific devices listed below.
      1) The beneficiary has a mobility limitation that impairs his or her ability to participate in one or more ADL or IADLs, and
      2) The beneficiary's mobility limitation cannot be safely resolved by the use of an appropriately fitted cane, crutches or walker, and
      3) The beneficiary does not have upper extremity function to self-propel an optimally-configured manual wheelchair to perform ADLs or IADLs during a typical day. Limitations of strength, endurance, range of motion, or coordination, presence of pain, or

deformity or absence of one or both upper extremities are relevant to the assessment of upper extremity function. An optimally-configured manual wheelchair is one with an appropriate wheelbase, device weight, seating options, and other appropriate non-powered accessories.

A four wheeled Power Operated Vehicle (POV) is covered if all of the basic coverage criteria 1) - 3) have been met and if criteria 4) - 9) are also met.

4) The beneficiary is able to:
   a) Safely transfer to and from a POV, and
   b) Operate the tiller steering system, and
   c) Maintain postural stability and position in standard POV seating while operating the POV without the use of any additional positioning aids
5) The beneficiary's mental capabilities (e.g., cognition, judgment) and physical capabilities (e.g., vision) are sufficient for safe mobility using a POV in or out of the home, and
6) The beneficiary's home provides adequate access between rooms, in and out of the home, maneuvering space, over surfaces and a secure storage space for the operation of the POV that is provided, and
7) The beneficiary's weight, as documented in clinical notes within the past 12 months, is less than or equal to the weight capacity of the POV that is provided, and
8) Use of a POV will significantly improve the beneficiary's ability to participate in ADLs or IADLs, and
9) The beneficiary has expressed willingness to use a POV

A Power Wheelchair (PWC) is covered if all of the basic coverage criteria 1) – 3) have been met and

a) The beneficiary does not meet coverage criterion 4), 5), or 6) above for a POV; and
b) Criteria 10) – 13) below are met; and
c) Any coverage criteria pertaining to the specific wheelchair grouping (see below) are met.

10) The beneficiary has the mental and physical capabilities to safely and independently operate the power wheelchair that is provided, and
11) The beneficiary's typical environment (in or out of the home) provides adequate access between rooms, maneuvering space, over surfaces and a secure storage space for the operation of the power wheelchair that is provided, and
12) The beneficiary has expressed willingness to use a power wheelchair.

Power Wheelchairs are segmented into the following groupings:

13) A Group 1 PWC (K0813-K0816) or a Group 2 (K0820-K0829) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and the wheelchair is appropriate for the beneficiary's weight.
14) Group 2 Single Power Option PWC (K0835 – K0840) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if Criterion a) or b) below is met;
   a) The beneficiary requires a drive control interface other than a hand or chin- operated standard proportional joystick (examples include but are not limited to head control, sip and puff, switch control), or
   b) The beneficiary meets coverage criteria for a power tilt or a power recline seating system and the system is being used on the wheelchair
15) A Group 2 Multiple Power Option PWC (K0841-K0843) is covered if all of the coverage

criteria [1) – 3), 10) - 13)] for a PWC are met and if Criterion a) or b) below is met;
   a) The beneficiary meets coverage criteria for a power tilt and recline seating system and the system is being used on the wheelchair, or
   b) The beneficiary uses a ventilator which is mounted on the wheelchair.

16) A Group 3 PWC with no power options (K0848-K0855) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if the beneficiary's mobility limitation is due to a neurological condition, myopathy, or congenital skeletal deformity.
17) A Group 3 PWC with Single Power Option (K0856-K0860) or with Multiple Power Options (K0861-K0864) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:
   a) The Group 3 criteria [17)] are met, and
   b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.
18) A Group 4 PWC with no power options (K0868-K0871) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:
   a) The Group 3 criteria [17)] are met, and
   b) The minimum range, top end speed, obstacle climb or dynamic stability incline that is medically necessary for the beneficiary engaging in frequent ADLs or IADLs cannot be performed in a Group 3 PWC.
19) A Group 4 PWC with Single Power Option (K0877-K0880) or with Multiple Power Options (K0884-K0886) is covered if all of the coverage criteria [1) – 3), 10) - 13)] for a PWC are met and if:
   a) The Group 4 criteria [19)] are met, and
   b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.
20) A Group 5 (Pediatric) PWC with Single Power Option (K0890) or with Multiple Power Options (K0891) is covered if the coverage criteria [1) – 3), 10) - 13)] for a PWC are met; and
   a) The beneficiary is expected to grow in height, and
   b) The Group 2 Single Power Option criteria [15)] or Multiple Power Options [16)] are met.
21) A push-rim activated power assist device (E0986) for a manual wheelchair is covered if the coverage criteria [1) – 3), 10) - 13)] for a PWC are met, and:
   a) The beneficiary has been self-propelling in a manual wheelchair for at least one year, and
   b) The beneficiary has a non-progressive disease, and
   c) The beneficiary has successfully completed a two-month trial period (reimbursable with prior approval as a rental).
22) SPC may be included with new wheelchair or billed separately under the following conditions:
   a) Refer to the SPC Coverage Criteria for information concerning coverage of general use, skin protection, positioning, powered and custom made components.
   b) A POV or PWC with Captain's Chair seating is not appropriate for a beneficiary who needs a separate SPC
   c) If a beneficiary needs a seat and/or back cushion but does not meet coverage criteria for a skin protection and/or positioning cushion, it is appropriate to provide a Captain's Chair seat (if the code exists) rather than a sling/solid seat/back and a separate general use seat and/or back cushion.
   d) A general use seat and/or back cushion provided with a PWC with a sling/solid seat/back will be considered equivalent to a power wheelchair with Captain's Chair and will be coded and priced accordingly, if that code exists.

23) If a beneficiary's weight, as documented in clinical notes within the past 12 months, combined with the weight of seating and positioning accessories can be accommodated by wheelchair with a lower weight capacity than the wheelchair that is requested or provided, approval or payment will be based on the appropriate HCPCS code that meets the medical need.
24) A power mobility device (PMD) will be denied as not medically necessary if the underlying condition is reversible and the length of need is less than 3 months (e.g., following lower extremity surgery which limits ambulation).

3. Backup manual wheelchairs are medically necessary when
   a. The beneficiary meets the criteria for a powered mobility device, and
   b. The beneficiary meets the criteria for the rented or purchased back-up manual wheelchair, and
   c. The beneficiary is unable to complete ADLs or IADLs without a backup manual wheelchair, and
   d. The backup wheelchair accommodates the SPC on the primary wheelchair.

C. Wheelchairs are NOT covered when:
1. Not medically necessary
2. Not used by the beneficiary
3. Used as a convenience item
4. Used to replace private or public transportation such as an automobile, bus or taxi
5. Not generally used primarily for health care and are not regularly and primarily used by persons who do not have a specific medical need for them
6. Used in a facility that is expected to provide such items to the beneficiary
7. Used in a skilled nursing facility, unless the beneficiary demonstrates the need for a custom wheelchair under Title 22 of the Code of Regulation section 51321(h)
8. Not prescribed by a licensed practitioner, or, in the case of a custom wheelchair, by a licensed practitioner after evaluation by a QHCP.

D. Seating and Positioning Component Coverage Criteria:
SPC are covered when criteria 1. 2. and 3. and~~,~~ at least one of criteria 4. – 9. are met.~~, and~~ Criteria 10. – 19. ~~(if applicable)~~ will then be applied if relevant features are requested~~are met~~. (*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*):
1. The beneficiary has met the criteria for wheelchair, and
2. The SPC meets the quality standards and coding definitions specified in the APL 15-018. The Medicaid program reserves the right to review any and all coding assignments by vendors/CRT suppliers and the Medicare Pricing, Data Analysis and Coding (MPDAC) web site based on submitted and published product specifications and other relevant information.
3. The primary and back-up wheelchair bases accommodate the SPC.
4. A general use seat cushion and a general use back cushion are covered when 1., 2. and 3. are met.
5. A skin protection seat cushion or decubitus wheelchair pad is covered when 1., 2. and 3. are met and that beneficiary has one of the following:
   a. A current pressure ulcer or past history of a pressure ulcer on the area of contact with the seating surface; or
   b. Absent or impaired sensation in the area of contact with the seating surface due to but not limited to one of the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease, multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn cell diseases including amyotrophic lateral sclerosis, post-polio paralysis traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease; or
   c. Inability to carry out a functional weight shift due to one of, but not limited to, the following diagnoses: spinal cord injury resulting in quadriplegia or paraplegia, other spinal cord disease,

multiple sclerosis, other demyelinating disease, cerebral palsy, anterior horn, cell diseases including amyotrophic lateral sclerosis, post-polio paralysis, traumatic brain injury resulting in quadriplegia, spina bifida, childhood cerebral degeneration, Alzheimer's disease, Parkinson's disease; or

d. Confined to their wheelchair for more than four (4) continuous hours on a daily basis
e. A well-documented history (as well as current status) of malnutrition.

6. A positioning seat cushion or positioning back cushion, is covered when 1., 2. and 3. are met and the beneficiary has one of the following:
   a. Significant postural asymmetries that are due to but not limited to one of the diagnoses listed in criterion "5." above; or
   b. One of the following diagnoses: monoplegia of the lower limb or hemiplegia due to stroke, traumatic brain injury, or other etiology, muscular dystrophy, torsion dystonias, spinocerebellar disease.
7. A positioning accessory is covered when criteria 1., 2., 3. and 6. are met and specifically:
   a. A headrest or headrest extension (sling support for the head) is covered when the recipient has a covered manual tilt-in space, manual semi or fully reclining back, or power tilt and/or recline power seating system or needs additional head support. The code for a headrest includes any type of cushioned headrest, fixed, removable or non-removable hardware.
   b. An upper extremity support system (UESS) is covered when the medical need for positioning in a wheelchair cannot be met with less costly alternatives such as any combination of a safety belt, pelvic strap, harness, prompts, armrest modifications, recline, tilt in space or other existing or potential seating or wheelchair features. UESS dimensions should not exceed the positioning length of the forearms (e.g., 12-15"). UESS and related accessories are not covered when used solely for activities of daily living.
   c. UESS padding and positioning blocks are covered in addition to a UESS when there is a medical need for stabilization of the UESS due to strong spasticity or exaggerated muscle activity.
   d. Foot-Ankle Padded Positioning Straps (e.g., "ankle huggers") are covered when there is a medical need for stabilization of the foot and ankle due to strong spasticity or exaggerated muscle activity, and positioning in the wheelchair cannot be met with less costly alternatives, such as any combination of heel loop/holders and or toe/loop/holders, with or without ankle straps.
8. A combination skin protection and positioning seat cushion is covered when 1., 2., 3., 5. and 6. are met, i.e., the criteria for both a skin protection seat cushion and a positioning seat cushion are met.
9. A custom fabricated seat cushion is covered if the criteria for 8. are met and there is a comprehensive written evaluation by a licensed clinician (who is not an employee of or otherwise paid by a vendor or manufacturer), which clearly explains why a standard seating system is not sufficient to meet the beneficiary's seating and positioning needs. (If a custom fabricated seat and back are integrated into a one-piece cushion, code using the custom seat plus the custom back codes.)
10. If foam-in-place or other material is used to fit a substantially prefabricated cushion to an individual recipient, the cushion must be billed as a customized cushion, not custom fabricated.
11. The code for a seat or back cushion includes any rigid or semi-rigid base or posterior panel, respectively, which is an integral part of the cushion.
12. Payment for all wheelchair seats, backs and accessory codes includes fixed, removable and/or quick-release mounting hardware if hardware is applicable to the item.
13. The swing away, multi-positioning or removable mounting hardware upgrade code may only be billed in addition to the codes for a headrest, lateral trunk, hip supports, medial thigh supports, calf supports, abductors/pommels, and foot supports when medically justified. It must not be billed in addition to the codes for shoulder harness/straps or chest straps, wheelchair seat cushions or back

cushions, or with PWCs with swing away, fixed or retractable joysticks.

14. A manual tilt in space option is covered when:
    a. Criteria 1. – 3. above are met, and
    b. The beneficiary is dependent for transfers, and
    c. The beneficiary has a plan of care that addresses the medical need for frequent positioning changes (e.g., for pressure reduction or poor/absent trunk control) that do not always include a tilt position.
15. A power tilt in space option for a PWC is covered when:
    a. Criteria 1. – 3. and 14. above are met, and
    b. The beneficiary has the mental and physical capabilities to safely and independently operate the power tilt in space that is provided.
16. A manual recline option is covered when:
    a. Criteria 1. – 3. above are met, and
    b. The beneficiary has a plan of care that requires a recline position to complete ADLs or IADLs, and
    c. The beneficiary has positioning needs that cannot be met by upright or fixed angle chair, or
    d. The beneficiary's postural control requires a recline feature.
17. A power recline option for a PWC is covered when:
    a. Criteria 1. – 3. and 16. above are met, and
    b. The beneficiary has a plan of care that requires a recline position to complete ADLs or IADLs, and
    c. The beneficiary has the mental and physical capabilities to safely and independently operate the power recline feature that is provided.
18. A combination manual tilt in space and recline option is covered when criteria 14. and 16. are met and if provided alone will not meet the seating and positioning needs.
19. A combination power tilt in space and recline option is covered when criteria 15. and 17. are met and if provided alone will not meet the seating and positioning needs.

E. Portable Ramps
   1. For Partnership's policy on portable ramps, please see policy MCUP3013 DME Authorization section VI.FG.9.

F. Loaner Rental During Repair
   1. Back-up or loaner rental power wheelchairs are ~~not~~ a Medi-Cal covered benefit with no TAR requirement for up to two (2) one-month rental periods per year.
      a. Providers may bill using HCPCS code K0462 for the separate reimbursement of a one-month rental by using required modifier RR, when a member-owned wheelchair is being repaired or undergoing maintenance that is expected to take more than one day.
      b. A TAR will be required to exceed the frequency limit of two times per year. When a TAR is required, documentation of medical necessity must be included to be reviewed by the Chief Medical Officer or Physician Designee.
      ~~b.~~c. ~~On a case by cases basis, up to a one-month rental of a wheelchair may be considered medically necessary (with maximum of one-month renewal with justification) if a Member-owned wheelchair requires an extended repair.~~ Payment for the rental is based on the type of replacement device that is provided. ~~Requests for loaner powered mobility device rentals will require documentation of medical necessity to be reviewed by the Chief Medical Officer or Physician Designee.~~

VII. REFERENCES:

A. Title 22, CCR Sections 52260, 51321
B. Medi-Cal Provider Manual/ Guidelines: Durable Medical Equipment (DME): Wheelchair and Wheelchair Accessories Guidelines (*dura wheel guide*) and Bill for Wheelchairs and Wheelchair

Accessories (*dura bil wheel*)

C. Department of Health Care Services (DHCS) All-Plan Letter (APL) 15-018 Criteria For Coverage of Wheelchairs and Applicable Seating and Positioning Components (07/09/2015)
D. CCS Numbered Letter (N.L.) 09-0703 Revised CCS Guidelines for Recommendation and Authorization of Rental or Purchase of Durable Medical Equipment-Rehabilitation (DME-R) (08/08/2003)
E. CCS Numbered Letter (N.L.) 09-0514 Powered Mobility Devices (PMD) (05/29/2014)
F. Senate Bill No.717 Complex Needs Patient Act, California Legislature 2021-2022 Regular Session, Amended in Senate May 20, 2021. https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220SB717

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

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

X. REVISION DATES: 08/17/16; 08/16/17; *09/12/18; 11/13/19; 11/11/20; 11/10/21; 05/11/22; 06/14/23; 08/14/24; 09/10/25; 05/13/26; 11/04/26

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

PREVIOUSLY APPLIED TO:

MCUP3083 - Wheelchair and Power Operated Vehicle Authorization was archived 11/18/2015
Original Date: 04/16/2008
Revision Dates: 07/15/09; 05/18/11

****

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.



MY2025 NCQA Health Plan Rating

NCQA Final HPR for MY2025

The NCQA projected HPR rating for MY2025 is **3.0 Stars, using the Child CAHPS Survey**.

	MY2023 – Final Used Adult CAHPS	MY2024 – Final Used Child CAHPS	MY2025 – Projected Used Child CAHPS
Patient Experience (CAHPS)	1.5	2.5	2.5
Prevention and Population (HEDIS domain)	3.5	3.0	3.0
Treatment (HEDIS domain)	3.5	2.5	2.5
Bonus for maintaining Accreditation	0.5	0.5	0.5
Overall HPR	**3.5**	**3.0**	**3.0**

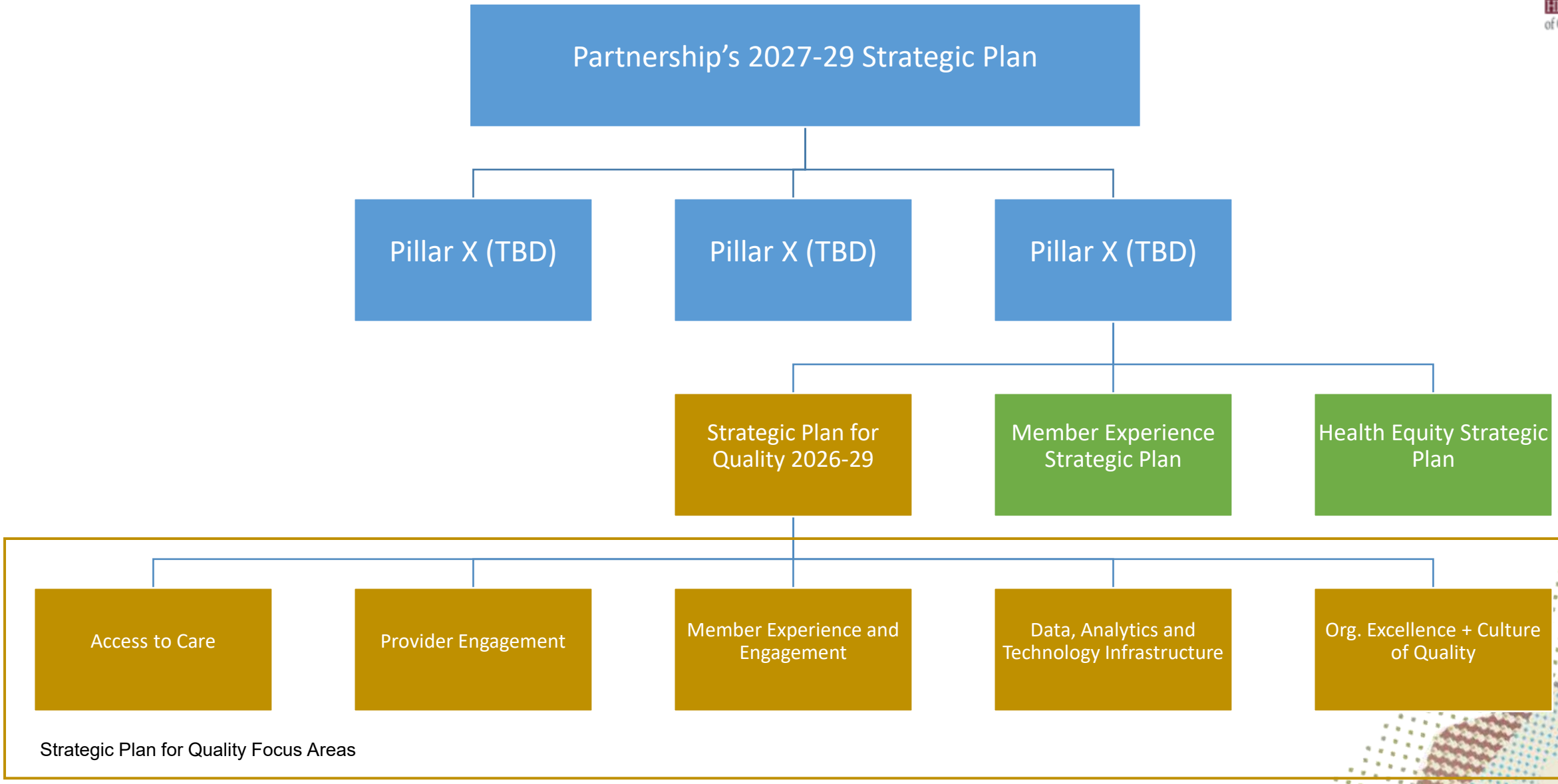
Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

Overall Rating Source	
Measure points	156
Overall Rating Not Rounded	2.689655172
Final Overall Rating +.5 Bonus	3.190
Final Score Rounded	3.0



Partnership's Strategic Plan for Quality Improvement 2026-2029

Partnership's Strategic Planning Initiatives



Why Partnership Needs a 5-Star Quality Strategic Plan

OUR MISSION

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

OUR VISION

To be the most highly regarded managed care plan in California

Quality Strategy Purpose:

- Define the priorities, goals, and strategies that guide Partnership's quality improvement work from 2026 to 2029
- Aligning staff, providers, and community partners around measurable improvements in members' health outcomes
- Protecting the organization's regulatory standing and financial sustainability.

WHY THIS MATTERS NOW

One Shared Direction

Without a unifying plan, departments optimize locally. This plan turns individual efforts into one coordinated push toward the same goals, and makes improving member health outcomes the shared responsibility of everyone at Partnership.

Accelerate Performance to Match Recent Trends

Dramatic changes in quality accountability programs and data exchange landscapes have led to quality performance improving nation-wide. Partnership needs to match the performance trajectory of other Medicaid Plans.

Consistency Across a Diverse Network

Consistency shouldn't depend on geography, language, or circumstance. A shared plan closes gaps in care across all communities we serve.

Alignment: *This plan complements Partnership's 2027-29 Strategic Plan, which sets direction for the whole organization, and aligns with the Health Equity Plan and Member Experience Plan.*

Our Strategic Planning Process

✓ Information Gathered

Information from the following sources resulted in a comprehensive SWOT:

- Leadership Input
- HEDIS and CAHPS Results
- QI Trilogy
- DHCS Quality Programs
- Staff and external partner feedback (focus groups and interviews)

✓ Quality Plan Drafted

Goals and Strategies are based on SWOT analysis and the impact on:

- Member Health
- Member Experience
- Regulatory & Financial Impact
- Organizational Capacity
- Timeline
- Sustainable Impact
- Regional Approach for Impact

❑ Communication and Change Management Planning

- ✓ Key stakeholders partner with QI to vet plan and refine goals and supportive strategies for shared ownership.
- ★ Solicit feedback from staff and Committees
- ❑ Share strategic plan with Board as part of CMO Update (October)
- ❑ Lead departments plan SMART Goals for focus areas
- ❑ Implementation begins November

Strategic Goals 2026–2029

Over the next three years, Partnership will pursue improvements across these five strategic goals:

Improve Member Experience - Member ratings of Getting Needed Care and Getting Care Quickly **performing at 67th Percentile or higher plan-wide**

Reduce Avoidable Utilization - Ambulatory-care sensitive admissions **reduced by 10 percent or higher annually plan-wide**, Hospital readmissions **performing at 90th Percentile plan-wide**

Improve Pediatric Preventive Care - Well-child visits, pediatric immunizations **performing at 67th Percentile or higher in all DHCS Rating Regions**

Improve Chronic Disease Outcomes - Glycemic control for diabetic members, Blood pressure control for members with hypertension **performing at 67th Percentile or higher in all DHCS Rating Regions**

Improve Timely Access to Prenatal Care - Prenatal care initiation during first trimester **performing at 67th Percentile or higher in all DHCS Rating Regions**

5 Star Quality Strategic Plan 2026–2029

This plan moves Partnership toward the vision of being **an NCQA 5-Star Plan.**

SUCCESS MEASURES

NCQA Star Rating — Overall quality performance & accreditation readiness

MCAS Quality Factor Score — Overall performance across the MCAS quality portfolio

STRATEGIC GOALS

With a special focus on our **rural regions** and **reducing health inequities,** we will:

★ **Improve member experience**

★ **Reduce avoidable utilization**

★ **Improve pediatric preventive care**

★ **Improve chronic disease outcomes**

★ **Improve timely access to prenatal care**

Progress will be tracked through Annual SMART goals set for each strategic goal.

FOCUS AREAS + KEY LEADS + OBJECTIVES

1 Access to Care

Network Services + Workforce Dev't + Regional Directors + Health Equity

- Strengthen Partnership's provider network capacity and stability in prioritized communities and services
- Expand alternative access models to meet community care needs

2 Provider Engagement

QI + Partners

- Build the capacity of the provider network toward high performance on prioritized quality measures

3 Member Experience & Engagement

Member Experience + Pop. Health + Health Equity + Care Coordination

- Build infrastructure to understand and act on member experience drivers
- Define and close the highest friction gaps in the member journey
- Improve outcomes for high-risk populations

4 Data, Analytics & Technology

Health Analytics + QI

- Build capacity for centralized quality measurement and analytics that maximize opportunities for improving member health and data interoperability

5 Org. Excellence & Culture of Quality

Administration + Fiscal + QI

- Create shared understanding and accountability for quality improvement org-wide
- Direct QI resources towards initiatives with the greatest impact on member health and financial performance

Next Steps

What Comes Next?

- Communicate to Committees and Board
- Engage with Lead departments to finalize annual SMART goals
- Build Tactical Plans for each Objective
- Annual progress report shared throughout organization and network

How Can My Organization Support?

- Review the Strategic Plan for Quality 2026-29 white paper (in packet)
- Familiarize yourself with the Goals and review your organization's strengths and opportunities
  - Annual Summaries of Performance, Disparity Dashboards, County Data Reports
- Discuss the Strategic Plan for Quality within your organization and how you can align your efforts
- Engage with Quality Improvement and Provider Relation teams and set SMART goals for your organization around priority measures
- Engage with emerging Partnership and community initiatives aligned with the Strategic Plan for Quality
- Embrace improving member experience and reducing health equities as strategies to improve member health

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Health Equity Disparities Grand Analysis

MY2025/RY2026 Summary of Performance

Presented by:

Mohamed Jalloh, PharmD, Director of Health Equity

Outline

- Review of Managed Care Accountable Measures (MCAS)
- Review of MY2025 MCAS Improvements in Disparities
- Review of MY2025 MCAS Measures that Need Support
- Review of MY2025 QIP Measures
- Prioritization and Annual Plan Review

MCAS: Accountable Measures MY2025

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

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

** Designates a Quality Withhold measure

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

Methodology

Measure Identity

MCAS measure stratification per DHCS and NCQA Needs

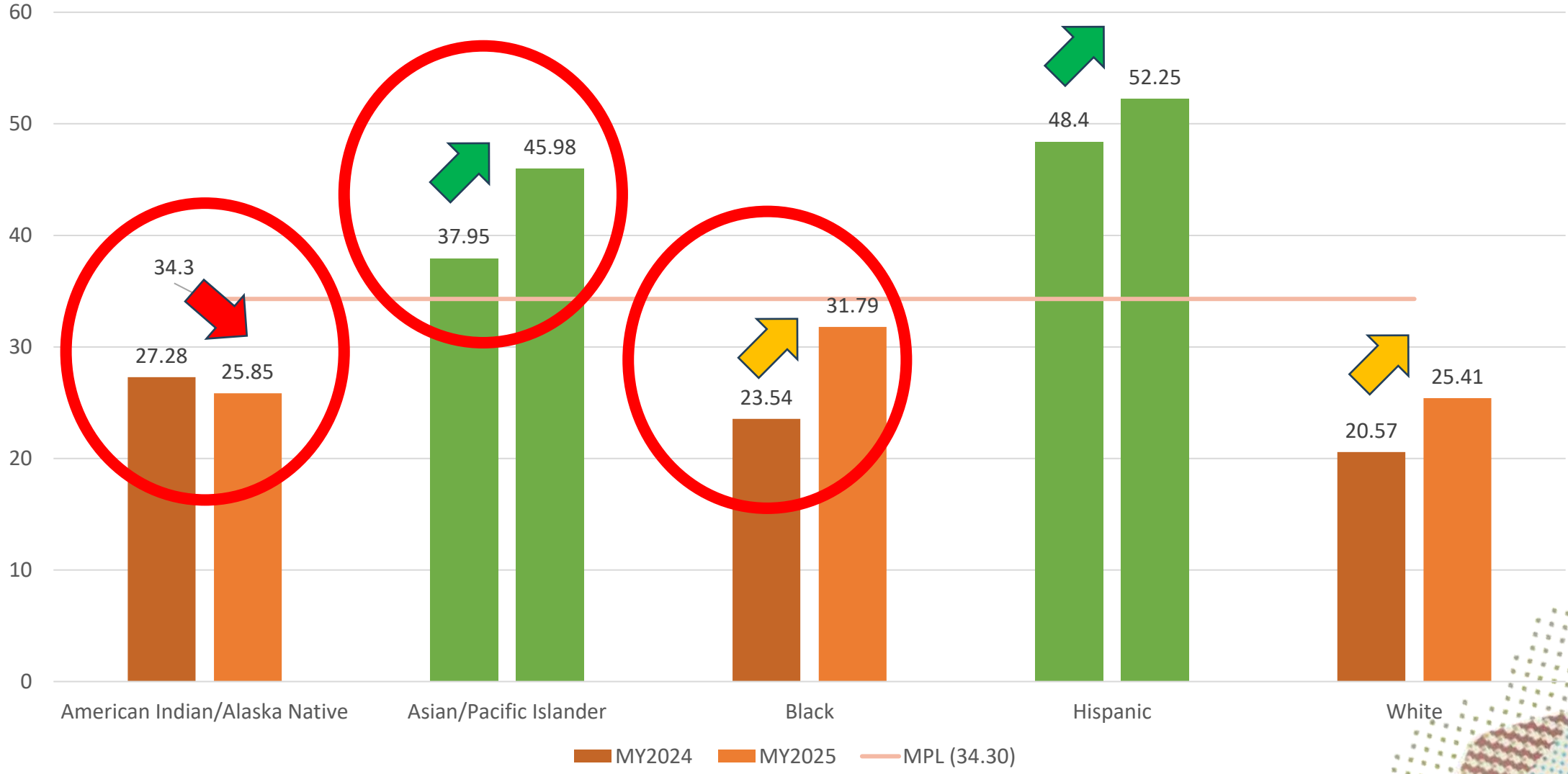
Measure Calculation

Health Analytics Statistical Analysis using “Estimated Race” (Race Stratification)

Measure Prioritization

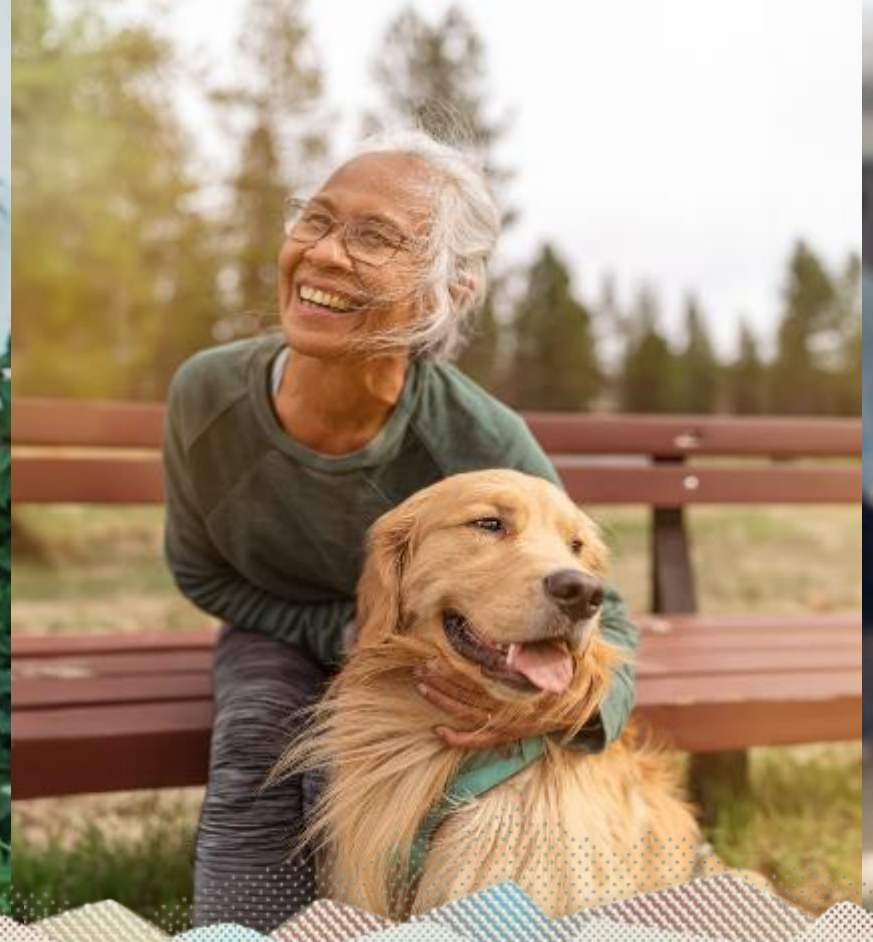
MCAS measure comparison with MPL (MCAS Sample)	QIP measure comparison with white population (QIP)

Example Measure Evaluation



Organization Quality MCAS Measures of Focus

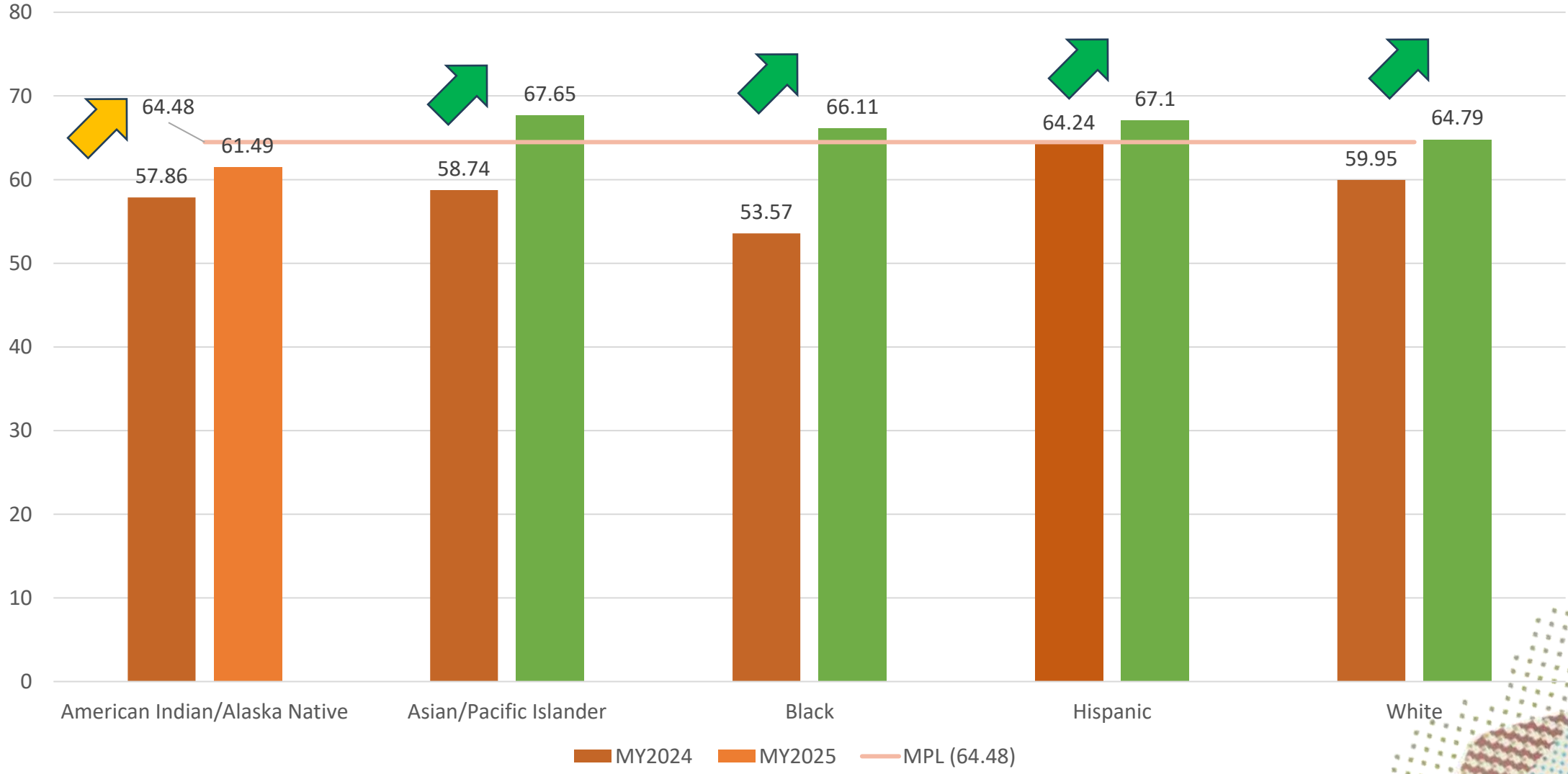
- Child and Adolescent Well Care Visits (WCV)
- Controlling High Blood Pressure (CBP)
- Glycemic Status Assessment for People with Diabetes (GSD)
- Adolescent Immunizations (IMA-2)
- Timely Prenatal Care (PPC-PRE)


PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

Review of MY2025 MCAS Improvements in Disparities

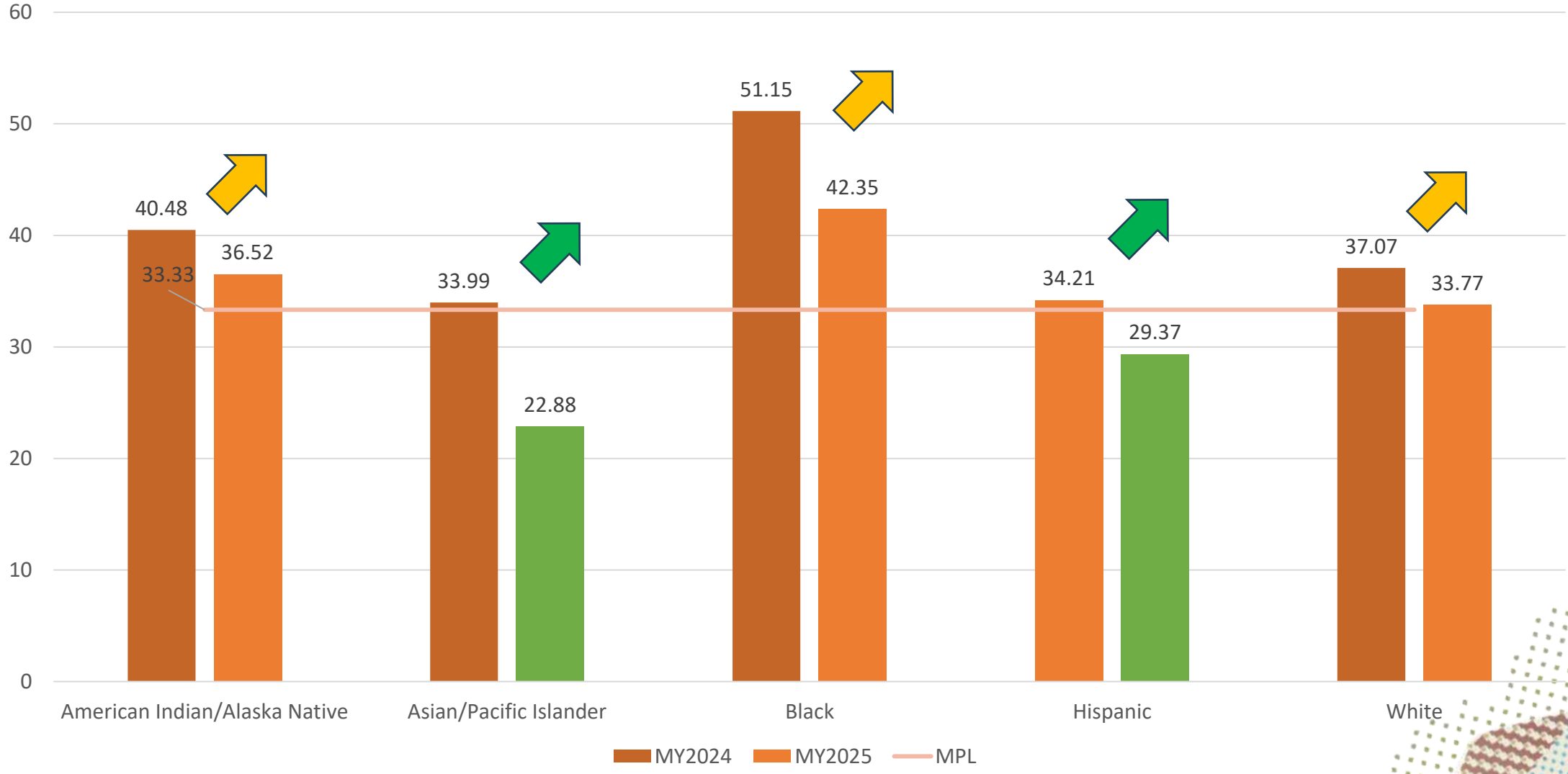
Controlled Blood Pressure (CBP)



Preliminary Impact Analysis for CBP

- Four Disparities Eliminated; Four Disparities Improved; Zero Disparities Worsened
- CHW-Barber Program Charter Development (Launched in 2026); Academic Detailing
- Health Equity Pay-for-Performance (QIP) Bonus launch

HbA1c Poor Control (>9%) (GSD)



Preliminary Impact Analysis for GSD

Two Disparities Eliminated; Five Disparities Improved; Zero Disparities Worsened

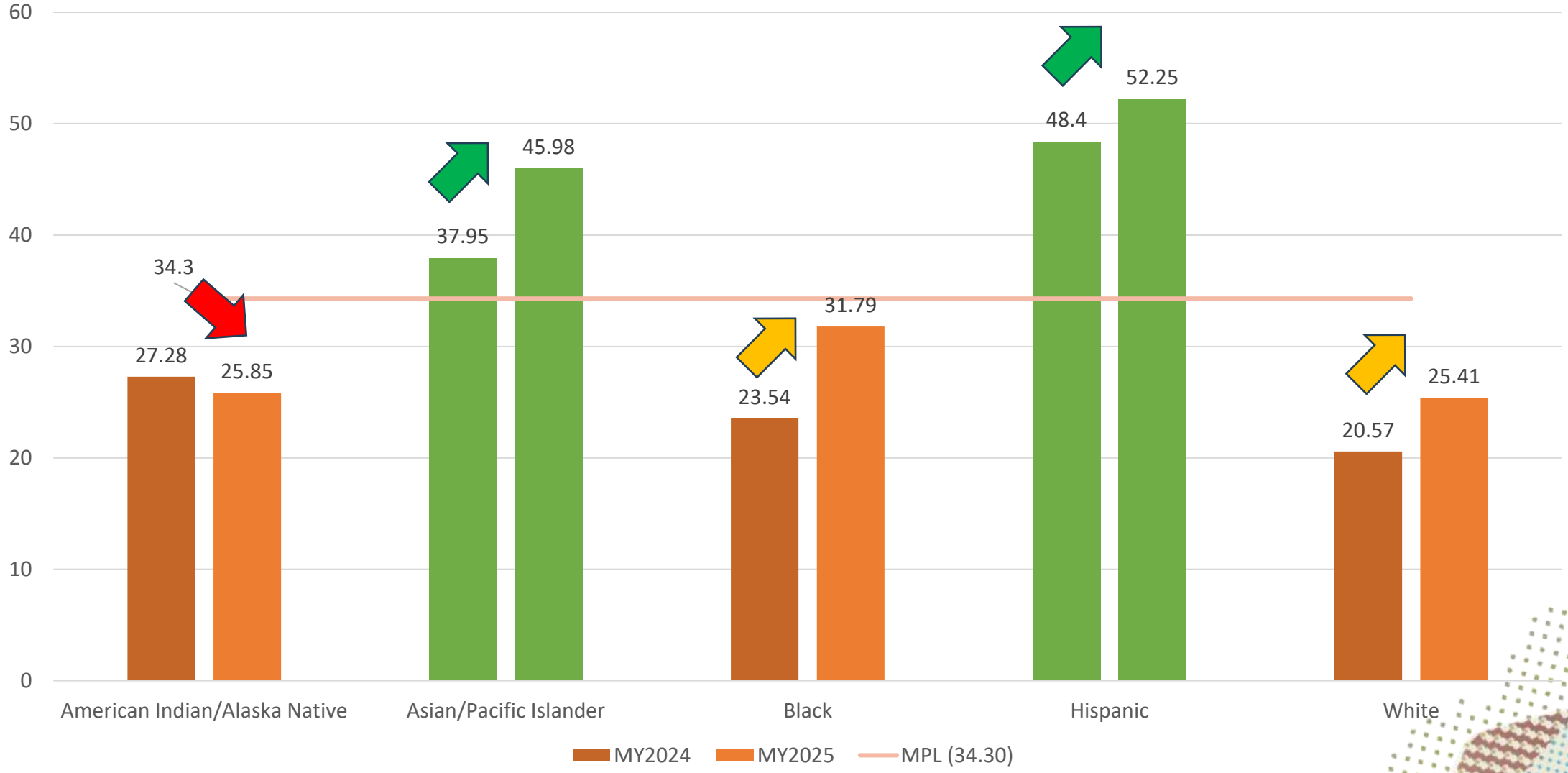
Academic Detailing

Measure Description	American Indian/ Alaska Native **MY2025** (YOY Change)	Asian/Pacific Islander **MY2025** (YOY Change)	Black **MY2025** (YOY Change)	Hispanic **MY2025** (YOY Change)	White **MY2025** (YOY Change)
Prenatal and Postpartum Care: PostPartum Care (PPC-POST)	**86.9** (~+6%)	**90.2** (~+4%)	**82.72** (~+6%)	**92.07** (~+2%)	**83.93** (~+1%)



Review of MCAS Measures That Continue to Need Support

Adolescent Immunizations (IMA-2)

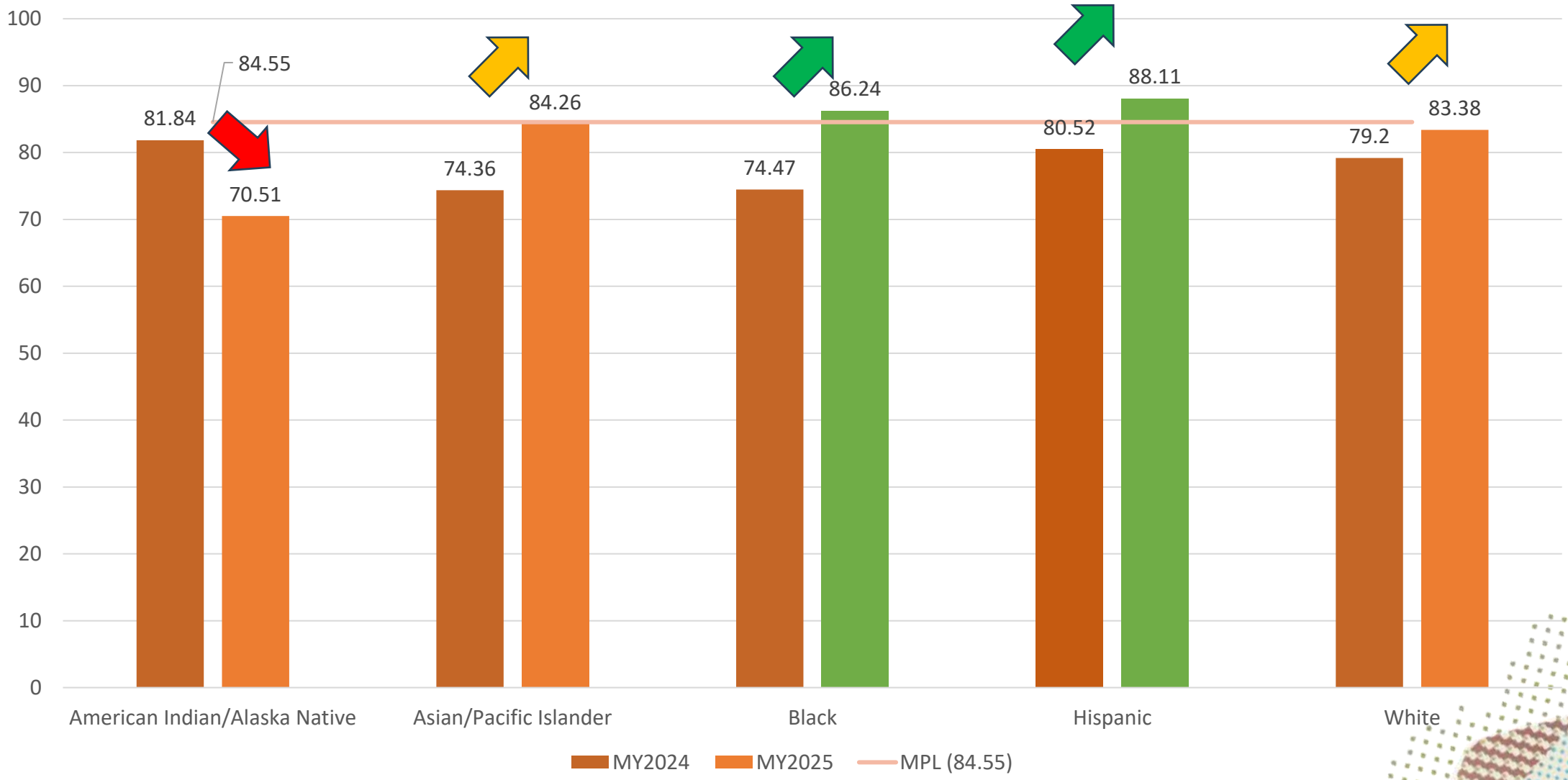


Preliminary Impact Analysis of IMA-2

Zero Disparities Eliminated; Two Disparities Improved; One Disparity Worsened

Focus Groups Planned but not executed in CY2025

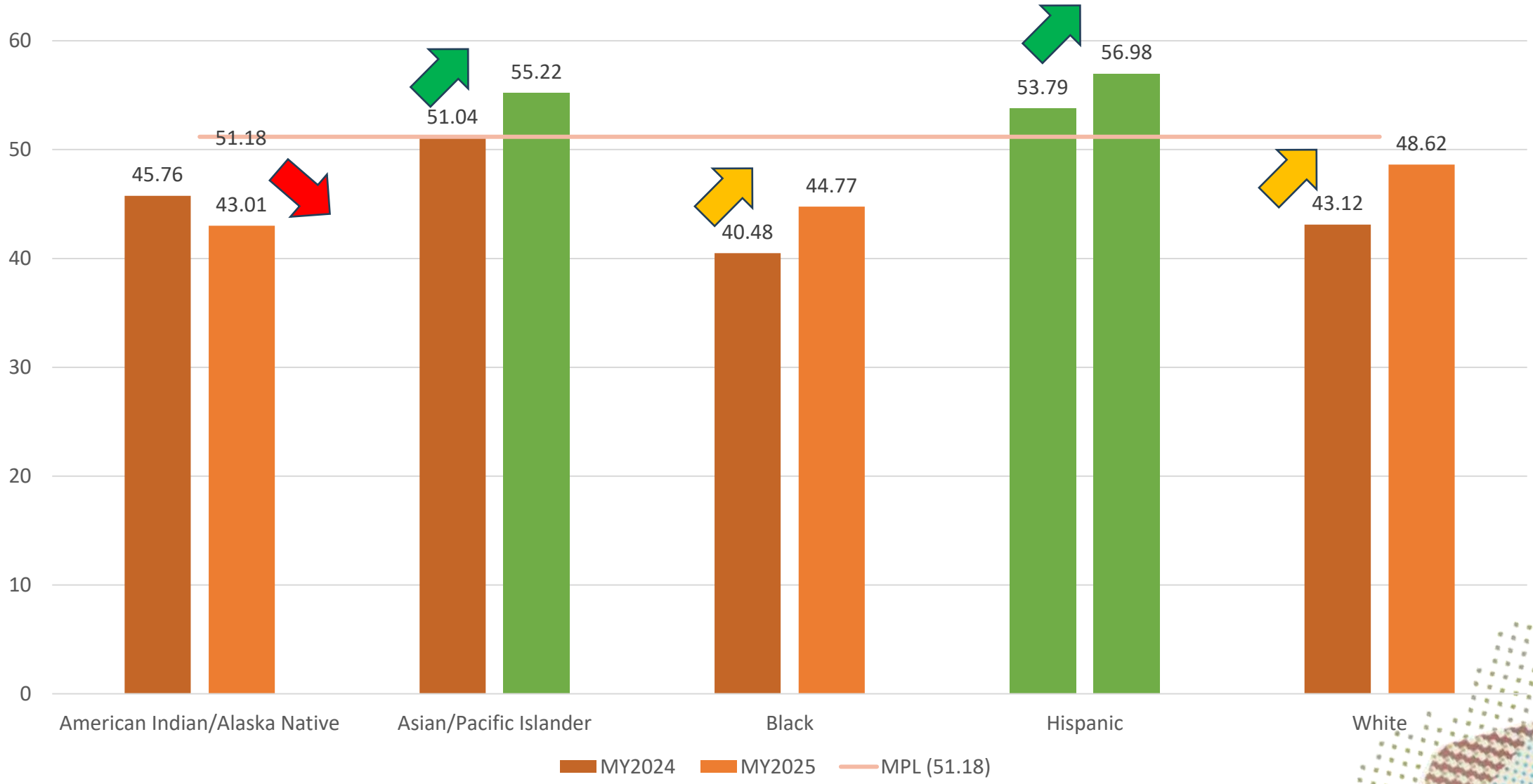
Timely Prenatal Care (PPC-PRE)



Preliminary Impact Analysis of PPC-PRE

- Two Disparities Eliminated; Two Disparities Improved; One Disparity Worsened
- Tribal Perinatal Program Recruitment
- Maternal Photoshoots Pilot; Perinatal Growing together Program in MY2025

Child and Adolescent Well Care Visits (WCV)



Preliminary Impact Analysis of WCV

One Disparity Eliminated; Two Disparities Improved; One Disparity Worsened (3 Disparities Total)

Healthy Babies Growing Together Program (GTP) Member Incentive continuation in MY2025

Health Equity Pay-for-Performance (QIP) Bonus launch in MY2025



Review of Additional Notable MY2025 MCAS Measures

Appendix A: Secondary MCAS Measures of Focus for Disparities

- Childhood Immunizations (CIS-10)
- Lead Screening (LSC)
- Post-Partum Care (PPC-POST)
- Breast Cancer Screening (BCS)
- Cervical Cancer Screening (CCS)

Measure Description	American Indian/ Alaska Native **MY2025** (YOY Change)	Asian/Pacific Islander **MY2025** (YOY Change)	Black **MY2025** (YOY Change)	Hispanic **MY2025** (YOY Change)	White **MY2025** (YOY Change)
Breast Cancer Screening (BCS)	**42.57** (~-2%)	**55.44** (~-2%)	**45.32** (~-5%)	**66.44** (~-3%)	**46.31** (~-2%)
Cervical Cancer Screening (CCS)	**43.56** (~-2%)	**45.76** (~-9%)	**45.1** (-5%)	**53.35** (~-5%)	**44.66** (~-2%)
Chlamydia Screening	**55.22** (~+1%)	**58.08** (~+4%)	**67.32** (~+3%)	**55.22** (~+3%)	**54.56** (~+2%)

Measure Description	American Indian/ Alaska Native **MY2025** (YOY Change)	Asian/Pacific Islander **MY2025** (YOY Change)	Black **MY2025** (YOY Change)	Hispanic **MY2025** (YOY Change)	White **MY2025** (YOY Change)
Childhood Immunization Status - Combination 10 (CIS-E)	**13.42** (~+5%)	**35.75** (~+1%)	**16.72** (~-2%)	**37.29** (~-2%)	**18.7** (~+6%)
Lead Screening (LSC)	**57.64** (~+5%)	**76.78** (~+5%)	**66.7** (~+5%)	**79.2** (~+5%)	**66.22** (~+5%)

Measure Description	American Indian/ Alaska Native **MY2025** (YOY Change)	Asian/Pacific Islander **MY2025** (YOY Change)	Black **MY2025** (YOY Change)	Hispanic **MY2025** (YOY Change)	White **MY2025** (YOY Change)
Well-Child in First 15 months	**49.39** (~-12%)	**71.5** (~+7%)	**60.72** (~+7%)	**71.5** (~+1%)	**59.4** (~-3%)

2025 Pay for Performance Data Analysis

Measure Name	ASIAN/ PACIFIC ISL..	BLACK	EAST ASIAN	HISPANIC	NATIVE AMERICAN	OTHER	SOUTH ASIAN	SOUTHEAST ASIAN	UNKNOWN	WHITE
Breast Cancer Screening	54.12	51.41	48.12	69.38	45.53	53.50	58.99	59.26	51.91	49.11
Breast Cancer Screening Monitoring	42.59	37.49	50.32	55.91	35.52	43.58	53.88	48.24	42.67	39.52
Cervical Cancer Screening	52.53	53.44	50.54	67.36	46.86	59.32	59.02	55.81	53.88	50.63
Child and Adolescent Well Care Visits	58.86	50.06	61.71	64.97	50.18	58.56	72.79	55.85	58.76	51.29
Childhood Immunization Status CIS 10	25.23	19.89	27.27	33.56	9.76	20.87	41.41	19.23	20.70	13.50
Chlamydia Screening	16.76	33.00	15.04	28.61	30.63	21.83	14.82	19.01	23.77	26.54
Colorectal Cancer Screening	41.17	35.46	47.39	48.24	29.76	44.76	44.45	47.35	39.12	37.80
Controlling High Blood Pressure	62.72	62.10	68.75	70.52	57.29	68.61	68.28	68.74	64.89	63.18
Diabetes - HbA1C Good Control	71.17	68.73	84.82	75.35	66.35	76.50	80.99	81.14	71.07	71.57
Diabetes - Retinal Eye exam	61.35	53.75	68.75	67.44	49.20	60.48	57.32	63.02	58.07	53.80
Immunization for Adolescents IMA 2	40.74	31.61	38.78	51.87	28.57	31.36	54.95	37.29	28.00	24.19
Lead Screening In Children	84.72	65.12	44.44	82.34	72.41	71.71	84.26	82.05	69.89	67.39
Topical Fluoride in Children Monitoring	6.99	10.18	5.00	14.35	4.08	7.30	9.41	12.24	7.07	5.82
Well Child 15-30 Months	76.14	55.68	66.67	80.68	52.63	67.00	90.00	75.00	70.66	65.30
Well Child First 15 Months	63.24	49.65	66.67	65.93	43.06	48.53	66.13	55.81	54.53	49.35

Partnership Disparity Classifications

Below MPL (HEDIS Sample)
And
Below White Group (QIP)
(Act)

Above MPL (HEDIS Sample)
And
Below White Group (QIP)
(Monitor)

Disparity Prioritizes

Below MPL (HEDIS Sam
And
Above White Group (QIP)
(Plan)
(Quality Concern if White is below MPL)

Above MPL (HEDIS Sample)
And
Above White Group (QIP)
(No Change)

Likely Quality Measure Concerns

Cervical Cancer

Chlamydia Screening

FUM/FUA

Breast Cancer Screening***

Topical Fluoride

Asthma Med Ratio***

Health Equity Executive Measure Assessment (Total Number of Disparities)***

MY2024 (RY2025)

- **Approx Number of Disparities: 46*****
- Number of Disparities Addressed: **N/A**
- DHCS Maternity Bold Goals Achieved (Maternity Care for BIPOC: **Zero**
- DHCS Child Bold Goals Achieved (Well-Child Visit: **One**
- DHCS Child Bold Goals Achieved (Childhood Immunization: **Two**

MY2025 (RY2026)

- **Approx Number of Disparities**: **25*****
- Number of Disparities Addressed: **19 Disparities****
- DHCS Maternity Bold Goals Achieved (Maternity Care for BIPOC: **Three**
- DHCS Child Bold Goals Achieved (Well-Child Visit: **Two**
- DHCS Child Bold Goals Achieved (Childhood Immunization: **Two**

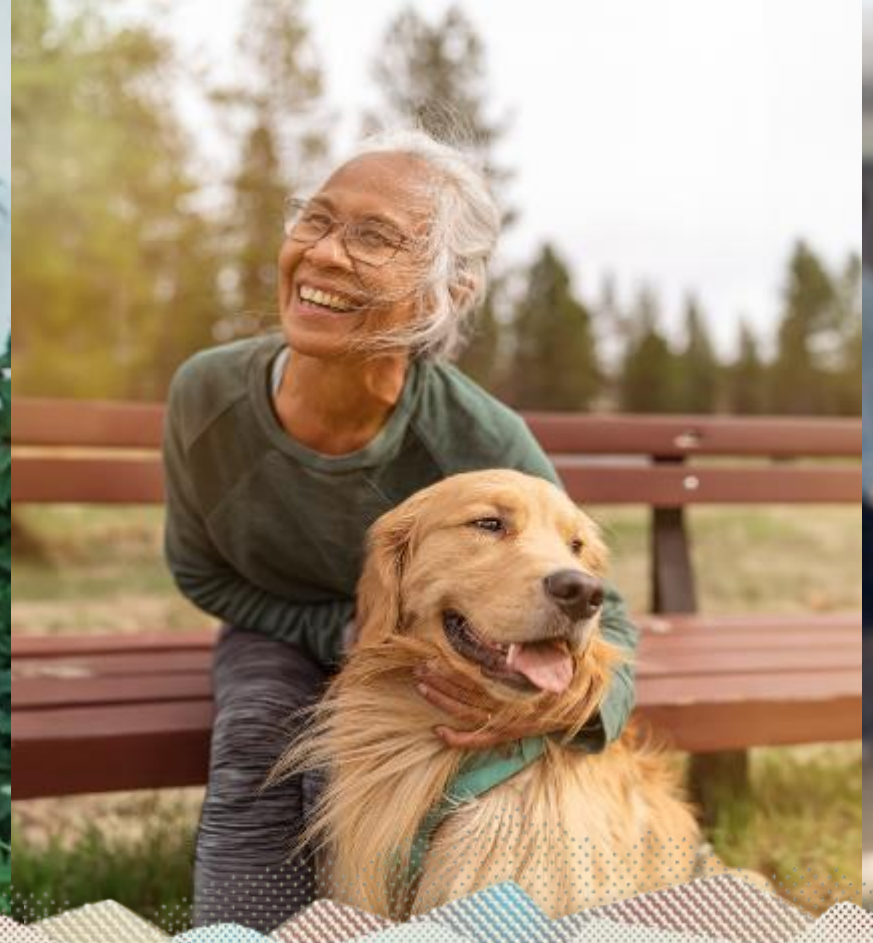
Health Equity Executive Measure Assessment (Total Number of Core Top 5 MCAS Measures)

MY2024 (RY2025)

- Total Number of MCAS disparities: **23 Disparities**
- Number of Disparities Addressed: **N/A**
- Number of QIHEC suggestions Implemented: **Zero**
- Number of reported PHM Campaigns for disparities**: One**
- Number of QIP interventions: **One**

MY2025 (RY2026)

- Total Number of MCAS disparities: **13 Disparities**
- Number of Disparities Addressed: **10 Disparities**
- Number of QIHEC suggestions Implemented: **Two**
- Number of reported PHM Campaigns for disparities: **One**
- Number of QIP interventions: **Two**


Annual Work Plan (MCAS Disparities is HE dept focus; Pop Health is separate with CL work)

Annual Workplan

2026-2027 Annual Workplan

3-Year Health Equity Strategic Plan Overview

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Item #	Project/Program	Type of Goal	Goal	Outcome Measure(s)	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status				Goal Met (Yes No)
1.a. (Health Equity Foundation)	Partnership Health Plan Health Equity 3 Year Strategic Plan Development and Launch	NEW	**Goal #1:** By December 2026, develop a comprehensive 3-year health equity strategic plan to address at least over 50 health disparites assoicated with race, ethnicity, language, disability status, etc across Partnership's six region network	**Measure:** Heatlh Equity Strategic Plan Review and Approval at QIHEC and Q/UAC	**Deliverable 1:** Generate Draft Health Equity Strategic Plan Draft	10/1/2025	9/30/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: Host Strategic Planning Session to present to strategic plan to internal staff members for feedback	10/1/2025	9/30/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #5: Submit Final Strategic Areas of Focus document for IQI / Q/UAC review and approval to launch in CY2027	10/1/2026	11/1/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #4: Generate at least 1 project to address health disparities regarding strategic area of focus #1	1/1/2027	7/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #5: Generate at least 1 project to address health disparities regarding strategic area of focus #2	1/1/2027	7/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
1.b. (Health Equity Foundation)	Health Disparities Grand Analysis Analysis and Annual Plan Upates (HE7)	Continued	**Goal #1**: By Oct 2027, complete draft Health Equity and Community Program Description and Strategy, HE Work Plan, and HE Evaluation revisions in preparation for October Quality Committee meetings.	**Measure:** Program Descirption, Disparity Grand Analysis Review, and Annual Plan Approval at QIHEC and Q/UAC	**Deliverable#1:** Statistical Analysis conducted by HA team and sent to HE team to evaluate to prioritize and measure health disparities	11/1/2026	12/10/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #2: Submit MY2025 HE 7 Grand Disparity Analysis sent to External Consultant for review	11/1/2026	12/10/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #3: Submit updated 2027 Work Plan for QIHEC approval, QI / Q/UAC review and approval to launch in CY2027	10/1/2026	2/1/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #4: Finalize 2027 - 2028 HE/CR Program Description Updates	10/1/2026	10/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31**	**Apr 1 - June 30**	**July 1 - Sep 30**	**Oct 1 - Dec 31**	
					Deliverable #5: Finalize 2026 - 2027 HE/CR Program Evaluation.	10/1/2026	10/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31**	**Apr 1 - June 30**	**July 1 - Sep 30**	**Oct 1 - Dec 31**	
					Deliverable #6: Finalzie of 2027 - 2028 HE/CR Work Plan	10/1/2026	10/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
1.c. (Health Equity Foundation)	Providing CARES Training Development for Staff and Network Providers, Subcontractors, etc. to fulfill DHCS All Plan Letter (APL) Requirements.	NEW	**Goal #1:** By Dec 30 2027, achieve at least a 10% CARES overall training completion rate across network providers, subcontractors, etc	**Measure:** CARES Training Submission Receipt from DHCS and training com	**Deliverable #1:** Training Completion Rate presentation in annual grand analysis	1/1/2027	12/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Health Equity Training Supervisor Name: Naz Sattari	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
1.d. (Health Equity Foundation)	Quality Improvement and Health Equity (QIHEC) Oversight of HE Program	NEW	**Goal #1:** By June 30, 2026, Ensure QIHEC oversight of Partnership's HE Program through annual monitoring of the HE Work Plan	**Measure:** On-Time Quarterly DHCS Submission Demonstrating impact of QIHEC	**Deliverable #1**: By December 30, 2027 HE Trilogy Documents to be reviewed for approval by QIHEC in December 2027, post-review of other Quality committees to include but not limited to: * FY 2027 - HE Annual QIHEC grrand analysis and quarterly DHCS reports	1/1/2026	12/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Administrative Assistant I Name: Bethany Hannah	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
Key American Indian/Alaska Native Health Disparities (Not fully exhausted)														
2.a (Disparity)	Prenatal Care	Continued	**Goal #1:** Improve prenatal care visits by at least 5% by end of MY2027 with a 3-year goal of at least a 15% increase among American Indian/Alaska Native Members	**Measure: T**he percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. **Numerator:** The total number of deliveries a woman had in the first first trimester **Denominator:** The total number of eligible deliveries, such as all live births between certain dates or all women who meet certain enrollment criteria.	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Health Equity Department	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Associate Director of Population Health Name: Monika Brunkal, RPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
2.b (Disparity)	Well Care Visits	Continued	Goal #1: By Dec 31, 2027, Improve well-child visits by at least 3% with a long-term 3-year goal of at least 9% increase among American Indian/Alaska Native Members	**Measure:** Percentage of members 3–21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement yea **Numerator:** Number of members who attend at least one well-care visit witha primary care practitioner **Denominator:** Total number of eligible members in age range	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Cultural Community Manager Name: Jesus Hermosillo, MPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title:Tribal Liaision Name: Sunshine Jackson	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	TBD	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
2.c (Disparity)	Controlling Blood Pressure	Continued	Goal #1: By Dec 31, 2027, improve controlled blood pressure rate among American Indian/Alaska Native members by by 1 % by end of MY2027 with a 3 year goal of at least 5% for American Indians/Alaska Natives	**Measure:** Percentage of members with controlled blood pressure per HEDIS- **Numerator:** Number of members who are considered controlled for blood pressure **Denominator:** Total number of eligible members with essential hypertension diagnosis	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title:Tribal Liaision Name: Sunshine Jackson	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
2.d (Disparity)	Breast Cancer Screening	NEW	Goal #1: By Dec 31, 2027, Improve Breast Cancer Screening by 4% with a 3-year goal of at least 10% increase for American Indians/Alaska Natives	**Measure:** Assesses the percentage of women aged 40–74 who had at least one appropriate mammogram to screen for breast cancer **Numerator:** The numerator includes the number of individuals from the denominator who had one or more mammograms during the measurement year or the two years prior. **Denominator:** Total number of eligible for screening	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title:Tribal Liaision Name: Sunshine Jackson	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	

Item #	Project/Program	Type of Goal	Goal	Outcome Measure(s)	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status				Goal Met (Yes No)
				for screening	**Deliverable #4:** Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
2.e (Disparity)	Poor A1c Control	NEW	Goal #1: By Dec 31, 2027, , imnprove Poor A1C control by 2% by end of MY2027 with a 3-year goal of at least 6% for American Indians/Alaska Natives	**Measure:** Percentage of members with uncontrolled diabetes **Numerator:** Number of members who are considered poor controlled for type 2 diabetes **Denominator:** Total number of eligible members with type 2 diabetes	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title:Tribal Liaision Name: Sunshine Jackson	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
Black Health Disparities														
3.a (Disparity)	Prenatal Care	Achieved	**Goal #1:** Improve prenatal care visits by at least 5% by end of MY2027 with a 3-year goal of at least a 15% increase among African American Members	**Measure: T**he percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. **Numerator:** The total number of deliveries a woman had in the first first trimester **Denominator:** The total number of eligible deliveries, such as all live births between certain dates or all women who meet certain enrollment criteria.	**Deliverable #1:** Conduct Root Cause Analysis to identify new sites or locations that have largest number of members experiencing disparity	10/1/2026	10/31/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	10/31/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Cultrual Community Manager Name:Jesus Hermosillo, MPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	10/31/2026	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Health Equity Department	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
3.b (Disparity)	Postpartum Care	Achieved	**Goal #1:** Improve postpartum care visits by at least 2% by end of MY2027 with 3-year goal of at least 5% among African American Members	**Measure:** The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery. **Numerator:** The total number of visits a woman had between 7 and 84 days after delivery. **Denominator:** The total number of eligible deliveries, such as all live births between certain dates or all women who meet certain enrollment criteria.	**Deliverable #1:** Conduct Root Cause Analysis to identify new sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Cultrual Community Manager Name:Jesus Hermosillo, MPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Health Equity Department	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
3.c (Disparity)	Well Care Visits	Continued	**Goal #1:**Improve well-child visits by at least 3% by end of MY2027 with 3-year goal of at least 9% increase among African American Members	**Measure:** Percentage of members 3–21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement yea **Numerator:** Number of members who attend at least one well-care visit witha primary care practitioner **Denominator:** Total number of eligible members in age range	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Cultural Community Manager Name: Jesus Hermosillo, MPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Health Equity Department	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	10/1/2026	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
White/Rural Health Disparities														
4.a (Disparity)	Well Care Visits	Continued	**Goal #1:**By December 2027, Improve well-child visits by at least 1.5% with by end of MY2027 with an overall 3-year goal of at least 4% increase	**Measure:** Percentage of members 3–21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement yea **Numerator:** Number of members who attend at least one well-care visit witha primary care practitioner **Denominator:** Total number of eligible members in age range	**Deliverable #1:** Conduct Root Cause Analysis to identify sites or locations that have largest number of members experiencing disparity	10/1/2024	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
					Deliverable #2: Conduct Focus Group in zipcodes where disparity is prevalent or major disparity is seen between populations	10/30/2024	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Cultrual Community Manager Name:Jesus Hermosillo, MPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #3: Generate at least 1 community-based solution to address the disparity	1/1/2025	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: Health Equity Department	**Jan 1 - Mar 31** ☐ Complete	**Apr 1 - June 30** ☐ Complete	**July 1 - Sep 30** ☐ Complete	**Oct 1 - Dec 31** ☐ Complete	
					Deliverable #4: Generate MCO-based PHM campaign, QMSI generated intervention to address the disparity	6/1/2025	9/30/2027	Title: Chief Health Services Officer Name: Katherine Barressi, RN, MSN	Title: TBD Name: TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	
Linguistic Health Disparities* **														
					Deliverable #1: TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed	

Item #	Project/Program	Type of Goal	Goal	Outcome Measure(s)	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status				Goal Met (Yes No)
5.a (Disparity)	TBD	TBD	TBD	TBD	**Deliverable #2:** TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #3: TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
Disability-Related Health Disparities**														
6.a (Disparity)	TBD	TBD	TBD	TBD	**Deliverable #1:** TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #3: TBD	TBD	3/30/2025	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
Geographic-Related Health Disparities**														
7.a (Disparity)	TBD	TBD	TBD	TBD	**Deliverable #1:** TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #3: TBD	TBD	3/30/2025	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
Gender Identify-Related Health Disparities**														
8.a (Disparity)	TBD	TBD	TBD	TBD	**Deliverable #1:** TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #2: TBD	TBD	TBD	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	
					Deliverable #3: TBD	TBD	3/30/2025	TBD	TBD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track	**Apr 1 - June 30** ☐ Complete ☐ On Track	**July 1 - Sep 30** ☐ Complete ☐ On Track	**Oct 1 - Dec 31** ☐ Complete ☐ On Track	

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Health Equity Strategic Plan (2027-2030)

Health Equity Mission

To help our members and the communities we serve, be healthy no matter their race, language, disability status, veteran status, rural location, immigration status, etc

Long-Term Vision for Partnership Members, who have experienced disparities

- **ZERO** excessive in-hospital deaths from potentially preventable admissions
- **ZERO** excessive maternal deaths due to complications from pregnancy or childbirth
- **ZERO** excessive infant mortalities

****Key indicators of a population's overall health and healthcare quality. While other factors (hospitalizations, emergency department use, adult mortality rate, literacy rate, etc) have been considered, many organizations (e.g World Health Organization) have attributed the under-5 mortality rate, maternal mortality ratio, etc as core mortality and morbidity proxies****

Health Equity Strategy Development Methodology Overview:

The heath equity strategic plan development was led by the Health Equity Department of Partnership Health Plan. Health Equity leaders conducted a systematic review in PubMed, Google Scholar, CENTRAL database, Google, and DHCS announcements to gather tertiary literature to conduct a Political Environment Analysis, Economic Analysis, Competitor Analysis, and Social Analysis. In addition, the team conducted a systematic review of tertiary literature to review core principles of addressing health disparities. Next, partnership leaders interviewed 30+ internal staff members and 80% of external QIHEC members. Finally, Health Equity leaders did an internal capabilities and portfolio analysis to assess feasibility of strategies and potential tactics. When assessing the potential tactics, Health Equity leaders conducted an assessment of 4A's model of execution and alignment. Located below are the core strategies that will be implemented to address the measurable inequities and tactics will be generated in alignment with them. After internal committee approval, this scope of the strategic plan will be updated within the Health Equity and Community Reinvestment Strategy and Program Description MCED6001. In addition, the Health Equity department will host various design thinking sessions throughout the year within their department, with other departments, and/or the community to design innovative tactics to address the disparities within each core strategy located below.

Health Equity Strategic Plan (2027-2030)

Three Core Strategies to Eliminate Measurable Inequities Overview:

1. Increase members' (who are experiencing disparities) health literacy and motivation to access, understand, and apply accurate health information to make informed judgements regarding disease prevention and treatment.

2. Equip key local communities (in areas with high amounts of disparities) with resources to provide timely basic Medi-Cal navigation, community benefit resource navigation, health education, care coordination to reconnect members back to Partnership and/or their respective medical home. Also, empower such communities to help co-design community-based solutions to address health disparities.

3. Increase access to excellent-quality, affordable, multilingual health services, including preventative, specialized, and complex care provided in various modalities (in-person, digital, peer-led, etc.) and by diverse practitioners, ancillary staff, community health workers, doulas, etc

Strategic Plan Administrative Goals

1.a. (Health Equity Foundation)	Partnership Health Plan Health Equity 3 Year Strategic Plan Development and Launch	NEW	**Goal #1:** By December 2026, develop a comprehensive 3-year health equity strategic plan to address at least over 50 health disparites assoicated with race, ethnicity, language, disability status, etc across Partnership's six region network	**Measure:** Heatlh Equity Strategic Plan Review and Approval at QIHEC and Q/UAC	**Deliverable 1:** Generate Draft Health Equity Strategic Plan Draft	10/1/2025	9/30/2026
					Deliverable #2: Host Strategic Planning Session to present to strategic plan to internal staff members for feedback	10/1/2025	9/30/2026
					Deliverable #5: Submit Final Strategic Areas of Focus document for IQI / Q/UAC review and approval to launch in CY2027	10/1/2026	11/1/2026
					Deliverable #4: Generate at least 1 project to address health disparities regarding strategic area of focus #1	1/1/2027	7/30/2027
					Deliverable #5: Generate at least 1 project to address health disparities regarding strategic area of focus #2	1/1/2027	7/30/2027

Partnership HealthPlan of California

5 Star Strategic Plan for Quality Improvement

2026–2029

Last updated 10/6/2026

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Health Equity Strategic Plan Summary, 2027-2030 18

Purpose

The 5 Star Strategic Plan for Quality establishes Partnership's priorities for improving quality of healthcare for Partnership's members between 2026 and 2029. It defines the goals, focus areas, objectives, and strategies that will align staff, providers, and community partners around a shared commitment to improving member health outcomes and enhancing the patient experience, while protecting the organization's regulatory standing and financial sustainability.

Problem Statement

Since the last Quality Strategic Plan seven years ago, Partnership added 10 additional counties to its service area in 2024, the Global Pandemic and its aftermath led to changes in many parts of the health care delivery system, and DHCS has steadily put in place a series of financial penalties related to plan performance on quality metrics. In addition, the data exchange landscape has been changing dramatically, with clinical quality performance improving nation-wide, leading to re-basing of quality benchmarks by NCQA, which negatively impacted Partnership's Quality Stars rating relative to our sister Plans in California.

For a lengthier summary of current challenges impacting Partnership quality performance, see **Appendix A.**

In the setting of Partnership's stagnant NCQA Star Ratings, there is an urgent need to evaluate and update our strategic approaches to improving quality outcomes.

The Plan at a Glance



Terminology

Success Measures: global composite measures provide a view of overall quality portfolio performance and help identify when strategic priorities or improvement efforts may need to be adjusted.

Strategic Goals: The long-term results Partnership seeks to achieve through this strategic plan.

Focus Areas are broad strategic domains that organize related objectives around a shared focus or theme. Each focus area defines where Partnership will concentrate its efforts over the next three years to make progress on the Strategic Goals.

Objectives: The specific organizational capabilities or improvements Partnership intends to achieve within each focus area over the next three years to advance the Strategic Goals.

Strategic Goals

The 5 Star Quality Strategic Plan for Quality is anchored by five Strategic Goals that define Partnership's highest quality improvement priorities for the next three years. The five Strategic Goals were selected because they represent the greatest opportunity to improve member health, enhance the member experience, and protect Partnership's financial sustainability (priority prioritization criteria - see **Appendix B**). See **Appendix C** for more information about specific measures, including baseline rates and Year 1 (MY2026) SMART goals, that will indicate performance on each Strategic Goal.

An internal analysis identified these measures as those with the greatest immediate financial impact on the organization, due to DHCS Accountability Programs (see **Appendix D** for more information). Failure to improve performance in these areas places significant revenue at risk, limiting Partnership's ability to invest in providers, members, and future quality improvement efforts.

1. **Improve member experience,** as measured by:
    - Member ratings of health care and health plan

2. **Reduce avoidable hospital utilization**, as measured by
    - Ambulatory-care sensitive admissions
    - Hospital readmissions

3. **Improve Pediatric Preventive Care**, as measured by:
    - Well-child visits
    - Pediatric immunizations

4. **Improve Chronic Disease Outcomes**, as measured by:
    - Glycemic control for diabetic members
    - Blood pressure control for members with hypertension

5. **Improve timely access to prenatal care**, as measured by:

- Prenatal care initiation during first trimester

Cross-Cutting Priority: Reduce geographic variation in quality and limit financial penalties for low performance by accelerating improvement in Partnership's rural regions (Rural Upper Central and Rural Upper North) while sustaining high performance across the North Bay Area region.

Cross-Cutting Priority: Reduce healthcare inequities across all five Strategic Goals

Setting Targets and Monitoring Performance

Each Strategic Goal will be translated into annual SMART goals set by QI in partnership with the relevant focus area leads, with particular attention to closing the gap in Partnership's rural regions. Progress will be reviewed quarterly, with results and any needed course corrections reported to the Board annually as part of the CMO Update.

The enterprise Success Measures (MCAS Quality Factor Score, NCQA Star Rating, and future CMS Star Rating) will also be monitored throughout, to confirm that concentrated effort on the five Strategic Goals isn't coming at the expense of Partnership's broader quality portfolio.

Focus Areas, Objectives and Strategies

Achieving improvement in Partnership’s Strategic Goals, while maintaining performance across our broader quality portfolio will require coordinated action across the organization. To support an organization-wide effort, there will be particular efforts aligned with the following five focus areas:

1. Access to Care
2. Provider Engagement
3. Member Experience and Engagement
4. Data, Analytics and Technology
5. Organizational Excellence and Culture of Quality

Accountability is shared. Each focus area has designated staff leads and workgroups responsible for co-creating measurable objectives, implementing strategies, tracking and reporting progress over time.

Focus Area 1: Access to Care

Objectives	Strategies
Strengthen Partnership's provider network capacity and stability in prioritized communities and services	• Use targeted network provider recruitment and retention strategies • Efforts to promote hospital and specialty network stability in rural communities • Strategic investment in community workforce training programs • Support advanced access in primary care settings
Expand ability for **alternative access models** to meet community care needs	• Expand telehealth and digital health care delivery • Prioritize community-based/mobile services and vendor/"bolt-on" service arrangements • Close engagement with California Tribes, Tribal Health Centers, and Tribal CBO's • Community paramedicine models • Home-based care models for select populations • Maternity care models for rural communities

Focus Area 2: Provider Engagement

Objectives	Strategies
Build the capacity of provider network towards high performance on prioritized quality improvement measures	• Align pay-for-performance measure sets and goals with HEDIS priority goals • Establish clear performance accountability and escalation pathways (e.g., joint leadership review, consequences for sustained underperformance) • Support relationship-building with provider network towards a culture of collaboration • Provide coaching, collaboration and training around measures, QI methodologies, workflows

Focus Area 3: Member Experience and Engagement

Objectives	Strategies
Build the infrastructure to understand and act on member experience drivers	• Create member experience governance structure, data systems and KPI's for understanding drivers of member satisfaction and experience • Develop a cohesive organizational approach to receiving, evaluating, and acting on member feedback • Increase provider engagement around member experience
Define and close the highest-friction gaps in the member journey	• Build key member journey maps to understand members' perceptions of health care and health plan • Implement targeted improvement in prioritized areas identified by key member journey maps
Improve outcomes for high-risk populations (e.g., high utilizers, multiple chronic conditions, communities experiencing inequities, maternal and child health, SMI, DSNP)	• Build systems and programs to deliver effective care management and coordination to specific high-risk populations • Build capacity to use data towards population health intelligence and targeted member and community interventions • Strengthen community and county partnerships • Build robust CHW and doula networks • Co-design community-based interventions to address health disparities

Focus Area 4: Data, Analytics and Technology

Objectives	Strategies
Build capacity for centralized quality measurement and analytics that maximizes opportunities for improving member health and data interoperability	• Leverage health analytics capabilities (e.g., trending, intervention support tools) to support strategic goals • Make key quality performance rates and member level information for current year visible and actionable for provider network • Scale Data Aggregator initiative and other data completeness and validation initiatives plan-wide to support accurate and current network-wide clearinghouse for member data • Consolidation of key quality data platforms

Focus Area 5: Organizational Excellence and Culture of Quality

Objectives	Strategies
Create **shared understanding and accountability for quality improvement** organization-wide	• Make key quality performance rates and trends visible, understandable, and actionable for all Partnership team members • Partnership leaders consistently model and promote the values and habits of quality improvement and excellence. • Set and share annual organization-wide SMART goals for each of the five quality Strategic Goals, with region-specific improvement targets • Strengthen communication of quality priorities across internal teams and partners, clarify roles and accountability for quality improvement • Build internal capability to drive quality improvement

Direct QI resources toward initiatives with the greatest impact on member health and financial performance, including revenue at risk from quality withholds and penalties	• Incorporate ROI and value-based analysis into the evaluation of QI priorities and investments • Establish joint prioritization processes that integrate clinical quality performance, cost impact and operational feasibility into decision making

Background and Planning Process

Alignment with Partnership's Other Strategic Priorities

This 5 Star Strategic Plan for Quality complements and supports Partnership HealthPlan's Strategic Plan, which sets the overall direction of the entire organization to fulfill its mission, and also aligns with other departments' Strategic Plans such as the Health Equity Plan (To specifically reduce health inequities) and the Member Experience Plan, which feed into this Quality Strategy. See **Appendix E** for summaries of these additional department-specific Strategic Plans.

At the time of developing this plan, Partnership is operating under its 2024–2027 Strategic Plan, in which quality is identified as a strategic pillar. Partnership is developing its next enterprise Strategic Plan now. We anticipate that quality will remain an important priority within the next version of the enterprise-wide plan.

Strategic Planning Process Overview

The strategic plan was developed through a comprehensive planning process that incorporated input from Partnership leadership, staff, external partners, and a review of recent quality reports.

The initial information gathering process included a SWOT analysis (see **Appendix A**), interviews with 6 Partnership leaders and 10 external partners, and five focus groups with 38 employees representing perspectives from across the organization. Stakeholders were asked to define what success for quality improvement would look like over the next three years, identify opportunities to improve quality performance, assess organizational and external risks, and identify the capabilities Partnership must strengthen to achieve meaningful improvement.

Several themes emerged from this process. Internal stakeholders consistently emphasized the need to improve performance on measures with significant financial and regulatory implications, including measures associated with quality sanctions and withholds. External stakeholders highlighted access to care as a foundational driver of quality improvement, emphasizing the importance of timely treatment and follow-up care across the continuum, ease of navigating the health care system, and addressing persistent access challenges in Partnership's rural communities.

Based on the insights gathered through the assessment process, Partnership leaders from the QI department developed the 5 Star Strategic Plan for Quality. The plan was then reviewed and refined through engagement with key stakeholders across the organization to ensure alignment

with Partnership's broader strategic priorities, strengthen shared ownership, and validate that the goals and strategies reflected the capabilities and partnerships needed to achieve meaningful quality improvement. Throughout the drafting and refinement process, Partnership staff used a set of agreed-upon criteria (see **Appendix B**) to help inform which outcomes, goals and strategies to prioritize.

Appendix A – Abbreviated SWOT Analysis

Strengths

- Leadership and staff commitment to improving quality
- Strong medical director leadership
- Provider recruitment and retention efforts to support access
- Strong provider and community relationships
    - Accessibility, responsiveness, and flexibility
    - Transparency and open communication
    - QIP is core strength and organizing structure
- Improvement 'bright spots", e.g., mobile mammography
- Established quality infrastructure and governance
- Established NCQA accreditation
- Growing data and analytics capabilities (e.g., data warehouse, HIE, specialized analytics team, Inovalon, PQD, DataLink pilot)
- Expanding health equity, member experience and regional leadership infrastructure
- Significant examples of cross-departmental collaboration (e.g. QSMI workgroups)

Weaknesses

- Significant access challenges, especially in rural areas
    - Behavioral health, maternity, specialty care, transportation, interpretation
- Limited care management and patient navigation partnerships with providers and unclear member handoffs across internal departments
- Overly focused on influencing provider behavior relative to direct member engagement → direct member engagement tools are underdeveloped
- Tendency toward role delineation over shared accountability with providers
- Gaps in alignment between QIP and HEDIS + significant resource allocation to QI without clear ROI
- Fragmented data infrastructure, complicated, not transparent, manual, no whole-person view, long wait times for data support, slow dashboard adoption
- Lots of data (and data collection) without strategic analysis and action
    - Limited use of predictive modeling capabilities
- Process-heavy vs. action/impact-orientation (vs. rush to execution)
- Legacy systems and operating models, outpaced by rapid growth
- Organizational complexity and siloed operations
- Heavy workloads, too many meetings, and operational pressures result in reduced staff capacity, and limit proactive, strategic problem solving
- Unclear roles and accountability for quality across the organization
- Long-tenured staff: cultural resistance to change, people dependencies
- Overall slow to change, low urgency, process- and regulation-driven over performance-driven culture
- Treating NCQA accreditation requirements as "check the box" activities versus leveraging to drive change

Opportunities

- Under-contracting in newest 10 counties
- Counties are developing aging and disability master plans to shape how community resources are coordinated for shared members
- Community Health Improvement Plans could reinforce shared goals and reduce duplication
- Expansion of telehealth, home-based care, and mobile models
- Reduced CalAIM focus → more focus on core Medicaid pop and HEDIS improvement
- D-SNP launch → integrated care redesign (Medicare as sophistication driver)
- MCAS measurement set stabilization will create more capacity to focus on improvement
- Member interest in digital/remote services
- Increased interoperability, HIE growth, broader EPIC adoption
- Expansion of predictive analytics and AI
- Increasing strength, functionality and reach of major HIE partners: PointClickCare and Sac Valley Med Share

Threats

- Membership volatility due to policy and eligibility changes + downstream quality and financial pressures
    - Hospital and provider network instability
    - High potential for quality to deteriorate in near term
- Financial penalties and withholds tied to quality scores (HEDIS, CAHPS, efficiency measures)
- Increasing measurement and policy/regulatory complexity
    - Unprepared for upcoming NCQA electronic data capture requirements
    - Unprepared for Medicare Star ratings complexity
    - Claims system migration poses risk of data disruption and performance reporting issues
- Workforce shortages and provider capacity constraints, especially in rural areas
    - Limited leadership capacity, staffing and infrastructure makes some providers hard to reach with traditional QI supports.
- Increasing healthcare misinformation and distrust

Appendix B – Prioritization Criteria

Given the high volume of quality improvement priorities for the health plan, driven by fiscal, regulatory, clinical and community needs, specific factors were used to determine which goals would be most important to achieve by 2029. Strategic goals, focus areas, and objectives were prioritized using several factors, with the most weight given to the impact on: member health, member access and experience, and the financial health of the organization.

Primary Prioritization Criteria

- **Member Health Impact**
  Goals were prioritized based on their potential to improve the health and well-being of Partnership members. This includes opportunities to improve clinical quality performance (e.g., HEDIS scores), achieve meaningful reductions in preventable illness and death, and address disparities in health outcomes across populations, geographic regions, or other member groups.

- **Member Access and Experience Impact**
  Goals were prioritized based on their ability to improve members' access to timely, appropriate, and high-quality care, recognizing that access to services and providers is a fundamental driver of health outcomes and member satisfaction. Particular emphasis was placed on opportunities to strengthen provider network access, reduce barriers to care, and improve members' ability to obtain the services they need. Goals were also evaluated for their potential to enhance the overall member experience, including satisfaction with care, communication, and interactions with the health plan and health care system.

- **Financial & Regulatory Impact**
  Goals were evaluated for their potential to support compliance with regulatory requirements, reduce the plan’s financial risk, and strengthen performance on key external quality and accreditation measures. Without a solid financial standing, Partnership will be unable to achieve its mission and improve quality, especially during a period of intense federal contraction of the Medicaid program.

Additional Considerations

- **Organizational Capacity**
  Goals were prioritized when the organization has, or can reasonably develop, the leadership, staffing, infrastructure, partnerships, and accountability structures needed to achieve and sustain results.

- **Timeline**
  Priority was given to goals that can demonstrate meaningful progress or achieve intended outcomes within the three-year strategic planning period, while also supporting longer-term improvement efforts.

- **Sustainable Impact**
  Goals were selected based on their potential to create lasting improvements in quality, outcomes, and organizational performance rather than temporary gains.

- **Regional Flexibility Impact**
  Goals were prioritized when they allow for adaptation to local community needs, recognizing that challenges, resources, and opportunities may vary across Partnership's service area.

Appendix C – Strategic Goal Measures and Baseline Performance

Specific improvement targets for each measure will be set annually.

Strategic Goal	Related Measure	MY 2025 Baseline Quality Compass Percentile	MY2026 SMART Goal Quality Compass Percentile
Improve member experience	CAHPS: Getting Care Quickly	Child: 10th percentile Adult: <10th percentile	Child: Pending Adult: Pending
	CAHPS: Getting Needed Care	Child: 33rd percentile Adult: 10th percentile	Child: Pending Adult: Pending
Improve chronic disease outcomes	GSD > 9%	Upper Central: 50th percentile Upper North: 50th percentile North Bay Area: 50th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 67th percentile
	CBP	Upper Central: 10th percentile Upper North: 50th percentile North Bay Area: 75th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 75th percentile
Improve Pediatric Preventive Care	WCV	Upper Central: 33rd percentile Upper North: 33rd percentile North Bay Area: 50th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 67th percentile
	IMA-E	Upper Central: 33rd percentile Upper North: 33rd percentile North Bay Area: 90th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 90th percentile
	W30-2	Upper Central: 50th percentile Upper North: 50th percentile North Bay Area: 75th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 75th percentile

	W30-6	Upper Central: 10th percentile Upper North: 67th percentile North Bay Area: 75th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 75th percentile
Improve timely access to prenatal care	PPC-Pre	Upper Central: 10th percentile Upper North: 25th percentile North Bay Area: 90th percentile	Upper Central: 50th percentile Upper North: 67th percentile North Bay Area: 90th percentile
Reduce avoidable utilization	Ambulatory Care Sensitive Admissions	Plan-Wide: Pending	Plan-Wide: Reduce baseline by 10%
	Plan All-Cause Readmissions (PCR)	Plan-Wide: 90th percentile	Plan-Wide: 90th percentile

Appendix D – Partnership's Quality Accountability Programs, MY2026

Program	Scope	Geographic Impact	Financial Impact	Low Performance Trigger
Quality Withholds and Incentive Program	9 HEDIS measures, 2 CAHPS measures (Child and Adult)	DHCS Quality Rating Regions	$Tens of Millions	<67th percentile performance AND <25% YoY improvement
Clinical Efficiencies	4 efficiency factors related to inpatient care	Plan Wide	$Tens of Millions	High repeat inpatient utilization by subset of members
Community Reinvestments - Quality	20 HEDIS measures (MCAS)	County	$Millions	2+ measures <50th percentile in any measure domain
Quality Sanctions	20 HEDIS measures (MCAS)	County	$100k - $500k	<50th percentile performance
Quality Factor Score	20 HEDIS measures (MCAS)	Plan Wide	None, reputational	None
NCQA Health Plan Rating	44 HEDIS measures, 4 CAHPS measures (Child or Adult)	Plan Wide	None, reputational	None

Appendix E – Summaries of Additional Strategic Plans Aligned with Strategic Plan for Quality Improvement

Health Equity Strategic Plan Summary, 2027-2030

Health Equity Mission

To help our members and the communities we serve, be healthy no matter their race, language, disability status, veteran status, rural location, immigration status, etc.

Long-Term Vision for Partnership Members, who have experienced disparities

- **ZERO** excessive in-hospital deaths from potentially preventable admissions
- **ZERO** excessive maternal deaths due to complications from pregnancy or childbirth
- **ZERO** excessive infant mortalities

****Key indicators of a population's overall health and healthcare quality. While other factors (hospitalizations, emergency department use, adult mortality rate, literacy rate, etc) have been considered, many organizations (e.g World Health Organization) have attributed the under-5 mortality rate, maternal mortality ratio, etc as core mortality and morbidity proxies****

Health Equity Strategy Development Methodology Overview:

The heath equity strategic plan development was led by the Health Equity Department of Partnership Health Plan. Health Equity leaders conducted a systematic review in PubMed, Google Scholar, CENTRAL database, Google, and DHCS announcements to gather tertiary literature to conduct a Political Environment Analysis, Economic Analysis, Competitor Analysis, and Social Analysis. In addition, the team conducted a systematic review of tertiary literature to review core principles of addressing health disparities. Next, partnership leaders interviewed 30+ internal staff members and 80% of external QIHEC members. Finally, Health Equity leaders did an internal capabilities and portfolio analysis to assess feasibility of strategies and potential tactics. When assessing the potential tactics, Health Equity leaders conducted an assessment of 4A's model of execution and alignment. Located below are the core strategies that will be implemented to address the measurable inequities and tactics will be generated in alignment with them. After internal committee approval, the entire comprehensive strategic plan will be updated within the Health Equity and Community Reinvestment Strategy and Program Description MCED6001. In addition, the Health Equity department will host various design thinking sessions throughout the year within their department, with other departments, and/or the community to design innovative tactics to address the disparities within each core strategy located below.

Three Core Strategies to Eliminate Measurable Inequities Overview:

1. Increase members' (who are experiencing disparities) health literacy and motivation to access, understand, and apply accurate health information to make informed judgements regarding disease prevention and treatment.

2. Equip key local communities (in areas with high amounts of disparities) with resources to provide timely basic Medi-Cal navigation, community benefit resource navigation, health education, care coordination to reconnect members back to Partnership and/or their respective medical home. Also, empower such communities to help co-design community-based solutions to address health disparities.

3. Increase access to excellent-quality, affordable, multilingual health services, including preventative, specialized, and complex care provided in various modalities (in-person, digital, peer-led, etc.); and access to diverse practitioners, ancillary staff, community health workers, doulas, etc.

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Healthcare Effectiveness Data and Information Set (HEDIS®)

Measurement Year 2025 / Reporting Year 2026

NCQA HealthPlan Accreditation (HPA) Summary of Performance

Partnership – HPA Star Rating

June 2026

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Introduction

As a Medi-Cal Managed Care Plan, Partnership provides health care coverage for 24 counties in Northern California – the largest geographic footprint of any Medi-Cal Managed Care Plan in California. The health plan covers over 900,000 members who qualify for coverage based on low household income, and who make up a substantial portion of Northern California's total population. The annual measure performance analysis contained in this Annual Summary of Performance, centered on Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures selected by the National Committee for Quality Assurance (NCQA), supports Partnership's Health Plan Accreditation and is intended to give the best possible understanding of the status of quality outcomes for the low-income population served in these counties.

Partnership generates a detailed Annual Summary of Performance and distributes it widely so that stakeholders in Northern California – local governments, county public health, medical and behavioral health providers, hospitals, and community foundations - can use current, local, accurate, and audited data to prioritize activities to meet the health care needs of their communities. The Summary of Performance contains regional and county-level data that show local strengths and opportunities for preventative health care, based on national benchmarks. Behind each measure are many community members who were able to access the preventative services they needed to stay healthy, or who faced challenges or struggles to receive care.

In the end, it takes the entire health care delivery system working together to improve the health outcomes contained in this report. Partnership encourages everyone reading this report to review their local data closely, and look for a handful of ways their organization, alone or with others, can drive improvement on one or more measure that is important to them.

Partnership is always happy to connect organizations and community members within our network to resources and activities to help our members, and the communities we serve, be healthy. Please reach out to our Performance Improvement team at ImprovementAcademy@partnershiphp.org if you would like to learn more about activities in your area.

Thank you for your dedication to improving the health of our communities.

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2.0 Overview of the MY2025 Annual Summary of Performance Report

As an NCQA Accredited plan, Partnership is required to report HEDIS and CAHPS annually. The overall Health Plan Rating (HPR) is the weighted average of a plan's HEDIS and CAHPS measure ratings, plus bonus points for plans with current Accreditation status. In MY2025 Partnership chose to be formally scored utilizing the Child CAHPS results.

Measure benchmarks achieved that are described in this report are based on final MY2025 benchmarks released annually by NCQA.

MY2025 continued to host two required separate audits:

- DHCS/MCAS required reporting: Health Service Advisory Group (HSAG) Auditor
- NCQA HEDIS Health Plan Accreditation/HPA: Advent Advisory Auditor (this report's focus)

Partnership HEDIS Reporting Populations – MY2025
In MY2025, Partnership observed slight decrease in overall membership by approximately 1.3%, to 895,339 assigned members in December 2025.

The impact of population shifts in Partnership's network from the 10 new counties joining the Partnership network in January 2024 continues to impact HEDIS measure reporting populations differently, depending on each measure's continuous enrollment requirements as defined in the NCQA HEDIS MY2025 Technical Specifications. One measure, Breast Cancer Screening, ECDS (BCS-E), requires continuous enrollment greater than one year for a member to be included in the measure's eligible population, which meant that very few members from incoming counties met the criteria to be included in the measures' plan-wide rates in MY2025. All other MCAS measures in the 10 incoming counties have eligible populations that reflect the current membership.

Partnership reports one plan-wide rate for all 24 counties in its network for the MCAS measure set to its DHCS auditor, Advent Advisory.

Changes to NCQA HEDIS Measures – MY2025
NCQA released changes to several existing clinical measures used in NCQA HPA for MY2025:

Measure Changes for MY2025 HPA Required Reporting:

- New Measures:
  - Well-Child Visits in the First 30 Months of Life – Well-Child Visits Birth – 15 Months (W30-6+)
  - Well-Child Visits in the First 30 Months of Life – Well-Child Visits 15-30 Months (W30-2+)
  - Child and Adolescent Well-Care Visits

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- Changed Measures:
  - Cervical Cancer Screening (CCS-E) is now an Electronic Clinical Data Systems (ECDS) measure.
  - Childhood Immunization Status – Combination 10 (CIS-E) is now an Electronic Clinical Data Systems (ECDS) measure.
  - Immunizations for Adolescents – Combination 2 (IMA-E) is now an Electronic Clinical Data Systems (ECDS) measure.
  - Language Diversity of Membership (LDM) increased its weight in Health Plan Rating calculations from 0.5 to 1
- Removed Measures:
  - Rating of Personal Doctor (CAHPS)
  - Appropriate Testing for Pharyngitis (CWP)
  - Pharmacotherapy Management of COPD Exacerbation – Systemic Corticosteroid (PCE)
  - Pharmacotherapy Management of COPD Exacerbation – Bronchodilator (PCE)
  - Antidepressant Medication Management – Effective Continuation Phase Treatment (AMM)
  - Use of Imaging Studies for Low Back Pain (LBP)

Partnership successfully launched our HEDIS® MY2025/RY2026 data collection and reporting audits incorporating all changes as noted above.

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3.0 HPA Summary of Performance Plan-wide Relative to National All Lines of Business Benchmarks

3.1 HPA Plan-wide Performance Child CAHPS Results – Patient Experience:

This table shows the results of the MY2024 - MY2025 performance on the Patient Experience NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business 10th, 33.33rd, 66.67th and 90th benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points

NCQA Accreditation Measures: Child CAHPS Survey Results MY2024-MY2025

Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Patient Experience						
Getting Care						
MY 2024	***Getting Needed Care (Usually + Always)	77.87%	76.79%	81.10%	85.70%	89.41%
MY 2025		84.40%	79.70%	83.30%	87.20%	90.10%
MY 2024	Getting Care Quickly (Usually + Always)	80.04%	78.92%	84.62%	89.35%	92.10%
MY 2025		82.10%	81.60%	86.10%	90.30%	92.60%
Satisfaction with Health Plan Services						
MY 2024	Rating of All Health Care (9+10)	66.40%	62.29%	67.49%	71.90%	76.27%
MY 2025		67.90%	66.10%	70.00%	74.20%	78.30%
MY 2024	***Rating of Health Plan (9+10)	72.87%	64.03%	69.01%	73.76%	78.19%
MY 2025		69.90%	65.40%	69.90%	74.20%	79.80%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.2 HPA HEDIS Plan-wide Performance – Prevention and Population

This table shows the MY2024 – MY2025 baseline performance on the **Prevention and Population** NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

🔵 4-5 points ⚪ 3 points 🟡 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures)

Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Prevention and Population						
Children and Adolescent Well-Care						
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	26.70%	16.10%	21.60%	27.60%	35.40%
MY 2025	***CIS-E - Childhood Immunization Status (Combination 10) ECDS Measure	26.74%	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	40.39%	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E - Immunizations for Adolescents (Combination 2) ECDS Measure	39.30%	28.10%	33.00%	40.00%	49.70%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	76.16%	66.91%	76.89%	86.20%	91.24%
MY 2025		83.20%	73.20%	84.40%	89.50%	93.60%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	64.60%	53.50%	63.20%	68.20%	73.90%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months - 30 Months)	76.60%	66.30%	72.20%	78.10%	84.40%
MY 2025	***WCV - Child and Adolescent Well-Care Visits—Total	52.50%	46.40%	53.70%	59.70%	69.70%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
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🔵4-5 points⚪ 3 points🟡 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures)

Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Women's Reproductive Health						
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	85.40%	73.48%	81.94%	86.89%	91.85%
MY 2025		87.10%	79.00%	85.80%	90.00%	93.30%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	89.54%	68.63%	77.37%	82.48%	86.62%
MY 2025		90.00%	74.90%	82.20%	86.60%	90.00%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	29.36%	8.42%	15.96%	24.92%	35.60%
MY 2025		33.50%	9.30%	17.00%	24.50%	34.50%
Cancer Screening						
MY 2024	BCS-E - Breast Cancer Screening	56.29%	42.86%	49.24%	56.66%	63.48%
MY 2025		53.40%	41.70%	49.70%	56.00%	63.60%
MY 2024	CCS - Cervical Cancer Screening	59.12%	43.31%	52.07%	60.10%	67.46%
MY 2025	CCS-E - Cervical Cancer Screening - ECDS Measure	48.00%	38.00%	50.00%	57.40%	64.30%
MY 2024	COL-E - Colorectal Cancer Screening	32.99%	27.27%	34.30%	41.59%	49.35%
MY 2025		35.40%	34.40%	42.40%	50.00%	57.80%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.2 HPA HEDIS Plan-wide Performance – Prevention and Population

This table shows the MY2024 – MY2025 baseline performance on the **Prevention and Population** NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

🔵 4-5 points ⚪ 3 points 🟡 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures)

Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Description of Membership						
MY 2024	*RDM - Race/Ethnicity Diversity of Membership (Reporting Only)	100.00%	100.00%	100.00%	100.00%	100.00%
MY 2025		100.00%	100.00%	100.00%	100.00%	100.00%
MY 2024	*LDM - Language Diversity of Membership	100.00%	0.00%	0.00%	13.07%	100.00%
MY 2025		100.00%	0.01%	0.31%	5.88%	71.15%
Other Preventive Services						
MY 2024	**CHL - Chlamydia Screening in Women—Total**	55.58%	43.53%	52.40%	61.46%	69.07%
MY 2025		58.90%	40.30%	51.00%	61.70%	70.90%
MY 2024	AIS-E - Adult Immunization Status -- Influenza Immunizations for Adults	14.33%	7.39%	12.55%	17.91%	26.40%
MY 2025		15.80%	9.70%	14.10%	18.80%	28.10%
MY 2024	AIS-E - Adult Immunization Status—Pneumococcal	44.03%	21.04%	38.73%	55.03%	68.07%
MY 2025		48.20%	30.70%	47.00%	60.70%	70.80%
MY 2024	AIS-E - Adult Immunization Status—Td/Tdap Immunizations for Adults	32.96%	21.26%	33.40%	47.30%	57.67%
MY 2025		38.30%	29.70%	40.10%	53.10%	64.10%
MY 2024	AIS-E - Adult Immunization Status—Zoster Immunizations for Adults	14.47%	2.23%	7.15%	13.49%	20.56%
MY 2025		17.00%	4.90%	10.20%	18.00%	25.70%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.3 HPA HEDIS Plan-wide Performance – Treatment: Respiratory, Diabetes, Heart Disease

This table shows the MY2025 baseline performance on the **Treatment** NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

🔵4-5 points⚪ 3 points🟡 1-2 points

Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Treatment						
Respiratory						
MY 2024	**AMR - Asthma Medication Ratio- Total**	64.71%	54.56%	62.35%	70.56%	76.65%
MY 2025		73.30%	54.90%	62.60%	71.90%	82.00%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	44.00%	49.48%	56.76%	67.03%	77.66%
MY 2025		46.10%	44.50%	51.90%	62.50%	74.10%
Diabetes						
MY 2024	EED - Eye Exams for Patients with Diabetes	52.31%	40.39%	49.15%	57.09%	64.06%
MY 2025		52.90%	39.50%	48.90%	56.60%	64.00%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	70.56%	58.15%	65.32%	71.78%	77.37%
MY 2025		69.80%	65.80%	72.00%	76.60%	81.00%
MY 2024	***GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	54.26%	44.25%	54.50%	59.64%	63.50%
MY 2025		63.70%	52.60%	61.30%	66.60%	70.80%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	64.93%	51.96%	62.66%	67.01%	71.41%
MY 2025		63.20%	55.70%	64.80%	69.20%	74.30%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	67.90%	53.23%	64.18%	70.91%	79.73%
MY 2025		65.10%	56.80%	67.00%	72.70%	79.90%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	40.88%	26.79%	33.00%	42.10%	49.72%
MY 2025		41.60%	36.00%	44.00%	51.00%	57.70%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

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Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Heart Disease						
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	81.06%	66.64%	79.82%	83.00%	85.89%
MY 2025		82.40%	72.60%	81.10%	84.40%	87.70%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	70.33%	59.20%	66.84%	73.75%	81.25%
MY 2025		68.70%	60.50%	69.50%	76.00%	82.60%
MY 2024	***CBP - Controlling High Blood Pressure	61.80%	54.61%	61.43%	67.40%	72.75%
MY 2025		67.30%	61.30%	67.80%	72.50%	76.80%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.4 HPA HEDIS Plan-wide Performance – Behavioral Health

This table shows the MY2025 baseline performance on the **Behavioral Health** NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Behavioral Health--Care Coordination						
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	23.55%	32.71%	42.86%	57.69%
MY 2025		21.50%	35.50%	45.20%	54.60%	64.80%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	13.39%	21.19%	33.01%	44.33%	59.95%
MY 2025		26.30%	30.00%	38.50%	48.40%	59.30%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	22.88%	12.73%	18.76%	27.62%	37.47%
MY 2025		28.30%	18.00%	24.20%	33.40%	41.00%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	29.83%	15.91%	26.90%	37.64%	50.80%
MY 2025		30.80%	19.40%	29.90%	42.30%	55.00%
Behavioral Health--Medication Adherence						
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	15.84%	12.05%	21.36%	29.01%	36.71%
MY 2025		15.30%	14.90%	21.60%	29.60%	36.70%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	68.58%	44.65%	58.60%	66.15%	74.83%
MY 2025		67.20%	48.50%	61.70%	69.20%	76.50%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

3.5 HPA HEDIS Plan-wide Performance – Risk Adjusted / Other

This table shows the MY2025 baseline performance on the **Risk Adjusted** / Other NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

🔵 4-5 points ⚪ 3 points 🟡 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

Year	Measure	Plan-level Performance	National Medicaid Benchmarks			
			10th	33.33rd	66.67th	90th
Behavioral Health-- Access, Monitoring and Safety						
MY 2024	APM - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	32.18%	25.86%	30.92%	41.41%	52.57%
MY 2025	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	32.40%	27.70%	34.70%	42.50%	58.60%
MY 2024	ADD -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	40.36%	37.19%	48.94%	56.83%	63.49%
MY 2025	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	45.30%	43.00%	52.30%	59.70%	65.70%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.85%	75.46%	79.51%	83.51%	87.27%
MY 2025		83.90%	78.20%	81.30%	85.20%	88.50%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	41.38%	41.57%	54.55%	64.10%	74.14%
MY 2025		53.40%	49.40%	59.20%	68.90%	76.70%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	7.63%	6.08%	10.51%	16.78%	26.72%
MY 2025		12.00%	8.20%	12.30%	18.00%	27.50%
Risk-Adjusted Utilization						

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
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*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.9944	1.1783	1.0290	0.9124	0.8188
MY 2025		0.9706	1.3971	1.2155	1.0696	0.9598

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA. NCQA calculates the Confidence Limits (CLs) for all health plans.

4.0 MY 2025 HPA HEDIS Rate Performance by County

The following tables show MY2025 county-level performance on HPA HEDIS measures in Partnership's six (6) Regions. MY2025 county-level performance is also included, showing year-over-year performance trends by county.

HPA measures not included in the county-level performance tables are:

- CAHPS Measures, which only have plan-wide rates;
- Description of Membership measures, which only have plan-wide rates

All tables show the MY2025 baseline performance on NCQA Accreditation measures relative to the MY2023 and MY2024 National All Lines of Business 10th, 33.33rd, 66.67th and 90th measure benchmarks and percentiles that are used for ratings, calculated as whole numbers on a 1–5 scale.

4.1 HPA HEDIS Rate Performance by County, Auburn Region: Nevada, Placer, Plumas, Sierra Counties

🔵 4-5 points ⚪ 3 points 🟡 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

S = Small Population (Denominator<11), N/A = No Population (Denominator = 0)

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Prevention and Population									
Children and Adolescent Well-Care									
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	S	S	N/A	N/A	18.25%	24.39%	31.32%	42.34%
MY 2025	***CIS-E - Childhood Immunization Status (Combination 10) ECDS Measure	13.61%	16.47%	0.00%	S	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	S	S	N/A	N/A	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E - Immunizations for Adolescents (Combination 2) ECDS Measure	13.01%	29.10%	10.13%	33.33%	25.00%	30.70%	37.78%	47.16%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	73.33%	90.48%	S	S	66.91%	76.89%	86.20%	91.24%
MY 2025		S	87.50%	S	S	65.21%	80.54%	87.69%	91.97%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	41.76%	60.71%	30.56%	S	49.46%	60.39%	66.35%	71.71%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months - 30 Months)	64.09%	70.53%	57.14%	S	64.14%	70.06%	75.87%	82.12%
MY 2025	***WCV - Child and Adolescent Well-Care Visits—Total	44.69%	50.27%	39.48%	32.61%	44.96%	51.48%	58.37%	67.63%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
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*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

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Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Prevention and Population									
Women's Reproductive Health									
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	S	75.00%	S	S	73.48%	81.94%	86.89%	91.85%
MY 2025		84.62%	80.77%	S	S	76.16%	84.40%	88.56%	91.97%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	S	83.33%	S	S	68.63%	77.37%	82.48%	86.62%
MY 2025		100.00%	88.46%	S	S	72.26%	79.73%	83.94%	88.32%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	11.28%	21.29%	31.11%	S	8.42%	15.96%	24.92%	35.60%
MY 2025		18.99%	26.68%	29.41%	S	8.23%	16.07%	25.25%	34.91%
Cancer Screening									
MY 2024	BCS-E- Breast Cancer Screening	S	S	N/A	S	42.86%	49.24%	56.66%	63.48%
MY 2025		52.94%	S	S	S	45.09%	52.22%	58.93%	66.31%
MY 2024	CCS - Cervical Cancer Screening	62.50%	50.00%	S	S	43.31%	52.07%	60.10%	67.46%
MY 2025	CCS-E - Cervical Cancer Screening - ECDS Measure	38.96%	38.27%	16.37%	30.77%	40.21%	48.91%	55.86%	64.21%
MY 2024	COL-E - Colorectal cancer Screening	18.18%	S	S	N/A	27.27%	34.30%	41.59%	49.35%
MY 2025		27.71%	28.87%	19.77%	27.91%	29.99%	38.05%	45.84%	53.31%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
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Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Prevention and Population									
Other preventive services									
MY 2024	**CHL - Chlamydia Screening in Women—Total**	48.06%	60.67%	23.26%	27.27%	43.53%	52.40%	61.46%	69.07%
MY 2025		48.90%	58.83%	27.07%	7.69%	41.71%	51.22%	62.81%	70.67%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	8.48%	11.84%	10.38%	12.12%	7.39%	12.55%	17.91%	26.40%
MY 2025		9.44%	13.91%	12.47%	11.20%	8.73%	13.56%	18.61%	26.60%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	35.21%	30.02%	31.25%	N/A	21.04%	38.73%	55.03%	68.07%
MY 2025		38.61%	33.12%	45.83%	N/A	28.84%	43.72%	58.40%	71.90%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	26.37%	24.48%	30.03%	37.12%	21.26%	33.40%	47.30%	57.67%
MY 2025		28.74%	29.53%	32.79%	36.68%	26.23%	36.85%	50.60%	61.22%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	13.02%	14.60%	6.87%	8.60%	2.23%	7.15%	13.49%	20.56%
MY 2025		9.91%	15.04%	8.44%	5.13%	3.62%	9.28%	16.63%	24.04%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Treatment									
Respiratory									
MY 2024	**AMR - Asthma Medication Ratio- Total**	N/A	N/A	S	N/A	54.56%	62.35%	70.56%	76.65%
MY 2025		67.27%	80.43%	63.16%	S	52.00%	59.38%	68.13%	76.25%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	23.33%	34.78%	42.31%	N/A	49.48%	50.98%	67.03%	77.66%
MY 2025		29.38%	29.60%	28.33%	S	48.00%	56.37%	65.97%	75.42%
Diabetes									
MY 2024	EED - Eye Exams for Patients with Diabetes	S	44.44%	S	S	40.39%	49.15%	57.09%	64.06%
MY 2025		40.14%	32.73%	20.29%	31.58%	42.09%	52.55%	60.83%	68.61%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	70.00%	72.22%	N/A	N/A	58.15%	65.32%	71.78%	77.37%
MY 2025		S	56.25%	S	S	60.34%	69.34%	74.21%	78.83%
MY 2024	***GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	S	44.44%	S	S	44.25%	54.50%	59.64%	63.50%
MY 2025		S	62.50%	S	S	49.30%	57.41%	63.04%	67.40%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	S	N/A	S	N/A	51.96%	62.66%	67.01%	71.41%
MY 2025		54.49%	64.79%	52.17%	66.67%	56.26%	64.27%	69.01%	73.76%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	S	N/A	S	N/A	53.23%	64.18%	70.91%	79.73%
MY 2025		70.33%	70.30%	68.75%	S	57.38%	65.75%	72.29%	80.89%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	45.34%	49.73%	14.62%	N/A	26.79%	33.00%	42.10%	49.72%
MY 2025		39.00%	41.47%	10.37%	22.22%	30.61%	38.74%	46.17%	54.15%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
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Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Treatment									
Heart Disease									
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	S	N/A	N/A	N/A	66.64%	79.82%	83.00%	85.89%
MY 2025		87.21%	83.45%	86.67%	S	69.48%	79.83%	82.94%	86.40%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	S	N/A	N/A	N/A	59.95%	67.42%	74.07%	81.79%
MY 2025		69.33%	69.42%	46.15%	S	61.58%	68.28%	75.45%	82.65%
MY 2024	***CBP - Controlling High Blood Pressure	S	S	S	N/A	54.61%	61.43%	67.40%	72.75%
MY 2025		S	50.00%	S	N/A	56.93%	65.21%	70.35%	75.43%
Behavioral Health - Care Coordination									
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2025		4.35%	18.60%	S	N/A	26.07%	35.29%	45.08%	57.76%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	17.58%	9.04%	10.71%	S	21.19%	33.01%	44.33%	59.95%
MY 2025		25.33%	17.40%	30.00%	S	26.32%	36.34%	46.71%	62.06%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	22.25%	22.72%	17.31%	S	12.73%	18.76%	27.62%	37.47%
MY 2025		24.63%	32.04%	34.29%	S	15.49%	21.62%	30.53%	39.38%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	13.46%	12.05%	S	S	15.91%	26.90%	37.64%	50.80%
MY 2025		17.46%	13.21%	S	S	18.61%	28.46%	40.55%	53.73%
Behavioral Health - Medication Adherence									
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	9.76%	12.50%	S	N/A	12.05%	21.36%	29.01%	36.71%
MY 2025		10.84%	11.39%	6.25%	16.67%	14.52%	20.92%	30.43%	36.44%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.45%	79.66%	72.73%	S	44.65%	58.60%	66.15%	74.83%
MY 2025		58.33%	74.83%	76.00%	S	49.57%	62.98%	69.67%	77.21%

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67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance				National Medicaid Benchmarks			
		Nevada	Placer	Plumas	Sierra	10th	33.33rd	66.67th	90th
Treatment									
Behavioral Health - Access, Monitoring and Safety									
MY 2024	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	39.29%	35.92%	38.46%	N/A	25.86%	30.92%	41.41%	52.57%
MY 2025		40.30%	42.86%	37.50%	S	26.70%	33.26%	41.52%	55.96%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	N/A	N/A	N/A	N/A	37.19%	48.94%	56.83%	63.49%
MY 2025		35.00%	42.86%	S	N/A	39.95%	51.20%	58.69%	65.18%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	85.08%	85.07%	89.29%	S	75.46%	79.51%	83.51%	87.27%
MY 2025		81.68%	81.67%	78.38%	S	77.16%	81.03%	84.36%	87.47%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	80.00%	6.25%	S	N/A	41.57%	54.55%	64.10%	74.14%
MY 2025		50.00%	40.43%	S	S	46.48%	58.39%	66.54%	75.82%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	3.82%	5.83%	3.08%	S	6.08%	10.51%	16.78%	26.72%
MY 2025		9.60%	11.04%	8.70%	5.88%	7.33%	11.35%	17.80%	27.95%
Risk-Adjusted Utilization									
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	2.0801	1.7290	N/A	12.8852	1.1783	1.029	0.9124	0.8188
MY 2025		0.8315	1.1128	1.0359	N/A	1.3971	1.2155	1.0696	0.9598

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10th – 32rd Percentile	2
< 10th Percentile	1

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA. NCQA calculates the Confidence Limits (CLs) for all health plans.

4.2 HPA HEDIS Rate Performance by County, Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties

🔵 4-5 points ⚪ 3 points 🟡 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures).

S = Small Population (Denominator<11), N/A = No Population (Denominator = 0)

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Prevention and Population										
Children and Adolescent Well-Care										
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	S	S	S	S	S	18.25%	24.39%	31.32%	42.34%
MY 2025	***CIS-E - Childhood Immunization Status (Combination 10) ECDS Measure	27.77%	28.78%	30.41%	33.50%	23.46%	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	S	S	S	S	S	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E - Immunizations for Adolescents (Combination 2) ECDS Measure	25.62%	29.13%	24.44%	51.93%	43.35%	25.00%	30.70%	37.78%	47.16%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	64.52%	100.00%	S	63.33%	58.82%	66.91%	76.89%	86.20%	91.24%
MY 2025		62.07%	S	86.67%	76.92%	66.67%	65.21%	80.54%	87.69%	91.97%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	59.95%	55.75%	35.88%	58.51%	54.14%	49.46%	60.39%	66.35%	71.71%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months - 30 Months)	74.16%	81.75%	75.17%	88.04%	76.98%	64.14%	70.06%	75.87%	82.12%
MY 2025	***WCV - Child and Adolescent Well-Care Visits—Total	44.32%	68.06%	57.58%	59.83%	50.26%	44.96%	51.48%	58.37%	67.63%

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< 10th Percentile	1

Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Prevention and Population										
Women's Reproductive Health										
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	93.33%	S	S	92.00%	90.00%	73.48%	81.94%	86.89%	91.85%
MY 2025		87.18%	S	S	72.73%	90.48%	76.16%	84.40%	88.56%	91.97%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	96.67%	S	S	88.00%	80.00%	68.63%	77.37%	82.48%	86.62%
MY 2025		84.62%	S	S	86.36%	76.19%	72.26%	79.73%	83.94%	88.32%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	19.02%	24.19%	25.82%	18.15%	17.99%	8.42%	15.96%	24.92%	35.60%
MY 2025		26.95%	24.81%	34.97%	24.07%	24.52%	8.23%	16.07%	25.25%	34.91%
Cancer Screening										
MY 2024	BCS-E- Breast Cancer Screening	26.32%	S	S	S	S	42.86%	49.24%	56.66%	63.48%
MY 2025		36.96%	S	S	S	S	45.09%	52.22%	58.93%	66.31%
MY 2024	CCS - Cervical Cancer Screening	53.19%	S	S	55.56%	60.00%	43.31%	52.07%	60.10%	67.46%
MY 2025	CCS-E - Cervical Cancer Screening - ECDS Measure	36.16%	49.25%	44.72%	46.08%	40.79%	40.21%	48.91%	55.86%	64.21%
MY 2024	COL-E - Colorectal cancer Screening	26.67%	20.00%	S	S	S	27.27%	34.30%	41.59%	49.35%
MY 2025		29.30%	33.30%	31.14%	34.81%	28.35%	29.99%	38.05%	45.84%	53.31%
Other preventive services										
MY 2024	CHL - Chlamydia Screening in Women—Total	55.64%	53.02%	51.47%	57.24%	57.89%	43.53%	52.40%	61.46%	69.07%
MY 2025		54.53%	50.94%	50.75%	55.91%	58.97%	41.71%	51.22%	62.81%	70.67%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	11.00%	17.54%	13.04%	12.57%	9.16%	7.39%	12.55%	17.91%	26.40%
MY 2025		11.33%	16.95%	14.09%	14.84%	10.79%	8.73%	13.56%	18.61%	26.60%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	39.50%	43.21%	32.31%	51.35%	36.51%	21.04%	38.73%	55.03%	68.07%
MY 2025		43.26%	54.26%	40.91%	59.35%	42.55%	28.84%	43.72%	58.40%	71.90%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	28.86%	30.82%	32.27%	30.26%	27.31%	21.26%	33.40%	47.30%	57.67%
MY 2025		33.40%	40.05%	40.81%	40.59%	33.43%	26.23%	36.85%	50.60%	61.22%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	13.42%	15.10%	17.50%	14.44%	9.08%	2.23%	7.15%	13.49%	20.56%
MY 2025		15.36%	20.82%	21.83%	19.23%	10.98%	3.62%	9.28%	16.63%	24.04%

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Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Treatment										
Respiratory										
MY 2024	**AMR - Asthma Medication Ratio- Total**	S	N/A	S	N/A	N/A	54.56%	62.35%	70.56%	76.65%
MY 2025		68.79%	80.00%	78.35%	69.62%	64.93%	52.00%	59.38%	68.13%	76.25%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	79.77%	53.33%	75.71%	57.62%	68.41%	49.48%	50.98%	67.03%	77.66%
MY 2025		77.02%	53.10%	71.55%	64.50%	65.81%	48.00%	56.37%	65.97%	75.42%
Diabetes										
MY 2024	EED - Eye Exams for Patients with Diabetes	59.09%	S	S	39.13%	52.94%	40.39%	49.15%	57.09%	64.06%
MY 2025		48.62%	30.17%	43.47%	50.19%	49.04%	42.09%	52.55%	60.83%	68.61%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	79.55%	100.00%	60.00%	65.22%	70.59%	58.15%	65.32%	71.78%	77.37%
MY 2025		50.00%	S	S	66.67%	66.67%	60.34%	69.34%	74.21%	78.83%
MY 2024	***GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	68.18%	S	S	56.52%	52.94%	44.25%	54.50%	59.64%	63.50%
MY 2025		60.00%	S	S	70.37%	57.14%	49.30%	57.41%	63.04%	67.40%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	63.64%	S	S	S	N/A	51.96%	62.66%	67.01%	71.41%
MY 2025		59.44%	69.14%	53.66%	70.18%	63.71%	56.26%	64.27%	69.01%	73.76%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	S	S	S	N/A	N/A	53.23%	64.18%	70.91%	79.73%
MY 2025		64.29%	44.64%	64.26%	62.62%	69.60%	57.38%	65.75%	72.29%	80.89%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	33.96%	37.39%	28.71%	32.35%	29.28%	26.79%	33.00%	42.10%	49.72%
MY 2025		34.90%	37.57%	24.30%	33.37%	32.97%	30.61%	38.74%	46.17%	54.15%
Heart Disease										
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	S	S	S	N/A	N/A	66.64%	79.82%	83.00%	85.89%
MY 2025		77.88%	90.48%	85.00%	91.14%	88.10%	69.48%	79.83%	82.94%	86.40%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	S	S	S	N/A	N/A	59.95%	67.42%	74.07%	81.79%
MY 2025		66.80%	63.16%	70.59%	78.47%	62.16%	61.58%	68.28%	75.45%	82.65%
MY 2024	***CBP - Controlling High Blood Pressure	S	75.00%	S	61.11%	37.50%	54.61%	61.43%	67.40%	72.75%
MY 2025		73.47%	S	S	50.00%	47.62%	56.93%	65.21%	70.35%	75.43%

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Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Treatment										
Behavioral Health - Care Coordination										
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2025		31.76%	S	S	18.18%	25.00%	26.07%	35.29%	45.08%	57.76%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	10.45%	22.22%	10.71%	12.32%	10.11%	21.19%	33.01%	44.33%	59.95%
MY 2025		26.02%	24.14%	22.32%	32.68%	39.57%	26.32%	36.34%	46.71%	62.06%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	26.69%	15.38%	28.26%	23.38%	22.71%	12.73%	18.76%	27.62%	37.47%
MY 2025		34.33%	26.09%	28.81%	30.92%	27.84%	15.49%	21.62%	30.53%	39.38%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	15.91%	S	S	17.65%	16.67%	15.91%	26.90%	37.64%	50.80%
MY 2025		16.90%	28.57%	S	8.33%	20.00%	18.61%	28.46%	40.55%	53.73%
Behavioral Health - Medication Adherence										
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	14.88%	S	S	25.00%	11.63%	12.05%	21.36%	29.01%	36.71%
MY 2025		18.08%	12.50%	8.57%	16.49%	15.00%	14.52%	20.92%	30.43%	36.44%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	67.83%	S	87.50%	86.96%	69.81%	44.65%	58.60%	66.15%	74.83%
MY 2025		67.94%	S	75.86%	76.54%	63.64%	49.57%	62.98%	69.67%	77.21%

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Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance					National Medicaid Benchmarks			
		Butte	Colusa	Glenn	Sutter	Yuba	10th	33.33rd	66.67th	90th
Treatment										
Behavioral Health - Access, Monitoring and Safety										
MY 2024	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	35.56%	S	25.81%	28.26%	34.44%	25.86%	30.92%	41.41%	52.57%
MY 2025		36.57%	S	20.69%	38.30%	35.00%	26.70%	33.26%	41.52%	55.96%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	N/A	N/A	N/A	N/A	N/A	37.19%	48.94%	56.83%	63.49%
MY 2025		41.89%	S	S	55.56%	45.00%	39.95%	51.20%	58.69%	65.18%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	86.90%	90.91%	86.36%	89.57%	85.26%	75.46%	79.51%	83.51%	87.27%
MY 2025		85.10%	100.00%	88.10%	81.58%	85.26%	77.16%	81.03%	84.36%	87.47%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	45.16%	S	44.44%	33.33%	29.63%	41.57%	54.55%	64.10%	74.14%
MY 2025		50.67%	S	83.33%	50.00%	65.22%	46.48%	58.39%	66.54%	75.82%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	4.59%	5.77%	3.28%	6.01%	5.12%	6.08%	10.51%	16.78%	26.72%
MY 2025		7.90%	14.85%	10.00%	13.77%	13.43%	7.33%	11.35%	17.80%	27.95%
Risk-Adjusted Utilization										
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	2.6863	1.3132	N/A	1.5553	2.337	1.1783	1.029	0.9124	0.8188
MY 2025		1.1826	0.3715	0.5332	0.8275	0.7274	1.3971	1.2155	1.0696	0.9598

Note: *PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA. NCQA calculates the Confidence Limits (CLs) for all health plans*

4.3 HPA HEDIS Rate Performance by County, Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

S = Small Population (Denominator<11), N/A = No Population (Denominator = 0)

Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
Prevention and Population									
Children and Adolescent Well-Care									
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	S	26.47%	26.09%	31.43%	18.25%	24.39%	31.32%	42.34%
MY 2025	***CIS-E - Childhood Immunization Status (Combination 10) ECDS Measure	5.07%	21.66%	26.90%	25.16%	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	S	36.36%	50.00%	35.71%	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E - Immunizations for Adolescents (Combination 2) ECDS Measure	33.94%	41.59%	50.19%	36.23%	25.00%	30.70%	37.78%	47.16%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	S	88.00%	100.00%	80.00%	66.91%	76.89%	86.20%	91.24%
MY 2025		S	88.00%	100.00%	88.46%	65.21%	80.54%	87.69%	91.97%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	56.92%	61.39%	80.12%	77.86%	49.46%	60.39%	66.35%	71.71%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months - 30 Months)	62.07%	75.81%	86.24%	79.66%	64.14%	70.06%	75.87%	82.12%
MY 2025	***WCV - Child and Adolescent Well-Care Visits—Total	55.90%	51.56%	50.46%	55.28%	44.96%	51.48%	58.37%	67.63%

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> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
Prevention and Population									
Women's Reproductive Health									
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	S	76.00%	86.67%	90.91%	42.86%	49.24%	56.66%	63.48%
MY 2025		S	72.22%	94.12%	78.26%	45.09%	52.22%	58.93%	66.31%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	S	88.00%	93.33%	90.91%	43.31%	52.07%	60.10%	67.46%
MY 2025		S	100.00%	100.00%	86.96%	40.21%	48.91%	55.86%	64.21%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	14.05%	20.24%	28.69%	37.32%	27.27%	34.30%	41.59%	49.35%
MY 2025		9.60%	20.34%	42.37%	37.59%	29.99%	38.05%	45.84%	53.31%
Cancer Screening									
MY 2024	BCS-E- Breast Cancer Screening	46.83%	51.35%	48.55%	56.75%	42.86%	49.24%	56.66%	63.48%
MY 2025		46.57%	52.24%	47.58%	53.30%	45.09%	52.22%	58.93%	66.31%
MY 2024	CCS - Cervical Cancer Screening	S	75.00%	30.00%	50.00%	43.31%	52.07%	60.10%	67.46%
MY 2025	CCS-E - Cervical Cancer Screening - ECDS Measure	46.91%	53.01%	54.00%	55.98%	40.21%	48.91%	55.86%	64.21%
MY 2024	COL-E - Colorectal cancer Screening	25.14%	28.05%	33.41%	31.50%	27.27%	34.30%	41.59%	49.35%
MY 2025		31.49%	33.09%	38.15%	38.20%	29.99%	38.05%	45.84%	53.31%
Other preventive services									
MY 2024	CHL - Chlamydia Screening in Women—Total	47.33%	54.61%	53.93%	52.00%	43.53%	52.40%	61.46%	69.07%
MY 2025		52.49%	53.82%	63.70%	56.29%	41.71%	51.22%	62.81%	70.67%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	10.32%	13.81%	13.21%	13.76%	7.39%	12.55%	17.91%	26.40%
MY 2025		11.11%	14.01%	15.28%	14.08%	8.73%	13.56%	18.61%	26.60%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	41.03%	50.90%	44.74%	43.85%	21.04%	38.73%	55.03%	68.07%
MY 2025		40.00%	55.60%	45.86%	50.57%	28.84%	43.72%	58.40%	71.90%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	36.08%	35.95%	39.66%	36.92%	21.26%	33.40%	47.30%	57.67%
MY 2025		43.87%	44.26%	47.65%	46.35%	26.23%	36.85%	50.60%	61.22%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	10.10%	10.46%	13.05%	10.64%	2.23%	7.15%	13.49%	20.56%
MY 2025		11.41%	12.33%	15.93%	13.01%	3.62%	9.28%	16.63%	24.04%

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Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance				National Medicaid Benchmarks			
		Del Norte	Humboldt	Lake	Mendocino	10th	33.33rd	66.67th	90th
Treatment									
Respiratory									
MY 2024	**AMR - Asthma Medication Ratio-Total**	60.83%	63.41%	57.84%	62.50%	54.56%	62.35%	70.56%	76.65%
MY 2025		74.07%	65.52%	81.37%	80.37%	52.00%	59.38%	68.13%	76.25%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	43.75%	43.14%	44.48%	37.92%	49.48%	50.98%	67.03%	77.66%
MY 2025		56.00%	40.45%	39.22%	33.72%	48.00%	56.37%	65.97%	75.42%
Diabetes									
MY 2024	EED - Eye Exams for Patients with Diabetes	S	33.33%	50.00%	S	40.39%	49.15%	57.09%	64.06%
MY 2025		43.72%	45.92%	54.56%	47.99%	42.09%	52.55%	60.83%	68.61%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	66.67%	66.67%	92.86%	60.00%	58.15%	65.32%	71.78%	77.37%
MY 2025		S	64.71%	87.50%	70.59%	60.34%	69.34%	74.21%	78.83%
MY 2024	***GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	S	59.26%	78.57%	S	44.25%	54.50%	59.64%	63.50%
MY 2025		S	70.59%	56.25%	64.71%	49.30%	57.41%	63.04%	67.40%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	59.47%	59.20%	61.94%	55.91%	51.96%	62.66%	67.01%	71.41%
MY 2025		60.58%	58.50%	59.54%	55.87%	56.26%	64.27%	69.01%	73.76%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	73.25%	70.16%	61.03%	65.32%	53.23%	64.18%	70.91%	79.73%
MY 2025		65.06%	67.16%	62.07%	62.87%	57.38%	65.75%	72.29%	80.89%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	29.02%	37.62%	35.38%	31.95%	26.79%	33.00%	42.10%	49.72%
MY 2025		31.91%	40.66%	35.03%	38.30%	30.61%	38.74%	46.17%	54.15%
Heart Disease									
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	64.00%	74.73%	71.67%	61.04%	66.64%	79.82%	83.00%	85.89%
MY 2025		73.91%	78.15%	84.29%	77.32%	69.48%	79.83%	82.94%	86.40%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	69.44%	75.83%	85.71%	77.78%	59.95%	67.42%	74.07%	81.79%
MY 2025		58.82%	74.19%	62.71%	70.67%	61.58%	68.28%	75.45%	82.65%
MY 2024	***CBP - Controlling High Blood Pressure	S	48.00%	68.18%	78.95%	54.61%	61.43%	67.40%	72.75%
MY 2025		S	83.87%	100.00%	56.67%	56.93%	65.21%	70.35%	75.43%

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Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance				National Medicaid Benchmarks			
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Behavioral Health - Care Coordination									
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2025		S	22.22%	0.00%	23.08%	26.07%	35.29%	45.08%	57.76%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	11.61%	17.14%	10.36%	12.77%	21.19%	33.01%	44.33%	59.95%
MY 2025		25.64%	27.30%	21.01%	22.86%	26.32%	36.34%	46.71%	62.06%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	18.24%	31.70%	13.33%	21.08%	12.73%	18.76%	27.62%	37.47%
MY 2025		28.35%	31.65%	21.03%	24.18%	15.49%	21.62%	30.53%	39.38%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	15.79%	37.24%	6.67%	52.52%	15.91%	26.90%	37.64%	50.80%
MY 2025		50.00%	42.94%	7.32%	43.08%	18.61%	28.46%	40.55%	53.73%
Behavioral Health - Medication Adherence									
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	16.95%	20.75%	13.82%	17.47%	12.05%	21.36%	29.01%	36.71%
MY 2025		14.47%	16.86%	15.38%	15.08%	14.52%	20.92%	30.43%	36.44%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	67.57%	68.39%	68.12%	62.81%	44.65%	58.60%	66.15%	74.83%
MY 2025		68.57%	63.89%	74.78%	69.84%	49.57%	62.98%	69.67%	77.21%
Behavioral Health - Access, Monitoring and Safety									
MY 2024	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	45.95%	21.14%	26.47%	29.09%	25.86%	30.92%	41.41%	52.57%
MY 2025		30.23%	19.27%	29.03%	32.20%	26.70%	33.26%	41.52%	55.96%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	18.18%	43.24%	50.00%	33.33%	37.19%	48.94%	56.83%	63.49%
MY 2025		38.46%	59.62%	76.92%	50.00%	39.95%	51.20%	58.69%	65.18%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.11%	79.15%	80.07%	88.03%	75.46%	79.51%	83.51%	87.27%
MY 2025		91.15%	80.38%	80.08%	86.90%	77.16%	81.03%	84.36%	87.47%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	S	48.98%	33.33%	75.00%	41.57%	54.55%	64.10%	74.14%
MY 2025		33.33%	48.48%	51.92%	54.55%	46.48%	58.39%	66.54%	75.82%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	5.94%	8.06%	3.82%	8.25%	6.08%	10.51%	16.78%	26.72%
MY 2025		10.42%	15.50%	7.97%	14.81%	7.33%	11.35%	17.80%	27.95%

Risk-Adjusted Utilization									
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.6596	0.9967	0.9747	0.9901	1.1783	1.029	0.9124	0.8188
MY 2025		1.0269	0.8488	1.0048	1.0164	1.3971	1.2155	1.0696	0.9598

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA. NCQA calculates the Confidence Limits (CLs) for all health plans.

4.4 HPA HEDIS Rate Performance by County, Fairfield Region: Solano, Yolo, and Napa Counties

4-5 points 3 points 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

S = Small Population (Denominator<11), N/A = No Population (Denominator = 0)

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Prevention and Population								
Children and Adolescent Well-Care								
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	47.06%	34.85%	21.62%	18.25%	24.39%	31.32%	42.34%
MY 2025	***CIS-E - Childhood Immunization Status (Combination 10) ECDS Measure	38.56%	32.03%	26.68%	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	50.00%	38.03%	55.56%	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E - Immunizations for Adolescents (Combination 2) ECDS Measure	57.56%	46.98%	48.03%	25.00%	30.70%	37.78%	47.16%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	100.00%	80.65%	45.00%	66.91%	76.89%	86.20%	91.24%
MY 2025		100.00%	89.19%	57.69%	65.21%	80.54%	87.69%	91.97%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	75.36%	62.18%	66.98%	49.46%	60.39%	66.35%	71.71%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months - 30 Months)	80.13%	72.82%	78.63%	64.14%	70.06%	75.87%	82.12%
MY 2025	***WCV - Child and Adolescent Well-Care Visits—Total	64.08%	48.38%	54.46%	44.96%	51.48%	58.37%	67.63%
Women's Reproductive Health								
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	88.24%	87.76%	76.00%	73.48%	81.94%	86.89%	91.85%
MY 2025		S	86.67%	100.00%	76.16%	84.40%	88.56%	91.97%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	100.00%	85.71%	68.00%	68.63%	77.37%	82.48%	86.62%
MY 2025		S	91.11%	100.00%	72.26%	79.73%	83.94%	88.32%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	38.62%	37.70%	40.00%	8.42%	15.96%	24.92%	35.60%
MY 2025		31.19%	43.39%	40.19%	8.23%	16.07%	25.25%	34.91%

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Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Prevention and Population								
Cancer Screening								
MY 2024	**BCS-E- Breast Cancer Screening**	66.84%	54.14%	60.29%	42.86%	49.24%	56.66%	63.48%
MY 2025		68.63%	52.50%	56.03%	45.09%	52.22%	58.93%	66.31%
MY 2024	**CCS - Cervical Cancer Screening**	75.00%	64.71%	47.62%	43.31%	52.07%	60.10%	67.46%
MY 2025	**CCS-E - Cervical Cancer Screening - ECDS Measure**	53.29%	45.82%	51.78%	40.21%	48.91%	55.86%	64.21%
MY 2024	COL-E - Colorectal cancer Screening	38.24%	31.74%	32.50%	27.27%	34.30%	41.59%	49.35%
MY 2025		45.04%	36.08%	38.29%	29.99%	38.05%	45.84%	53.31%
Other preventive services								
MY 2024	**CHL - Chlamydia Screening in Women—Total**	49.58%	62.14%	51.37%	43.53%	52.40%	61.46%	69.07%
MY 2025		60.46%	69.97%	55.05%	41.71%	51.22%	62.81%	70.67%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	21.99%	16.50%	21.83%	7.39%	12.55%	17.91%	26.40%
MY 2025		22.40%	18.06%	21.98%	8.73%	13.56%	18.61%	26.60%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	51.67%	51.11%	47.74%	21.04%	38.73%	55.03%	68.07%
MY 2025		54.48%	52.84%	51.56%	28.84%	43.72%	58.40%	71.90%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	35.69%	34.58%	39.96%	21.26%	33.40%	47.30%	57.67%
MY 2025		40.39%	40.02%	42.63%	26.23%	36.85%	50.60%	61.22%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	24.27%	17.30%	19.20%	2.23%	7.15%	13.49%	20.56%
MY 2025		31.03%	20.64%	22.49%	3.62%	9.28%	16.63%	24.04%

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Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Treatment								
Respiratory								
MY 2024	**AMR - Asthma Medication Ratio- Total**	79.82%	65.79%	67.84%	54.56%	62.35%	70.56%	76.65%
MY 2025		84.88%	74.58%	77.20%	52.00%	59.38%	68.13%	76.25%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	31.21%	19.66%	19.23%	49.48%	50.98%	67.03%	77.66%
MY 2025		46.15%	21.24%	24.47%	48.00%	56.37%	65.97%	75.42%
Diabetes								
MY 2024	EED - Eye Exams for Patients with Diabetes	46.67%	59.65%	44.83%	40.39%	49.15%	57.09%	64.06%
MY 2025		69.69%	55.68%	56.68%	42.09%	52.55%	60.83%	68.61%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	86.67%	84.21%	68.97%	58.15%	65.32%	71.78%	77.37%
MY 2025		S	71.67%	91.30%	60.34%	69.34%	74.21%	78.83%
MY 2024	***GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	66.67%	52.63%	55.17%	44.25%	54.50%	59.64%	63.50%
MY 2025		S	60.00%	69.57%	49.30%	57.41%	63.04%	67.40%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	67.58%	68.90%	69.47%	51.96%	62.66%	67.01%	71.41%
MY 2025		72.21%	67.20%	67.02%	56.26%	64.27%	69.01%	73.76%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	65.16%	70.86%	71.09%	53.23%	64.18%	70.91%	79.73%
MY 2025		60.11%	71.39%	67.64%	57.38%	65.75%	72.29%	80.89%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	48.46%	50.53%	39.00%	26.79%	33.00%	42.10%	49.72%
MY 2025		55.58%	51.56%	41.50%	30.61%	38.74%	46.17%	54.15%
Heart Disease								
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	64.62%	69.87%	81.42%	66.64%	79.82%	83.00%	85.89%
MY 2025		84.00%	79.55%	87.84%	69.48%	79.83%	82.94%	86.40%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	87.84%	77.89%	82.48%	59.95%	67.42%	74.07%	81.79%
MY 2025		70.24%	72.65%	71.54%	61.58%	68.28%	75.45%	82.65%
MY 2024	***CBP - Controlling High Blood Pressure	52.38%	62.75%	78.13%	54.61%	61.43%	67.40%	72.75%
MY 2025		84.62%	77.78%	60.71%	56.93%	65.21%	70.35%	75.43%

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> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
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< 10th Percentile	1

Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance			National Medicaid Benchmarks			
		Napa	Solano	Yolo	10th	33.33rd	66.67th	90th
Treatment								
Behavioral Health - Care Coordination								
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2025		11.11%	20.00%	20.69%	26.07%	35.29%	45.08%	57.76%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	13.04%	9.98%	10.69%	21.19%	33.01%	44.33%	59.95%
MY 2025		17.07%	24.21%	21.07%	26.32%	36.34%	46.71%	62.06%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	10.83%	20.83%	17.30%	12.73%	18.76%	27.62%	37.47%
MY 2025		23.16%	32.46%	21.57%	15.49%	21.62%	30.53%	39.38%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	12.90%	32.17%	15.07%	15.91%	26.90%	37.64%	50.80%
MY 2025		20.00%	34.57%	16.67%	18.61%	28.46%	40.55%	53.73%
Behavioral Health - Medication Adherence								
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	3.57%	13.07%	3.85%	12.05%	21.36%	29.01%	36.71%
MY 2025		15.25%	18.43%	8.74%	14.52%	20.92%	30.43%	36.44%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	65.67%	65.96%	64.89%	44.65%	58.60%	66.15%	74.83%
MY 2025		72.46%	68.47%	64.29%	49.57%	62.98%	69.67%	77.21%
Behavioral Health - Access, Monitoring and Safety								
MY 2024	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	40.00%	41.57%	23.88%	25.86%	30.92%	41.41%	52.57%
MY 2025		27.78%	31.37%	19.35%	26.70%	33.26%	41.52%	55.96%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	28.57%	25.00%	48.84%	37.19%	48.94%	56.83%	63.49%
MY 2025		58.82%	43.90%	48.65%	39.95%	51.20%	58.69%	65.18%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	83.85%	87.32%	80.00%	75.46%	79.51%	83.51%	87.27%
MY 2025		82.11%	85.57%	87.68%	77.16%	81.03%	84.36%	87.47%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	9.09%	58.33%	28.00%	41.57%	54.55%	64.10%	74.14%
MY 2025		S	73.08%	57.58%	46.48%	58.39%	66.54%	75.82%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	4.79%	8.85%	3.50%	6.08%	10.51%	16.78%	26.72%
MY 2025		16.31%	11.58%	8.97%	7.33%	11.35%	17.80%	27.95%
Risk-Adjusted Utilization								
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.8874	1.1087	1.0775	1.1783	1.029	0.9124	0.8188
MY 2025		1.2404	0.9766	0.8632	1.3971	1.2155	1.0696	0.9598

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.

NCQA calculates the Confidence Limits (CLs) for all health plans.

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4.5 HPA HEDIS Rate Performance by County, Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties

🔵 4-5 points ○ 3 points 🟡 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

S = Small Population (Denominator<11), N/A = No Population (Denominator = 0)

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Prevention and Population											
Children and Adolescent Well-Care											
MY 2024	***CIS - Childhood Immunization Status (Combination 10)	S	S	16.00%	S	S	S	18.25%	24.39%	31.32%	42.34%
MY 2025	***CIS-E - Childhood Immunization Status (Combination 10) ECDS Measure	3.23%	11.11%	10.02%	16.49%	20.05%	3.45%	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA - Immunizations for Adolescents (Combination 2)	S	S	21.57%	10.00%	S	S	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E - Immunizations for Adolescents (Combination 2) ECDS Measure	11.54 %	16.92%	18.75%	19.22%	26.33%	15.49 %	25.00%	30.70%	37.78%	47.16%
MY 2024	WCC - Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	S	S	95.12%	66.67%	56.25%	N/A	66.91%	76.89%	86.20%	91.24%
MY 2025		S	S	100.00%	S	84.62%	S	65.21%	80.54%	87.69%	91.97%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	58.70 %	45.71%	64.69%	59.05%	57.81%	46.51 %	49.46%	60.39%	66.35%	71.71%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months - 30 Months)	54.08 %	59.52%	71.36%	67.91%	77.10%	62.71 %	64.14%	70.06%	75.87%	82.12%
MY 2025	***WCV - Child and Adolescent Well-Care Visits—Total	33.68 %	47.08%	49.71%	50.13%	51.95%	49.07 %	44.96%	51.48%	58.37%	67.63%

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Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Prevention and Population											
Women's Reproductive Health											
MY 2024	***PPC - Prenatal and Postpartum Care—Timeliness of Prenatal Care	S	S	84.38%	S	S	S	73.48%	81.94%	86.89%	91.85%
MY 2025		S	S	80.00%	S	76.92%	S	76.16%	84.40%	88.56%	91.97%
MY 2024	***PPC - Prenatal and Postpartum Care—Postpartum Care	S	S	N/A	S	S	S	68.63%	77.37%	82.48%	86.62%
MY 2025		S	S	82.14%	100.00%	86.67%	S	72.26%	79.73%	83.94%	88.32%
MY 2024	PRS-E - Prenatal Immunization Status - Combination Rate	26.67%	17.14%	24.12%	27.33%	22.51%	15.38%	8.42%	15.96%	24.92%	35.60%
MY 2025		19.10%	18.60%	20.20%	34.97%	26.38%	7.14%	8.23%	16.07%	25.25%	34.91%
Cancer Screening											
MY 2024	**BCS-E- Breast Cancer Screening**	43.08%	48.52%	54.90%	52.64%	38.46%	49.39%	42.86%	49.24%	56.66%	63.48%
MY 2025		39.31%	51.72%	45.02%	50.99%	50.00%	34.53%	45.09%	52.22%	58.93%	66.31%
MY 2024	**CCS - Cervical Cancer Screening**	S	S	53.85%	S	36.84%	S	43.31%	52.07%	60.10%	67.46%
MY 2025	**CCS-E - Cervical Cancer Screening - ECDS Measure**	44.09%	49.74%	51.11%	51.49%	40.93%	49.61%	40.21%	48.91%	55.86%	64.21%
MY 2024	COL-E - Colorectal cancer Screening	23.17%	31.51%	32.16%	27.63%	25.00%	27.13%	27.27%	34.30%	41.59%	49.35%
MY 2025		25.06%	34.67%	35.93%	30.69%	26.89%	30.62%	29.99%	38.05%	45.84%	53.31%
Other preventive services											
MY 2024	**CHL - Chlamydia Screening in Women—Total**	41.55%	32.89%	52.12%	45.38%	54.34%	34.72%	43.53%	52.40%	61.46%	69.07%
MY 2025		53.59%	46.05%	54.35%	51.43%	53.02%	40.00%	41.71%	51.22%	62.81%	70.67%
MY 2024	AIS-E-Adult Immunization Status—Influenza - Total	12.02%	10.14%	8.49%	10.20%	9.42%	8.18%	7.39%	12.55%	17.91%	26.40%
MY 2025		10.47%	10.13%	10.34%	10.08%	11.12%	9.21%	8.73%	13.56%	18.61%	26.60%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal - 66+	30.00%	46.15%	36.81%	32.43%	27.00%	9.09%	21.04%	38.73%	55.03%	68.07%
MY 2025		36.84%	47.83%	32.90%	24.56%	35.66%	31.25%	28.84%	43.72%	58.40%	71.90%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap - Total	28.42%	31.51%	33.87%	31.68%	29.20%	31.10%	21.26%	33.40%	47.30%	57.67%
MY 2025		32.18%	30.94%	33.68%	33.65%	36.08%	31.27%	26.23%	36.85%	50.60%	61.22%
MY 2024	AIS-E-Adult Immunization Status—Zoster - Total	4.50%	10.87%	10.49%	5.84%	9.87%	6.96%	2.23%	7.15%	13.49%	20.56%
MY 2025		4.18%	11.44%	11.02%	6.11%	11.74%	6.18%	3.62%	9.28%	16.63%	24.04%

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Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Treatment											
Respiratory											
MY 2024	**AMR - Asthma Medication Ratio- Total**	58.70%	63.16%	57.28%	59.62%	S	50.00%	54.56%	62.35%	70.56%	76.65%
MY 2025		71.43%	100.00%	65.33%	78.26%	69.06%	45.71%	52.00%	59.38%	68.13%	76.25%
MY 2024	**AAB - Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	40.38%	40.00%	38.22%	34.34%	46.95%	35.29%	49.48%	50.98%	67.03%	77.66%
MY 2025		40.63%	17.39%	43.50%	34.65%	50.71%	52.00%	48.00%	56.37%	65.97%	75.42%
Diabetes											
MY 2024	EED - Eye Exams for Patients with Diabetes	S	S	58.33%	71.43%	30.77%	N/A	40.39%	49.15%	57.09%	64.06%
MY 2025		27.94%	35.67%	58.08%	50.09%	41.61%	40.49%	42.09%	52.55%	60.83%	68.61%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	20.00%	N/A	62.50%	57.14%	30.77%	N/A	58.15%	65.32%	71.78%	77.37%
MY 2025		S	S	75.00%	S	84.21%	S	60.34%	69.34%	74.21%	78.83%
MY 2024	***GSD -Glycemic Status Assessment for Patients with Diabetes–HbA1c Control (<8%)	S	S	54.17%	42.86%	38.46%	N/A	44.25%	54.50%	59.64%	63.50%
MY 2025		S	S	66.67%	S	68.42%	S	49.30%	57.41%	63.04%	67.40%
MY 2024	SPD – Statin Therapy for Patients With Diabetes—Received Statin Therapy	53.90%	60.61%	57.12%	61.60%	46.15%	51.09%	51.96%	62.66%	67.01%	71.41%
MY 2025		54.65%	57.14%	53.18%	55.16%	52.24%	53.06%	56.26%	64.27%	69.01%	73.76%
MY 2024	SPD – Statin Therapy for Patients With Diabetes—Statin Adherence 80%	67.47%	73.33%	71.68%	67.71%	S	82.98%	53.23%	64.18%	70.91%	79.73%
MY 2025		62.77%	60.00%	68.79%	58.29%	69.53%	65.38%	57.38%	65.75%	72.29%	80.89%
MY 2024	KED – Kidney Health Evaluation for Patients with Diabetes	17.08%	24.22%	42.26%	38.86%	37.70%	31.72%	26.79%	33.00%	42.10%	49.72%
MY 2025		21.19%	33.33%	39.71%	38.13%	32.63%	28.57%	30.61%	38.74%	46.17%	54.15%
Heart Disease											
MY 2024	SPC – Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	60.00%	S	68.00%	60.87%	S	73.33%	66.64%	79.82%	83.00%	85.89%
MY 2025		76.47%	S	76.50%	80.77%	79.12%	76.47%	69.48%	79.83%	82.94%	86.40%
MY 2024	SPC – Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	78.95%	S	80.65%	76.67%	S	78.95%	59.95%	67.42%	74.07%	81.79%
MY 2025		76.92%	S	65.36%	47.62%	69.44%	69.23%	61.58%	68.28%	75.45%	82.65%
MY 2024	***CBP – Controlling High Blood Pressure	S	S	51.52%	S	S	S	54.61%	61.43%	67.40%	72.75%
MY 2025		S	S	76.19%	S	45.45%	S	56.93%	65.21%	70.35%	75.43%

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Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance						National Medicaid Benchmarks			
		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Treatment											
Behavioral Health – Care Coordination											
MY 2024	FUH – Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	NB	NB	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2025		S	S	20.00%	S	7.14%	S	26.07%	35.29%	45.08%	57.76%
MY 2024	FUM – Follow-UP After Emergency Department Visit for Mental Illness 7 days total	9.38%	5.88%	18.90%	23.61%	6.67%	6.25%	21.19%	33.01%	44.33%	59.95%
MY 2025		33.64%	18.75%	34.82%	31.66%	22.79%	29.41%	26.32%	36.34%	46.71%	62.06%
MY 2024	FUA – Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	14.52%	27.27%	34.01%	22.29%	22.94%	20.93%	12.73%	18.76%	27.62%	37.47%
MY 2025		16.67%	40.00%	39.82%	26.19%	20.48%	19.23%	15.49%	21.62%	30.53%	39.38%
MY 2024	FUI – Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	37.04%	31.25%	36.40%	39.29%	25.00%	S	15.91%	26.90%	37.64%	50.80%
MY 2025		38.46%	58.82%	39.38%	44.07%	15.00%	S	18.61%	28.46%	40.55%	53.73%
Behavioral Health – Medication Adherence											
MY 2024	POD – Pharmacotherapy for Opioid Use Disorder—Total	5.56%	S	16.40%	27.83%	4.00%	10.00%	12.05%	21.36%	29.01%	36.71%
MY 2025		10.34%	S	17.52%	13.48%	15.71%	11.11%	14.52%	20.92%	30.43%	36.44%
MY 2024	SAA – Adherence to Antipsychotic Medications for Individuals With Schizophrenia	73.91%	46.15%	66.19%	57.58%	60.53%	S	44.65%	58.60%	66.15%	74.83%
MY 2025		69.57%	S	63.61%	51.06%	65.67%	36.36%	49.57%	62.98%	69.67%	77.21%

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		Lassen	Modoc	Shasta	Siskiyou	Tehama	Trinity	10th	33.33rd	66.67th	90th
Treatment											
Behavioral Health – Access, Monitoring and Safety											
MY 2024	APM-E – Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	31.03%	S	29.56%	29.73%	29.52%	S	25.86%	30.92%	41.41%	52.57%
MY 2025		12.00%	S	29.54%	35.00%	30.08%	S	26.70%	33.26%	41.52%	55.96%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	S	S	48.53%	53.85%	N/A	S	37.19%	48.94%	56.83%	63.49%
MY 2025		38.46%	S	36.47%	26.67%	41.94%	S	39.95%	51.20%	58.69%	65.18%
MY 2024	SSD – Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	80.43%	90.48%	81.42%	82.76%	84.08%	88.89%	75.46%	79.51%	83.51%	87.27%
MY 2025		81.63%	93.75%	81.74%	87.80%	82.69%	83.87%	77.16%	81.03%	84.36%	87.47%
MY 2024	APP – Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	6.25%	S	54.55%	50.00%	20.69%	S	41.57%	54.55%	64.10%	74.14%
MY 2025		S	S	60.26%	55.56%	27.66%	S	46.48%	58.39%	66.54%	75.82%
MY 2024	IET – Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement – Total	9.57%	8.94%	12.24%	11.41%	4.96%	2.87%	6.08%	10.51%	16.78%	26.72%
MY 2025		9.52%	10.92%	14.89%	17.65%	10.36%	8.45%	7.33%	11.35%	17.80%	27.95%
Risk-Adjusted Utilization											
MY 2024	PCR – Plan All-Cause Readmission – Observed to – Expected Ratio (18-64 years)	0.9224	0.9456	0.8900	0.4606	2.7723	0.6961	1.1783	1.029	0.9124	0.8188
MY 2025		0.9683	0.7650	1.0554	1.0053	0.7756	0.6492	1.3971	1.2155	1.0696	0.9598

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA.
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Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

4.6 HPA HEDIS Rate Performance by County, Santa Rosa Region: Marin, Sonoma Counties

Note: CAHPS is not captured by County

🔵 4-5 points ○ 3 points 🟡 1-2 points Administrative measures: The entire eligible population is used in calculating performance (versus a systematic sample drawn from the eligible population for the hybrid measures). Denominators less than 20 at the county level are suppressed.

S = Small Population (Denominator<11), N/A = No Population (Denominator = 0)

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Prevention and Population							
Children and Adolescent Well-Care							
MY 2024	***CIS – Childhood Immunization Status (Combination 10)	35.14%	34.25%	18.25%	24.39%	31.32%	42.34%
MY 2025	***CIS-E – Childhood Immunization Status (Combination 10) ECDS Measure	45.92%	40.14%	14.67%	21.34%	26.93%	34.79%
MY 2024	***IMA – Immunizations for Adolescents (Combination 2)	57.14%	53.85%	25.41%	31.39%	38.69%	48.66%
MY 2025	***IMA-E – Immunizations for Adolescents (Combination 2) ECDS Measure	67.47%	55.78%	25.00%	30.70%	37.78%	47.16%
MY 2024	WCC – Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	90.91%	69.49%	66.91%	76.89%	86.20%	91.24%
MY 2025		88.89%	88.46%	65.21%	80.54%	87.69%	91.97%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits in the First 15 months)	78.83%	74.53%	49.46%	60.39%	66.35%	71.71%
MY 2025	***W30- Well-Child Visits in the First 30 Months of Life (Well-Child Visits for Age 15 Months – 30 Months)	91.59%	78.86%	64.14%	70.06%	75.87%	82.12%
MY 2025	***WCV – Child and Adolescent Well-Care Visits—Total	60.35%	58.16%	44.96%	51.48%	58.37%	67.63%
Women's Reproductive Health							
MY 2024	***PPC – Prenatal and Postpartum Care—Timeliness of Prenatal Care	100.00%	90.00%	73.48%	81.94%	86.89%	91.85%
MY 2025		76.47%	98.39%	76.16%	84.40%	88.56%	91.97%
MY 2024	***PPC – Prenatal and Postpartum Care—Postpartum Care	100.00%	96.67%	68.63%	77.37%	82.48%	86.62%
MY 2025		100.00%	96.77%	72.26%	79.73%	83.94%	88.32%
MY 2024	PRS-E – Prenatal Immunization Status – Combination Rate	46.87%	39.15%	8.42%	15.96%	24.92%	35.60%
MY 2025		57.09%	49.95%	8.23%	16.07%	25.25%	34.91%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Prevention and Population							
Cancer Screening							
MY 2024	**BCS-E- Breast Cancer Screening**	63.44%	59.17%	42.86%	49.24%	56.66%	63.48%
MY 2025		60.55%	57.12%	45.09%	52.22%	58.93%	66.31%
MY 2024	**CCS – Cervical Cancer Screening**	71.43%	68.00%	43.31%	52.07%	60.10%	67.46%
MY 2025	**CCS-E – Cervical Cancer Screening – ECDS Measure**	55.26%	57.41%	40.21%	48.91%	55.86%	64.21%
MY 2024	COL-E – Colorectal cancer Screening	34.44%	38.68%	27.27%	34.30%	41.59%	49.35%
MY 2025		38.90%	45.42%	29.99%	38.05%	45.84%	53.31%
Other preventive services							
MY 2024	**CHL – Chlamydia Screening in Women—Total**	77.63%	51.89%	43.53%	52.40%	61.46%	69.07%
MY 2025		77.57%	60.86%	41.71%	51.22%	62.81%	70.67%
MY 2024	AIS-E-Adult Immunization Status—Influenza – Total	21.41%	18.25%	7.39%	12.55%	17.91%	26.40%
MY 2025		24.03%	21.78%	8.73%	13.56%	18.61%	26.60%
MY 2024	AIS-E-Adult Immunization Status—Pneumococcal – 66+	49.58%	40.21%	21.04%	38.73%	55.03%	68.07%
MY 2025		56.43%	45.73%	28.84%	43.72%	58.40%	71.90%
MY 2024	AIS-E-Adult Immunization Status—Td/Tdap – Total	40.27%	31.66%	21.26%	33.40%	47.30%	57.67%
MY 2025		43.29%	38.18%	26.23%	36.85%	50.60%	61.22%
MY 2024	AIS-E-Adult Immunization Status—Zoster – Total	27.44%	13.98%	2.23%	7.15%	13.49%	20.56%
MY 2025		32.92%	16.69%	3.62%	9.28%	16.63%	24.04%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Treatment							
Respiratory							
MY 2024	**AMR – Asthma Medication Ratio- Total**	61.27%	70.42%	54.56%	62.35%	70.56%	76.65%
MY 2025		73.23%	79.28%	52.00%	59.38%	68.13%	76.25%
MY 2024	**AAB – Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	11.98%	22.67%	49.48%	50.98%	67.03%	77.66%
MY 2025		19.78%	23.61%	48.00%	56.37%	65.97%	75.42%
Diabetes							
MY 2024	EED - Eye Exams for Patients with Diabetes	63.16%	65.52%	40.39%	49.15%	57.09%	64.06%
MY 2025		66.05%	65.12%	42.09%	52.55%	60.83%	68.61%
MY 2024	BPD -Blood Pressure Control (<140/90) for Patients with Diabetes	89.47%	67.24%	58.15%	65.32%	71.78%	77.37%
MY 2025		82.61%	65.15%	60.34%	69.34%	74.21%	78.83%
MY 2024	***GSD -Glycemic Status Assessment for Patients with Diabetes-- HbA1c Control (<8%)	52.63%	44.83%	44.25%	54.50%	59.64%	63.50%
MY 2025		56.52%	63.64%	49.30%	57.41%	63.04%	67.40%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Received Statin Therapy	67.69%	68.61%	51.96%	62.66%	67.01%	71.41%
MY 2025		71.73%	66.67%	56.26%	64.27%	69.01%	73.76%
MY 2024	SPD - Statin Therapy for Patients With Diabetes—Statin Adherence 80%	69.25%	62.65%	53.23%	64.18%	70.91%	79.73%
MY 2025		66.45%	58.50%	57.38%	65.75%	72.29%	80.89%
MY 2024	KED - Kidney Health Evaluation for Patients with Diabetes	50.23%	47.24%	26.79%	33.00%	42.10%	49.72%
MY 2025		50.34%	50.23%	30.61%	38.74%	46.17%	54.15%
Heart Disease							
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	72.84%	70.46%	66.64%	79.82%	83.00%	85.89%
MY 2025		87.70%	84.82%	69.48%	79.83%	82.94%	86.40%
MY 2024	SPC - Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	89.01%	82.29%	59.95%	67.42%	74.07%	81.79%
MY 2025		75.70%	65.37%	61.58%	68.28%	75.45%	82.65%
MY 2024	***CBP - Controlling High Blood Pressure	62.07%	62.67%	54.61%	61.43%	67.40%	72.75%
MY 2025		63.64%	74.00%	56.93%	65.21%	70.35%	75.43%

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
* RDM and LDM are reporting only measures, full credit received for reporting.
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*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

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> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Partnership HealthPlan of California
Measurement Year 2025 - Reporting Year 2026

Year	Measure	County Performance		National Medicaid Benchmarks			
		Marin	Sonoma	10th	33.33rd	66.67th	90th
Treatment							
Behavioral Health - Care Coordination							
MY 2024	FUH - Follow-Up After Hospitalization for Mental Illness-7 days	NB	NB	23.74%	33.61%	46.35%	61.68%
MY 2025		13.04%	22.45%	26.07%	35.29%	45.08%	57.76%
MY 2024	FUM - Follow-UP After Emergency Department Visit for Mental Illness 7 days total	20.50%	16.83%	21.19%	33.01%	44.33%	59.95%
MY 2025		28.92%	27.56%	26.32%	36.34%	46.71%	62.06%
MY 2024	FUA - Follow-Up After Emergency Department Visit for Alcohol and Other Drug Abuse or Dependence—7 days—Total	21.33%	18.89%	12.73%	18.76%	27.62%	37.47%
MY 2025		25.00%	21.69%	15.49%	21.62%	30.53%	39.38%
MY 2024	FUI - Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	10.53%	22.86%	15.91%	26.90%	37.64%	50.80%
MY 2025		15.00%	19.18%	18.61%	28.46%	40.55%	53.73%
Behavioral Health - Medication Adherence							
MY 2024	POD - Pharmacotherapy for Opioid Use Disorder—Total	5.19%	12.62%	12.05%	21.36%	29.01%	36.71%
MY 2025		11.24%	10.57%	14.52%	20.92%	30.43%	36.44%
MY 2024	SAA - Adherence to Antipsychotic Medications for Individuals With Schizophrenia	77.88%	68.80%	44.65%	58.60%	66.15%	74.83%
MY 2025		71.30%	66.01%	49.57%	62.98%	69.67%	77.21%
Behavioral Health - Access, Monitoring and Safety							
MY 2024	APM-E - Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total (ECDS)	51.72%	35.29%	25.86%	30.92%	41.41%	52.57%
MY 2025		44.12%	42.61%	26.70%	33.26%	41.52%	55.96%
MY 2024	ADD-E -Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ECDS)	50.00%	31.82%	37.19%	48.94%	56.83%	63.49%
MY 2025		S	53.19%	39.95%	51.20%	58.69%	65.18%
MY 2024	SSD - Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	78.61%	85.90%	75.46%	79.51%	83.51%	87.27%
MY 2025		88.77%	85.51%	77.16%	81.03%	84.36%	87.47%
MY 2024	APP - Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	S	31.48%	41.57%	54.55%	64.10%	74.14%
MY 2025		S	59.57%	46.48%	58.39%	66.54%	75.82%
MY 2024	IET - Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment—Engagement - Total	5.39%	8.69%	6.08%	10.51%	16.78%	26.72%
MY 2025		10.74%	13.59%	7.33%	11.35%	17.80%	27.95%
Risk-Adjusted Utilization							
MY 2024	PCR - Plan All-Cause Readmission - Observed to - Expected Ratio (18-64 years)	0.9704	0.8308	1.1783	1.029	0.9124	0.8188
MY 2025		0.9309	0.9443	1.3971	1.2155	1.0696	0.9598

NB Not a Benefit - Auditor Approval required
NR Not Rated - Not included in the MY's measurement set
N/A No NCQA benchmark to apply in Measurement Year
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** Inverted measures, a lower rate results in better performance
*** DHCS Withhold Measures
BOLD Indicates MCAS measures held to the MPL

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Note: PCR calculations are based on the scoring algorithm for risk-adjusted utilization measures as defined by NCQA. NCQA calculates the Confidence Limits (CLs) for all health plans.

5.0 HEDIS HealthPlan Accreditation (HPA) – Health plan Rating Methodology

Health plans are rated in three categories: private/commercial plans in which people enroll through employers or on their own; plans that serve Medicare beneficiaries in the Medicare Advantage program (not supplemental plans); and plans that serve Medicaid beneficiaries.

NCQA ratings are based on three types of quality measures: 1) measures of clinical quality from NCQA's Healthcare Effectiveness Data and Information Set (HEDIS®) and Health Outcomes Survey (HOS); 2) measures of patient experience using the Consumer Assessment of Healthcare Providers and Systems (CAHPS®); and 3) results from NCQA's review of a health plan's health quality processes (NCQA Accreditation). NCQA rates health plans that choose to report measures publicly.

The overall rating is the weighted average of a plan's HEDIS, HOS, and CAHPS measure ratings, plus Accreditation bonus points (if the plan is Accredited by NCQA), rounded to the nearest half point displayed as stars.

The overall rating is based on performance on dozens of measures of care and is calculated on a 0–5 scale in half points (5 is highest). Performance includes three subcategories:

1. **Patient Experience:** Patient-reported experience of care, including experience with doctors, services and customer service (measures in the Patient Experience category).
2. **Rates for Clinical Measures:** The proportion of eligible members who received preventive services (prevention measures) and the proportion of eligible members who received recommended care for certain conditions (treatment measures).
3. **NCQA Health Plan Accreditation:** For a plan with an Accredited or Provisional status, 0.5 bonus points are added to the overall rating before rounding to the nearest half point and displayed as stars.

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6.0 HEDIS/CAHPS Measures Required for HP Accreditation—Medicaid

HEDIS MY 2025 & CAHPS MY 2025 (Reporting Year 2026)

Measure Name		Display Name	Weight
PATIENT EXPERIENCE			
Getting Care			
Getting Needed Care (Usually + Always)		Getting care easily	1.5
Getting Care Quickly (Usually + Always)		Getting care quickly	1.5
Satisfaction With Plan and Plan Services			
Rating of Health Plan (9 + 10)		Rating of health plan	1.5
Rating of All Health Care (9 + 10)		Rating of care	1.5
PREVENTION AND POPULATION			
Children and Adolescent Well-Care			
CIS-E	Childhood Immunization Status—Combination 10 ***(NEW REPORTING METHOD)***	Childhood immunizations	3
IMA-E	Immunizations for Adolescents—Combination 2 ***(NEW REPORTING METHOD)***	Adolescent immunizations	3
WCC	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total	BMI percentile assessment	1
W30	Well-Child Visits in the First 30 Months of Life—*Well-Child Visits in the First 15 Months* ***(NEW MEASURE)***	Well care for children in the first 15 months of life	1
	Well-Child Visits in the First 30 Months of Life—*Well-Child Visits for Age 15 Months–30 Months* ***(NEW MEASURE)***	Well care for children ages 15-30 months	1
WCV	Child and Adolescent Well-Care Visits—Total ***(NEW MEASURE)***	Well care for children and adolescents	1
Women's Reproductive Health			
PPC	Prenatal and Postpartum Care—Timeliness of Prenatal Care	Prenatal checkups	1
	Prenatal and Postpartum Care—Postpartum Care	Postpartum care	1
PRS-E	Prenatal Immunization Status—Combination Rate	Prenatal immunizations	1
Cancer Screening			
BCS-E	Breast Cancer Screening—Total	Breast cancer screening	1
COL-E	Colorectal Cancer Screening—Total	Colorectal cancer screening	1
CCS-E	Cervical Cancer Screening ***(NEW REPORTING METHOD)***	Cervical cancer screening	1

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Measure Name		Display Name	Weight
Description of Membership			
RDM	Race/Ethnicity Diversity of Membership	Race and ethnicity of members	1
LDM	Language Diversity of Membership	Language preferences of members	1
Other Preventive Services			
CHL	Chlamydia Screening—Total	Chlamydia screening	1
AIS-E	Adult Immunization Status—Influenza—Total	Influenza immunizations for adults	1
	Adult Immunization Status—Td/Tdap—Total	Td/Tdap immunizations for adults	1
	Adult Immunization Status—Zoster—Total	Zoster immunizations for adults	1
	Adult Immunization Status—Pneumococcal—65+	Pneumococcal immunizations for adults	1
TREATMENT			
Respiratory			
AMR	Asthma Medication Ratio—Total	Asthma control	1
AAB	Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total	Appropriate antibiotic use for acute bronchitis/bronchiolitis	1
Diabetes			
BPD	Blood Pressure Control for Patients With Diabetes	Patients with diabetes—blood pressure control (140/90)	3
EED	Eye Exam for Patients With Diabetes	Patients with diabetes—eye exams	1
GSD	Glycemic Status Assessment for Patients With Diabetes—Glycemic Status (<8%)	Patients with diabetes—glycemic status	3
SPD	Statin Therapy for Patients With Diabetes—Received Statin Therapy	Patients with diabetes—received statin therapy	1
	Statin Therapy for Patients With Diabetes—Statin Adherence 80%	Patients with diabetes—statin adherence 80%	1
KED	Kidney Health Evaluation for Patients With Diabetes—Total	Patients with diabetes—kidney health evaluation	1
Heart Disease			
SPC	Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total	Patients with cardiovascular disease—received statin therapy	1
	Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total	Patients with cardiovascular disease—statin adherence 80%	1
CBP	Controlling High Blood Pressure	Controlling high blood pressure	3

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Measure Name		Display Name	Weight
Behavioral Health—Care Coordination			
FUH	Follow-Up After Hospitalization for Mental Illness—7 days—Total	Follow-up after hospitalization for mental illness	1
FUM	Follow-Up After Emergency Department Visit for Mental Illness—7 days—Total	Follow-up after ED for mental illness	1
FUA	Follow-Up After Emergency Department Visit for Substance Use—7 days—Total	Follow-up after ED for substance use disorder	1
FUI	Follow-Up After High-Intensity Care for Substance Use Disorder—7 days—Total	Follow-up after high-intensity care for substance use disorder	1
Behavioral Health—Medication Adherence			
SAA	Adherence to Antipsychotic Medications for Individuals With Schizophrenia	Adherence to antipsychotic medications for individuals with schizophrenia	1
POD	Pharmacotherapy for Opioid Use Disorder—Total	Patients with opioid use disorder—medication adherence for 6 months	1
Behavioral Health—Access, Monitoring and Safety			
APM-E	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total	Cholesterol and blood sugar testing for youth on antipsychotic medications	1
ADD-E	Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase	Continued follow-up after ADHD diagnosis	1
SSD	Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	Diabetes screening for individuals with schizophrenia or bipolar disorder	1
APP	Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total	First-line psychosocial care for youth on antipsychotic medications	1
IET	Initiation and Engagement of Substance Use Disorder Treatment—Engagement of SUD Treatment—Total	Substance use disorder treatment engagement	1
Risk-Adjusted Utilization			
PCR	Plan All-Cause Readmissions—Observed-to-Expected Ratio—18-64	Plan all-cause readmissions	1

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7.0 HEDIS/CAHPS MY2025 / RY2026 HPA Overall Star Rating Results: with Child CAHPS Survey Results

Partnership's MY2025 HPA Star Rating is 3.0 Stars. This rating is calculated based on the MY2025 Child CAHPS® (regulated) survey results and plan-wide HEDIS rates per the NCQA Health Plan scoring methodology. Final scores are published by NCQA in Fall of 2026.



Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

Overall Rating Source	
Measure points	156
Overall Rating Not Rounded	2.689655172
Final Overall Rating +.5 Bonus	3.190
Final Score Rounded	3.0

7.1 Factors in MY2025 HPA Star Rating

The following factors were important drivers of Partnership's performance on the MY2025 HPA measures:

Changes to MY2025 HPA Measure Set: Several measures were added to the HPA measure set in MY2025 that align with Partnership's Managed Care Accountability Set (MCAS): Well Child Visits in the First 30 Months of Life (W30) and Child and Adolescent Well-Care Visits (WCV). These measures have been prioritized and incentivized throughout Partnership's provider network for many years. In addition, several medication management measures were retired from the Treatment section that historically performed below the 67th percentile.

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Benchmark Performance Declines and Stagnation: While a number of measures showed significant year-over-year improvement, the improvement was not enough to keep up with increases in the Measurement Year's NCQA measure benchmarks, which are based on national Medicaid performance. Also, maintenance of a stable plan-wide rate year-over-year is not enough to drive benchmark improvement; many measures with stable rates saw benchmark declines in MY2025. Finally, a number of measures showed plan-wide declines in benchmark performance, which is driven by respective rate declines as well as stable rates for measures with increasing benchmark thresholds.

44 of 48 HPA CAHPS and clinical measures declined or stayed flat in year-over-year benchmark performance. The minimal movement to higher benchmarks drove Partnership's Health Plan Rating remaining at 3.0 Stars in MY2025, despite the changes in the HPA measure set listed above that could have worked to Partnership's advantage in the MY2025 Health Plan Rating.

The table below illustrates the MY2024-2025 benchmark movement in the MY2025 HPA CAHPS and clinical measure sets.

Partnership's Year-over-year plan-wide rate change, MY2024-2025	**Partnership's Year-over-Year Benchmark Movement, MY2024-2025**		
	YOY Decline in Benchmark Placement	No Change in Benchmark Placement	YOY Improvement in Benchmark Placement
Rate Declined	10 measures	1 measure	
Rate Stable (<1% YOY)	6 measures	8 measures	
Rate Improved	3 measures	16 measures	4 measures
Total	**19 measures**	**25 measures**	**4 measures**

Several of the clinical measures with a benchmark placement decline, or no change in the benchmark placement despite rate improvement, are highly prioritized by NCQA's Health Plan Rating Algorithm (i.e., are triple weighted) as well as other Partnership accountability programs. HPA measures that have been prioritized for improvement by Partnership in MY2026 as a strategy to improve benchmark movement and ultimately the Plan's Health Plan Rating include:

NCQA HPA Measure	**NCQA Weight**	**YOY Rate Change MY2024-25**	**YOY Benchmark Placement Change MY2024-2025**
Child Survey - General Population: Getting Needed Care (Usually + Always)	1.5	Improved	Improved
Child Survey - General Population: Getting Care Quickly (Usually + Always)	1.5	Improved	No change
Child Survey - General Population: Rating of Health Plan (9+10)	1.5	Decline	No change

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Child Survey - General Population: Rating of All Health Care (9+10)	1.5	Improved	No change
Controlling High Blood Pressure	3	Decline	Decline
Blood Pressure Control for Patients With Diabetes	3	Decline	Decline
Glycemic Status Assessment for Patients With Diabetes - Glycemic Status <8.0%	3	Improved	No change
Immunizations for Adolescents (IMA-2)	3	Decline	Decline
Child and Adolescent Well-Care Visits (Total)	1	Decline	Decline
Well-Child Visits in the First 30 Months of Life (First 15 Months)	1	Decline	Decline
Well-Child Visits in the First 30 Months of Life (15 Months-30 Months)	1	Improved	No change
Prenatal and Postpartum Care - Timeliness of Prenatal Care	1	Improved	No change

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7.2 MY2025 HEDIS HealthPlan Accreditation (HPA) – HealthPlan Rating Score Child CAHPS - Change from Prior Year

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

MY2025 Star Rating w/Child CAHPS survey results (submitted for HPA):

Preliminary Overall Rating +.5 Bonus	3.189655172

HEDIS HealthPlan Accreditation Star Rating Scoring MY2025 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2025	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points overall
Overall Rating (CAHPS + Accreditation Measures)	58	125	156	3.189655172	3.0
Patient Experience	6	10	15	2.500	2.5
Prevention and Population	23	59	71	3.087	3.5
Treatment	29	56	70	2.414	3.0

MY2024 Star Rating w/Child CAHPS survey results:

Final Overall Rating +.5 Bonus	3.24166667

HEDIS HealthPlan Accreditation Star Rating Scoring MY2024 With Child CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2024	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points overall
Overall Rating (CAHPS + Accreditation Measures)	60	135	164.5	3.241666667	3.0
Patient Experience	7.5	12	18	2.400	2.5
Prevention and Population	19.5	52	61.5	3.154	3.0
Treatment	33	71	85	2.576	2.5

Percentile	Score Rating
> 90th Percentile	5
67th – 90th Percentile	4
33rd – 66th Percentile	3
10th – 32rd Percentile	2
< 10th Percentile	1

Rounding Rules	
0.000–0.249 → 0.0	2.750–3.249 → 3.0
0.250–0.749 → 0.5	3.250–3.749 →3.5
0.750–1.249 → 1.0	3.750–4.249 → 4.0
1.250–1.749 → 1.5	4.250–4.749 → 4.5
1.750–2.249 → 2.0	≥4.750 → 5.0
2.250–2.749 → 2.5	

7.3 MY2025 HEDIS HealthPlan Accreditation (HPA) – HealthPlan Rating Score Adults CAHPS - Change from Prior Year

MY2025 Projected Star Rating w/Adult CAHPS survey results:

Preliminary Overall Rating +.5 Bonus	3.189655172

HEDIS HealthPlan Accreditation Star Rating Scoring MY2025 With Adult CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2025	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points overall
Overall Rating (CAHPS + Accreditation Measures)	58	125	156	3.189655172	3.0
Patient Experience	6	10	15	2.500	2.5
Prevention and Population	23	59	71	3.087	3.5
Treatment	29	56	70	2.414	3.0

MY2024 Projected Star Rating w/Adult CAHPS survey results:

Final Overall Rating +.5 Bonus	3.19166667

HEDIS HealthPlan Accreditation Star Rating Scoring MY2024 With Adult CAHPS Survey Results	TOTAL Weight	TOTAL ACCRD Score MY2024	TOTAL Measure Score (Weight*Score)	Calculated Score (Not-Rounded)	Star Rating (Rounded) + 0.5 Bonus points overall
Overall Rating (CAHPS + Accreditation Measures)	60	133	161.5	3.191666667	3.0
Patient Experience	7.5	10	15	2.000	2.5
Prevention and Population	19.5	52	61.5	3.154	3.0
Treatment	33	71	85	2.576	2.5

8.0 MY2025 HEDIS HealthPlan Accreditation (HPA) – Measurement Set Descriptions

HEDIS Measure	Measure Indicator	Measure Definition
PREVENTION AND POPULATION		
Children and Adolescent Well-Care		
Childhood Immunization Status (CIS-E)	• Combination 10	• The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates. ○ Combination 10. Children who have had all ten indicators (DTaP, IPV, MMR, HiB, HepB, VZV, PCV, HepA, RV and Influenza).
Immunizations for Adolescents (IMA-E)	• Combination 2	• The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. ○ Combination 2. Adolescents who have had all three indicators (meningococcal, Tdap and HPV).
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents (WCC)	• BMI Percentile Documentation	• The percentage of members 3–17 years of age who had an outpatient visit with a PCP or OB/GYN and who had evidence of the following during the measurement year. ○ *BMI Percentile Documentation.* Because BMI norms for youth vary with age and gender, this measure evaluates whether BMI percentile is assessed rather than an absolute BMI value.

HEDIS Measure	Measure Indicator	Measure Definition
PREVENTION AND POPULATION		
Well-Child Visits in the First 30 Months of Life (W30)	• Well-Child Visits in the First 15 Months • Well-Child Visits for Age 15 Months–30 Months	• The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: ○ *Well-Child Visits in the First 15 Months.* Children who turned 15 months old during the measurement year: Six or more well-child visits. ○ *Well-Child Visits for Age 15 Months–30 Months.* Children who turned 30 months old during the measurement year: Two or more well-child visits.
Child and Adolescent Well-Care Visits (WCV)	• Total	• The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year.
Women's Reproductive Health		
Prenatal and Postpartum Care (PPC)	• Timeliness of Prenatal Care • Postpartum Care	• The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these members, the measure assesses the following facets of prenatal and postpartum care: ○ *Timeliness of Prenatal Care.* The percentage of deliveries that received a prenatal care visit in the first trimester on or before the enrollment start date or within 42 days of enrollment in the organization. ○ *Postpartum Care.* The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.

HEDIS Measure	Measure Indicator	Measure Definition
PREVENTION AND POPULATION		
Prenatal Immunization Status (PRS-E)	• Combination Rate	• The percentage of deliveries in the measurement period in which members had received influenza and tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccinations.
Cancer Screening		
Breast Cancer Screening (BCS-E)	• Total	• The percentage of members 40–74 years of age who were recommended for routine breast cancer screening and had a mammogram to screen for breast cancer.
Cervical Cancer Screening (CCS-E)	• Total	• The percentage of members 21–64 years of age who were recommended for routine cervical cancer screening who were screened for cervical cancer using any of the following criteria: ○ Members 21–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology performed within the last 3 years. ○ Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years. ○ Members 30–64 years of age who were recommended for routine cervical cancer screening and had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years.
Colorectal Cancer Screening (COL-E)	• Total	• The percentage of members 45–75 years of age who had appropriate screening for colorectal cancer.

HEDIS Measure	Measure Indicator	Measure Definition
PREVENTION AND POPULATION		
Description of Membership		
Race/Ethnicity Diversity of Membership- (RDM)	• Race/Ethnicity Direct	• An unduplicated count and percentage of members enrolled any time during the measurement year, by race and ethnicity.
Language Diversity of Membership (LDM)	• Spoken Language Preferred • Preferred Language for Written Materials	• An unduplicated count and percentage of members enrolled at any time during the measurement year by spoken language preferred for health care and preferred language for written materials.
Other Preventative Services		
Chlamydia Screening (CHL)	• Total	• The percentage of members 16–24 years of age who were recommended for routine chlamydia screening, were identified as sexually active and had at least one test for chlamydia during the measurement year.
Adult Immunization Status (AIS-E)	• Influenza immunizations for adults • Td/Tdap immunizations for adults • Zoster immunizations for adults • Pneumococcal immunizations for adults	• The percentage of members 19 years of age and older who are up to date on recommended routine vaccines for influenza, tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap), zoster, pneumococcal and hepatitis B.

HEDIS Measure	Measure Indicator	Measure Definition
TREATMENT		
Respiratory		
Asthma Medication Ratio (AMR)	• 5–64 years • Total	• The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis (AAB)	• Total	• The percentage of episodes for members ages 3 months and older with a diagnosis of acute bronchitis/ bronchiolitis that did not result in an antibiotic dispensing event. ***Note**: This measure is reported as an inverted rate [1–(numerator/eligible population)]. A higher rate indicates appropriate acute bronchitis/bronchiolitis treatment (i.e., the proportion for episodes that did not result in an antibiotic dispensing event).*
Diabetes		
Blood Pressure Control for Patients With Diabetes (BPD)	• Total	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose blood pressure (BP) was adequately controlled (<140/90 mm Hg) during the measurement year.
Eye Exam for Patients With Diabetes (EED)	• Eye Exam for Patients With Diabetes	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) who had a retinal eye exam.

HEDIS Measure	Measure Indicator	Measure Definition
TREATMENT		
Glycemic Status Assessment for Patients With Diabetes (GSD)	• Glycemic Status <8.0%	• The percentage of members 18–75 years of age with diabetes (types 1 and 2) whose most recent glycemic status (hemoglobin A1c [HbA1c] or glucose management indicator [GMI]) was at the following levels during the measurement year: ○ *Glycemic Status <8.0%.* ○ *Glycemic Status >9.0%.* *Note: Organizations must use the same data collection method (Administrative or Hybrid) to report these indicators.*
Statin Therapy for Patients With Diabetes (SPD)	• Received Statin Therapy • Statin Adherence 80%	• The percentage of members 40–75 years of age during the measurement year with diabetes who do not have clinical atherosclerotic cardiovascular disease (ASCVD) who met the following criteria. Two rates are reported: ○ *Received Statin Therapy.* Members who were dispensed at least one statin medication of any intensity during the measurement year. ○ *Statin Adherence 80%.* Members who remained on a statin medication of any intensity for at least 80% of the treatment period.
Kidney Health Evaluation for Patients with Diabetes (KED)	• Kidney Health Evaluation for Patients With Diabetes—Total	• The percentage of members 18–85 years of age with diabetes (type 1 and type 2) who received a kidney health evaluation, defined by an estimated glomerular filtration rate (eGFR) and a urine albumin-creatinine ratio (uACR), during the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
TREATMENT		
Heart Disease		
Statin Therapy for Patients With Cardiovascular Disease (SPC)	• Total • Received Statin Therapy • Statin Adherence 80%	• The percentage of males 21–75 years of age and females 40–75 years of age during the measurement year, who were identified as having clinical atherosclerotic cardiovascular disease (ASCVD) and met the following criteria. The following rates are reported: ○ *Received Statin Therapy.* Members who were dispensed at least one high-intensity or moderate-intensity statin medication during the measurement year. ○ *Statin Adherence 80%.* Members who remained on a high-intensity or moderate-intensity statin medication for at least 80% of the treatment period.
Controlling High Blood Pressure (CBP)	• Total	• The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Behavioral Health – Care Coordination		
Follow-Up After Emergency Department Visit for Mental Illness (FUM)	• 7 days • Total	• The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, or any diagnosis of intentional self-harm, and had a mental health follow-up service. ○ The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).
Follow-Up After Emergency Department Visit for Substance Use (FUA)	• 7 days • Total	• The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. ○ The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).

HEDIS Measure	Measure Indicator	Measure Definition
TREATMENT		
Follow-Up After High-Intensity Care for Substance Use Disorder (FUI)	• 7 days • Total	• The percentage of acute inpatient hospitalizations, residential treatment or withdrawal management visits for a diagnosis of substance use disorder among members 13 years of age and older that result in a follow-up visit or service for substance use disorder. o The percentage of visits or discharges for which the member received follow-up for substance use disorder within the 7 days after the visit or discharge.
Behavioral Health – Medication Adherence		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia (SAA)	• Non-Medicare 80% Coverage	• The percentage of members 18 years of age and older during the measurement year with schizophrenia or schizoaffective disorder who were dispensed and remained on an antipsychotic medication for at least 80% of their treatment period.
Pharmacotherapy for Opioid Use Disorder (POD)	• Total	• The percentage of opioid use disorder (OUD) pharmacotherapy events that lasted at least 180 days among members 16 years of age and older with a diagnosis of OUD and a new OUD pharmacotherapy event. o *Intake period.* A 12-month period that begins on July 1 of the year prior to the measurement year and ends on June 30 of the measurement year.
Behavioral Health – Access, Monitoring and Safety		
Metabolic Monitoring for Children and Adolescents on Antipsychotics (APM-E)	• Total	• The percentage of children and adolescents 1–17 years of age who had two or more antipsychotic prescriptions and had metabolic testing. Three rates are reported: o The percentage of children and adolescents on antipsychotics who received blood glucose testing. o The percentage of children and adolescents on antipsychotics who received cholesterol testing. o The percentage of children and adolescents on antipsychotics who received blood glucose and cholesterol testing.

HEDIS Measure	Measure Indicator	Measure Definition
TREATMENT		
Follow-Up Care for Children Prescribed ADHD Medication—Continuation & Maintenance Phase (ADD-E)	• Initiation Phase • Continuation and Maintenance (C&M) Phase	• The percentage of children newly prescribed attention-deficit/hyperactivity disorder (ADHD) medication who had at least three follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of when the first ADHD medication was dispensed. Two rates are reported. ○ *Initiation Phase.* The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase. ○ *Continuation and Maintenance (C&M) Phase.* The percentage of members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD)	• Diabetes Screening	• The percentage of members 18–64 years of age with schizophrenia, schizoaffective disorder or bipolar disorder, who were dispensed an antipsychotic medication and had a diabetes screening test during the measurement year.
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total (APP)	• Total	• The percentage of children and adolescents 1–17 years of age who had a new prescription for an antipsychotic medication and had documentation of psychosocial care as first-line treatment.

HEDIS Measure	Measure Indicator	Measure Definition
TREATMENT		
Initiation and Engagement of Substance Use Disorder Treatment— (IET)	• Engagement of SUD Treatment • Total	• The percentage of new substance use disorder (SUD) episodes that result in treatment initiation and engagement. Two rates are reported: ○ Initiation of SUD Treatment. The percentage of new SUD episodes that result in treatment initiation through an inpatient SUD admission, outpatient visit, intensive outpatient encounter, partial hospitalization, telehealth visit or medication treatment within 14 days. ○ Engagement of SUD Treatment. The percentage of new SUD episodes that have evidence of treatment engagement within 34 days of initiation.
Risk-Adjusted Utilization		
Plan All-Cause Readmissions— (PCR)	• Observed-to-Expected Ratio • 18-64 years • Total	• For members 18 years of age and older, the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. ***Note**: Members with dual Medicaid/Medicare enrollment "dual eligible" and with Medicare-Medicaid (MMP) enrollment may only be reported in the Medicare product line.*

Health Equity and Community Reinvestment Strategy and PROGRAM DESCRIPTION

MCED6001

September 2026

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

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PROGRAM PURPOSE AND GOALS

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

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

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

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

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

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

The Partnership QIHETP serves as an organized framework to:

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

PROGRAM OBJECTIVES

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

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

The QIHETP program accomplishes these goals by:

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

AUTHORITY AND RESPONSIBILITY

Board of Commissioners

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

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

Key Roles

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

PROGRAM STAFF

Chief Medical Officer

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

Deputy Chief Medical Officer

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

Chief Health Services Officer

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

revision of provider contracts to ensure QI reporting requirements and value-based program contingencies are met. The CHSO also has purview over the Care Coordination, Utilization Management, Enhanced Health Services, Behavioral Health and Health Equity departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The CHSO's level of involvement fulfills the need for executive support and accountability for improvements with data quality, and coordination of activities between QI and these departments. Collaborates with the Chief Medical Officer and members of PAC, Q/UAC, and IQI in matters involving quality of care, clinical, and medical procedures.

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

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

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

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

Behavioral Health Clinical Director

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

Administrative Assistant

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

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

Project Coordinator II

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

Uploads and maintains policy documents in PowerDMS

COMMITTEES

Board of Commissioners

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

Quality/Utilization Advisory Committee (Q/UAC)

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

Director for Quality, Associate and Regional Medical Directors and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, Care Coordination, Population Health, Health Equity, Pharmacy, and Grievance departments attend the Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The

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

- Annually reviewing, making recommendations to, and approving this Program Description
- Analyzing summary data and making recommendations for action
- Reviewing action plans for quality improvements of QIHETP activities and providing ongoing monitoring and evaluation

Quality Improvement and Health Equity Committee (QIHEC)

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

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

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

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

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

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

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

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

QUALITY AND PERFORMANCE IMPROVEMENT COLLABORATION

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

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

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

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

NCQA Accreditation Program Management

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

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

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

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

DATA SOURCES

DHCS Bold Goals

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

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

Partnership Health Plan Quality Improvement Priorities

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

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

Timely Prenatal Care (PPC-Pre)

Partnership uses several methods to identify and prioritize the health disparities of focus

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

MCAS Sample Evaluation

Step 1: Sample Selection to Evaluate Disparities

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

Step 2: Statistical Analysis to Identify Key Disparities

After receiving the data from Inovalon, members from Partnership's Health Analytics team conducted various statistical analyses. The Chi-Square and Fisher's Exact statistical tests were utilized, based upon

sample size, to determine if there were significant differences for the various categorical measure outcomes.

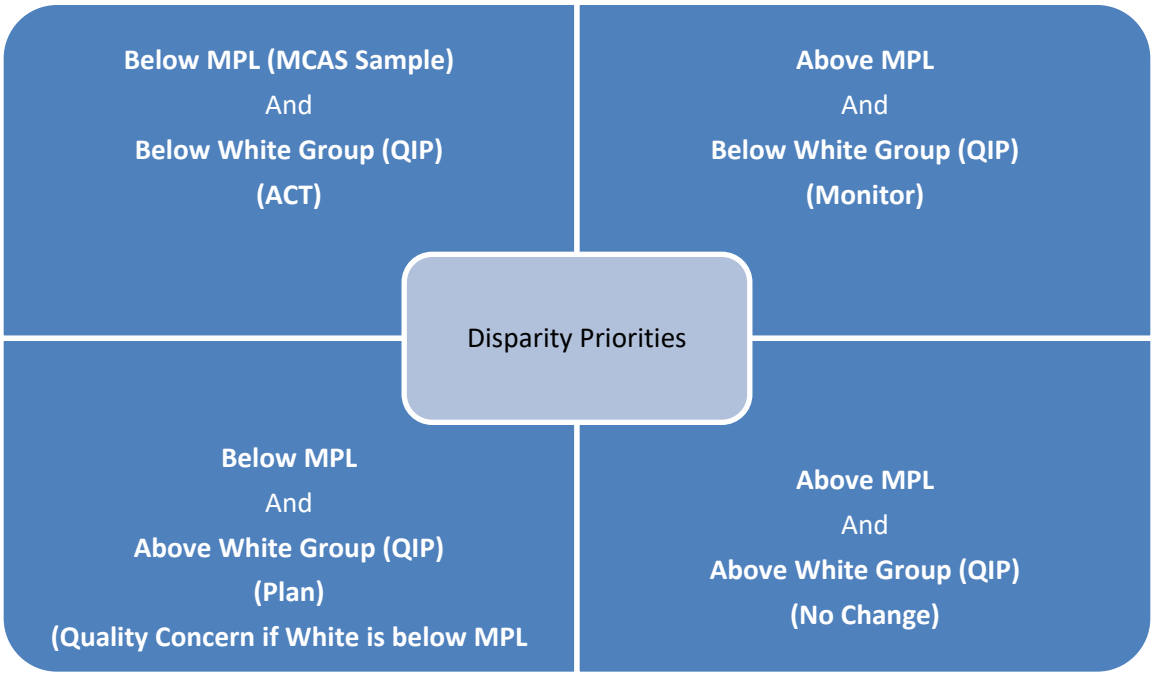
When analyzing disparities based upon race/ethnicity, Partnership conducted various statistical analyses using the White group as the key comparator group. When analyzing disparities based upon language, Partnership conducted various statistical analyses using the English language group as the key comparator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

Step 3: Analysis of Measures

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

Step 4: Prioritization of Disparities

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



Step 5: Distribution of Disparity Data for Community Feedback

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

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

Step 6: Distribution of Disparity Data into Department Activities

Quality Improvement

Department	Description of Activities	Annual QIHETP Key Administrative Measures
Quality Improvement	For internal QI/PI related activities, the Health Equity department, in collaboration with the QI/PI team, will	• MCAS

	ensure that HEDIS/CAHPS–associated disparities (e.g. racial, ethnic, linguistic, disability, SOGI, etc.) are specifically being addressed in QI/PI programs (e.g., value-based payment programs, provider improvement plans, Corrective Action Plans (CAPS) etc.). Specifically, the QIHETP and QI/PI teams will review the internal value based payment programs (e.g., primary care provider quality improvement program (PCP QIP), hospital quality improvement program, (HQIP) etc.) and performance improvement projects to assess whether adjustments need to be made to ensure the projects can address HEDIS/ CAHPS –associated disparities. For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the Health Equity department supports ongoing QI/PI efforts in the identification of potential quality or equity of care issues, improvement of HEDIS quality measures in context with social determinants of health. The QIHETP and QI/PI teams will collaborate to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. Finally, the QIHETP and QI/PI teams will share data with NCQA team members to validate that disparity reduction goals/targets are compliant with NCQA HEA standards. The QIHEC will review, among other reports, the updated QI/PI Program Evaluation to ensure that one or more HEDIS/CAHPS-associated racial disparity, HEDIS/CAHPS-associated linguistic disparity, or a mandated disparity reduction target for specific populations and/or measures as identified by DHCS has been addressed in response to findings from Partnership's annual QI Work Plan.	measures of health disparities • Amount of QIP Health Equity funds awarded to Parent Organizations • Number of Quality Improvement Projects executed to address specific • Impact Analysis of each quality improvement project to address health disparities
Population Health Management	For internal population-health specific activities, the Health equity department and Population Health teams will collaborate to generate a finalized report to help refine the various population health reports and analyses. (The PHM Strategy provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population served in the program. Specifically, teams will review tertiary and	• Assessment of Health Disparities from PNA • Analysis of each PHM Campaign to address health

	primary medical literature and health indices, review findings from other managed care organizations, collaborate with community key opinion leaders or subject matter experts, and survey members of the CAC and FAC to find credible interventions that can be executed by a managed care organization based upon the synthesized findings of the preliminary report. The Population Health and Health Equity teams will review and assess corresponding social drivers of health metrics. t. Social determinants or drivers of health have been classified as conditions in various environments that affect health and overall quality-of-life outcomes The QIHEC will review, among other reports, relevant Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) information, Population Health and Cultural and Linguistics (C&L)-associated work plans to ensure that one or more HEDIS-associated racial/ethnic disparity(ies), and one or more HEDIS-associated disparity(ies) related to one additional category of stratification (e.g., disability, geographical representation, etc.) is addressed based on the findings from the assessed reports. The QIHEC will also review reports regarding the utilization of language services, individual experience with language services, staff experience with language services, and member experience with language services during health care encounters to ensure that one or more interventions is identified and incorporated into work plan(s) to address one or more culturally and linguistically appropriate services (CLAS) disparity or HEDIS-associated linguistic disparity. The QIHEC will review these elements to ensure they correlate appropriately with Partnership's annual QI Work Plan.	disparities • Analysis of community events or activities (e.g. photoshoot) to address health disparities
Enhanced Care Management	The Health equity department and Enhanced Care Management teams will collaborate to increase the number of Community Health Workers (CHWs) and Doulas in non-traditional community settings (e.g. Barbershops, Beauty Salons, etc). Also, HE department and EHS team will review the annual CHW/Doula training to validate that it meets all the criteria to be considered appropriate per any related APL set forth by DHCS.	• Number of Community Health Workers per County • Number of Doulas per county • Annual Analysis of claims data
Grievances	In collaboration with the Grievances and Appeals	• Analysis of

and Appeals	team, the HE department will review and provide input on discrimination grievances. For grievance and appeals-related activities, the Health Equity department, in collaboration with leadership from the Population Health and Grievance and Appeals departments, will review for any patterns of disparities in reported grievances. The QIHEC will review, among other reports, the updated PNA, Cultural and Linguistics (C&L) Program Description and Work Plan, and/or Grievance and Appeals-associated Work Plans to ensure that one or more CAHPS-associated racial disparity(ies) or CAHPS-associated linguistic disparity(ies) is addressed with a Work Plan action item The HE department will review all discrimination grievances and provide a written opinion regarding the likelihood of discrimination. For clinicians who are deemed "likely," they are referred to complete the CARES training. In accordance with APL 24-016, the Partnership CARES (formerly known as DEI) training provides staff with specific, structured instruction to address health inequities across DHCS programs. Training content is designed to increase awareness, sensitivity, and practical application of diversity, equity, inclusion and cultural responsiveness principles. Training is tailored to member demographics to ensure relevance and effectiveness.	discrimination grievances • Annual Analysis of completion of CARES training • Survey Analysis of CARES training
Human Resources	For internal Human Resources (HR) related activities, the Health Equity department, in collaboration with the HR department, will review submitted data for annual CARES-related training for employees, network providers, etc. to ensure review of completion. Specifically, the QIHETP and HR team will review the annual training on culturally and linguistically appropriate practices to ensure they are teaching principles to reduce bias and promote inclusion. Also, HE department and HR team will review the annual training to validate that it meets all the criteria to be considered appropriate per any related APL set forth by DHCS. The HE department and HR team will also review internal recruiting and hiring processes to ensure they support diversity in staff leadership, committees, and governance bodies. Also, the Health Equity department will conduct an annual survey of the DEI satisfaction from staff, leadership,	

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

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

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

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

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

Funding Requirements

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

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

Community Reinvestment Spending Categories (Inclusion/Exclusion Criteria)

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

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

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

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

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

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

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

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

Community Reinvestment Management

Step 1: Community Reinvestment Team Engagement with Community

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

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

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

Step 3: Community Reinvestment Team Review

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

Step 4: DHCS Submission

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

Step 5: CAC and Board Review

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

Initial Community Reinvestment Plan

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

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

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

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

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

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

CULTURALLY & LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

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

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

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

Population Health

QUALITY IMPROVEMENT AND HEALTH EQUITY ANNUAL WORK PLAN

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

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

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

ANNUAL PROGRAM EVALUATION

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

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

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

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

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

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

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

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

NON-DISCRIMINATION STATEMENT

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

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

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

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

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

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

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

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

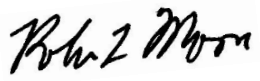
No Cost Linguistic Services

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
- Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for Partnership Members according to regulatory timeframes, and into other languages or alternative formats upon request. Alternative material formats include audio, large print and electronically for members with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. Auxiliary aids are also available upon request. Please refer to MPND9002 Cultural and Linguistic Program Description for more information. The organization may continue to provide translated materials in other languages represented by the population at the discretion of Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735-2929 or 711]

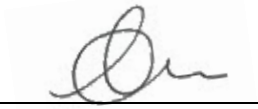
Partnership regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. (See policy MPND9002 *Cultural and Linguistic Program Description*)

REFERENCES

1. Department of Health Care Services (DHCS) standards

	**08/19/26**

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

	**09/09/26**

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

	10/28/26

Dean Germano *Date Approved*
Board of Commissioners Chairperson