PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality & Performance Improvement (QI)
DATE: Sept. 11, 2026
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

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

Meeting Time/Date: 7:30 – 9:00 a.m., Wednesday, Sept. 16, 2026
Meeting Locations:

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

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

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

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

PHC Staff (Ex-Officio) Members:
Barresi, Katherine, RN, BSN, PHN, NE-BC, Chief Health Equity Officer
Bides, Robert, RN, BSN, Mgr, Member Safety-Quality Investigations, QI
Bontrager, Mark, Sr. Director of Behavioral Health, Behavioral Health
Brown, Isaac, MHA/MBA, Sr. Dir. of Quality & Perf. Improvement
Cox, Bradley, DO, 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
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
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, MPH, Policy Analyst, UM Regulations
Conery, Irem, Director of Member Experience, Administration
Cunningham, Aryana, Policy Analyst, Care Coordination
Davis, Wendi, Chief Operations Officer
Durst, Jennifer, Senior Manager of Quality Incentive Programs, QI
Gual, Kristine, 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
Krznarich, Jackie, RN, Manager, Member Safety Inspections, QI
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
Sengdara, Tony, Program Manager II, QI, (EXT QIP)
Smith, Christine, Community Health Needs Liaison, Pop Health
Stark, Rebecca, Regional Director, Chico
Trosky, Renee, Manager of Provider Relations Compliance
Vaisenberg, Liat, Director of Health Analytics, Finance

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

Date: Sept. 16, 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:
Open Door Community Health Center, 770 10th St., Arcata
Chapa-de Indian Health, 11670 Atwood Road, Auburn

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

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

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

	Item	Lead	Time	Page #
I.	**Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes**			
1	*Approval of* Aug. 19, 2026 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	5 – 14
2	*Acknowledgment and acceptance of draft minutes of the* • Aug. 11 Internal Quality Improvement (IQI) Committee *as amended at IQI Sept. 8* • July 29 Over/Under Utilization Workgroup			15 – 31
3	Announcements			--
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isaac Brown, MHA/MBA	7:40	33 – 45
2	HealthPlan Update	Robert Moore, MD	7:50	--
III.	**Old Business – None.**			
IV.	**New Business - Consent Calendar**			
Reports	Consent Calendar	All	8:00	46
	Extended Care Quality Incentive Program (EXT QIP) CY 2027 Proposed Measure Set – *direct questions to Tony Sengdara*			47 – 49
	Pharmacy/Utilization Management TAR Timeliness, IRR and UM Rates Reports – Quarters 1 & 2 2026 – *direct questions to Stan Leung, Pharm.D, and Tony Hightower, CPhT*			51 – 63
	Grievance & Appeals' PULSE Report, Issue 22, September 2026 – *direct questions to Latrice Innes*			65 – 78
HS Policies	**Quality Improvement MPQP1008**			
	MPQP1002 – Quality/Utilization Advisory Committee			79 – 83
	MPQP1008 – Conflict of Interest Policy for QI Activities			85 – 87
	MPQP1022 – Site Review Requirements & Guidelines (with four changed attachments)			89 – 126
	MPQP1053 – Peer Review Committee			127 – 131

	Item	Lead	Time	Page #
	Utilization Management			
	MCUG3022 – Incontinence Guidelines			133 – 143
	MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/D-H, ICF/DD-N Facilities			145 – 151
	MCUP3115 – Community Based Adult Services			153 – 187
	MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump			189 – 193
	MPUP3078 – Second Medical Opinions			195 – 197
V.	**New Business – Discussion Policy**			
	Synopsis of Changes		--	199 – 200
	Provider Relations			
	MPPRGR10 – Provider Grievance – *CLEAN copy begins on p. 205*	Aaron Brincko, MPH	8:10	201 – 207
VI.	**Presentations**			
1	Grand Analysis: Network Access Assessment of Network Adequacy – CY 2025	Renee Trosky, BSRRT, MOL	8:20	209 – 228
VII.	**Adjournment scheduled by 8:45 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Oct. 21, 2026**			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

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

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

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

Voting Members Present:	Brian Montenegro, MD	Quon, Robert, MD, FACP
Gwiazdowski, Steven, MD, FAAP	Mulligan, Meagan, FNP-BC	Strain, Michael, Consumer Member
Hackett, Emma, MD, FACOG	Murphy, John, MD	Swales, Chris, MD
		Thomas, Randy, MD

Voting Members Absent: Sara Choudhry, MD; Brandy Lane, Consumer Member; Jennifer Wilson, MD, MPH

Partnership *Ex-Officio* Members Present:

Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI	Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Srvcs
Bontrager, Mark, Senior Director of Behavioral Health	Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Brown, Isaac, MBA/MHA, Senior Director of Q & P Improvement	Newman, Rachel, RN, BSN, Assoc. Dir., Credentialing
Cox, Bradley, DO, Regional Medical Director (Northeast)	O'Connell, Lisa, Director, Enhanced Health Services
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Glickstein, Mark, MD, Associate Medical Director	Spiller, Bettina, MD, Associate Medical Director
Hightower, Tony, CPhT, Associate Director, UM Regulations	Townsend, Colleen, MD, Regional Medical Director (Southeast)
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)	Ward, Lisa, MD, Regional Medical Director (Southwest)
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination	Watkins, Kory, MBA-HM, Director, Grievance & Appeals

Partnership *Ex-Officio* Members Absent:

Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Leung, Stan, Pharm.D, Director of Pharmacy Services
DeVido, Jeff, MD, Behavioral Health Clinical Director	Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Guillory, Ledra, Senior Manager of Provider Relations Representatives	Randhawa, Manleen, Senior Health Educator, Population Health
Katz, Dave, MD, Associate Medical Director	Ruffin, DeLorean, DrPH, MPH, Director of Population Health

Guests:

Beard, Alyssa, RN, Manager of CC Regulatory Performance	Isola, Brandy, Manager of Performance Improvement (Chico)
Brackett, Jacquelyn, Administrative Assistant I, Pharmacy	Krznarich, Jackie, RN, Mgr, Member Safety – Quality Inspections
Brunkal, Monika, Associate Director, Population Health	Kubota, Marshall, MD, Reg. Medical Director
Campbell, Anna, Health Policy Analyst, UM Regulations	Morris, Matthew, MD, Regional Medical Director (Auburn)
Cunningham, Aryana, Policy Analyst, Care Coordination	O'Leary, Hannah, Manager of Population Health, Pop Health
Devan, James, Director of Quality Management	Ribordy, Jeff, MD, Regional Medical Director (Northeast)
Durst, Jennifer, Senior Manager, Quality Incentive Programs	Shamoiel, Shantal, County Child Welfare Liaison, Behavioral Health
Elder, Alaina, Manager of Provider Network Services, Provider Relations	Smith, Christine, Community Health Needs Liaison, Pop Health
Frankovich, Terry, MD, Associate Medical Director	Stites, Jaylyn, Program Manager II, Provider Relations
Guevarra, Angelea, RN, Director of Care Coordination	Thornton, Aaron, MD, Associate Medical Director

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

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

II. Standing Updates		
Quality and Performance Improvement Program – *Isaac Brown, MBA/MHA, Senior Director of Quality & Process Improvement*		
• On Aug. 12, the various QIP measure sets were taken through our Physician Advisory Committee and approved there. (Two of these measure sets are on today's Q/UAC consent calendar.) This is a precursor for getting out our contract amendments that are now required each year. We have annual contract amendments that are required by the federal government that basically explain the measure set and the amount of money that a provider can earn through our performance programs. In the next few weeks, we will be getting out those amendments, and we encourage the providers to review and get those back to us so they can participate in our upcoming QIP program this next year (Jan. 1, 2027). • Our team will be providing a new training to those of our providers who have been trying to figure out how to address some problems. So, in addition to our ABCs of Quality, we will be providing a "performance improvement in action" course to help providers identify problems, test solutions, *etc.* We will launch the pilot in September and then officially launch this training at the beginning of 2027. This will be for all providers: community-based organizations (CBOs), skilled nursing facilities (SNFs), anybody who wants to join in. We are hoping to have a large cohort. • There has been some discussion of our community reinvestments in the past couple of months. This is money that we are reinvesting back in the communities based off any income that we earn as an organization. Our expansion counties, or Eastern Region, were not a part of those initial dollars and so Partnership decided we would appropriate some monies there. We are in the middle of Phases One and Two, providing roughly $2M to providers in the Eastern Region, many of whom have already received awards. We are excited to provide those dollars to the network. *There were no questions.*		
Health Plan Update – *Kermit Jones, MD, JD – Deputy Chief Medical Officer & Medical Director for Medicare Services*		
• Partnership has started our internal cross functional meetings to prepare for the federal and state mandated transition of the Unsatisfactory Immigration Status (UIS) population from managed care to fee-for-service (FFS), effective Jan. 1, 2027, at which time roughly two million Californians will face "a managed care and continuity of care cliff." o There will be a stoppage of benefits associated with CalAIM (California Advancing and Innovating Medi-Cal): transportation, community supports and other care managed/case managed programs.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

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

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

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

III. Old Business

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

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

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

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

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

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

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

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

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

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

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

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

V. Presentations

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

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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• A change of vendor allowed us to complete our annual Healthcare Effectiveness Data Information Set (HEDIS®) work earlier than usual, eliminating the need to build out a monthly dashboard. • Goals associated with the Dual-Eligible Special Needs (D-SNP) program were either postponed or terminated when our Medicare program implementation was delated to a Jan. 1, 2028 go-live date. • Goals associated with the Health Rules Payor (HRP) replacement of our core claims system AMISYS were terminated or delayed as kinks continued to be worked out. • The HEDIS® team significantly expanded their use of clinical data acquired through use of a National Committee for Quality Assurance (NCQA) Data Aggregator (DataLink) for MY2025 HEDIS measure rate generation, increasing participating practices from six to more than 30. Partnership will continue to scale up these activities in the 2026-2027 fiscal year (July 1, 2026 - June 30, 2027). • Our Site Review Inspections team created a comprehensive directory of Medi-Cal dental providers, something DHCS had not been able to provide to the Managed Care Plans (MCPs). The directory captures provider type, staffing demographics, and estimated monthly patient volume with a desktop created to ensure that the information remains complete and accurate. This supports Partnership's Care Coordination department in identifying dental providers for our members. (Many thanks to Rose Aarons for spearheading this work.) • Partnership teams spent some time working on validation frameworks for the PCP and other QIPs. We want to ensure all data providers provide to us is accounted for so we may incentivize providers as much as possible. • The Quality Measure Score Improvement (QMSI) initiative successfully engaged for measure-specific workgroups: Behavioral Health, Chronic Disease, Women's Health and Perinatal, and Pediatrics. Follow-up within seven days for mental illness after an emergency department visit and educating providers on colorectal cancer screening modalities to serve their unique populations were just two of the many efforts that improved rates and member outcomes. • QI Program and Project Management piloted a QI Project Toolkit & Training Program with 26 participants representing 13 organizations, launching it into a full-scale program in early CY 2026 to a first cohort of 61 participants from more than 30 provider and community-based organizations (CBOs), enabling participants to improve their project management skills. The Tool Kit is available on Partnership's public-facing webpage.	
2	**The QI Trilogy Documents –** Q/UAC voters posed no questions. ***Motion to approve: John Murphy, MD / Second: Robert Quon, MD – Motion carries unanimously*** Annually, the Quality and Performance Improvement Team updates three documents that reflect past, present, and future work related to quality improvement at Partnership HealthPlan of California (Partnership): 1. Quality Improvement Program Description 2. Quality Improvement Program Evaluation 3. Quality Improvement Work Plan Each document is a regulatory and NCQA Accreditation requirement. The Quality Improvement Project Management team, in partnership with the Senior Director of Quality and Performance Improvement and Director of Quality Management, serves as the QI Trilogy Document Team. The team leads the preparation of the documents for review by Partnership's quality committees. These documents will be presented during the quality committees in August and final approval will be sought from the Board of Commissioners on Oct. 28. Along with this review cycle, each document accounts for activities on a fiscal year cycle. These documents will be submitted to the State after Board approval and shared with Partnership members via the website and upon request. **The QI Program Description** is a summary of the QI program with content including the structure, processes, and intra and interdepartmental work that supports quality improvement efforts at Partnership. The program description contains the following components per the NCQA accreditation standards (QI 1A): • The QI program structure. • The behavioral healthcare aspects of the program.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

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

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

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

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

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

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

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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

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

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

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

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

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

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

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

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

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

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

Mark Netherda, MD, Medical Director for Quality

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

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

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

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

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

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

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

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

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

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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

V. Presentations

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

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

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

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

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

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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

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

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

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

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

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

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

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

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

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

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

Isaac called out some special accomplishments:

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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

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

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

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

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

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

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

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

1) Program Scope & Strategic Direction

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

2) Governance & Committee Structure

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

3) Leadership & Accountability

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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

4) Health Equity & Accreditation Alignment

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

5) Behavioral Health Oversight & Delegation

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

6) Value-Based Payment Programs

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

7) Pathway to Excellence (P2E)

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

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

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

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

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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- Quality of service
- Members' experience

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

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

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

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

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

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

VI. Adjournment

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

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

Approval Signature: *Date:*

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

Over/Under Utilization Workgroup

Meeting Name: Over/Under Utilization Workgroup

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

Date: July 29th, 2026 **Time**: 3:00pm – 4:00pm

Location: Board Room **Owner:** Dr. Ribordy

Facilitator: Radha Chebolu (Health Analytics)

Attendees:

Partnership Health Plan	Partnership Health Plan	Partnership Health Plan
☒ Robert Moore	☐ Ledra Guillory	☐ Brigid Gast
☒ Jeff Ribordy	☐ Melissa Perez	☐ Doreen Crume
☒ Kermit Jones	☐ Wendi Davis	☐ Sharon Hoffman-Spector
☐ Dejene Bikila	☒ Stan Leung	☐ Lisa Malvo
☒ Liat Vaisenberg	☐ Brian Spiker	☐ Melanie Lam
☒ Kristine Gual	☐ Shivani Sivasankar	☐ Cody West
☒ Amber Newell	☒ Radha Chebolu	☐ Angela Guevarra
☐ Athena Beltran-Nampraseut	☒ Tiphanie Salehi	☒ Renee Trosky
☐ Garnet Booth	☐ Kim Palfini	☐ Lisa O'Connell
☐ Lindsey Bushey	☐ Mark Aguirre	☒ Jen Kung
☐ Sarah Browning	☐ Shell Swift	☒ James Devan
☐ Emily Stoller	☐ Stephanie Nakatani Phipps	☒ Isaac Brown
☒ Monika Brunkal	☐ David Lopez	☐ Katherine Barresi
☐ Penny Thomas	☒ Candis Flournoy	☒ Deanna Watson
☐ Christopher Triolo	☐ Alex Brito	☐ Kristina Coester
☐ Jeffrey DeVido	☐ Ruth Hood	☐ David Lavine
☒ Anthony Sackett	☐ Derick Stacy	☐ Elijah Allen
☐ Tim Sharp	☐ Mark Bontrager	☐ Erin Hall
☒ Rasitha Rathnayake	☐ Greg Allen Friedman	☐ Dominic Salido
☐ DeLorean Ruffin	☐ Akshay Sharma	☒ Mohamed Jalloh
☒ Vander Harris	☐ Danielle Ogren	☐ Florentina Torres
☐ Michelle Rodriguez	☐ Hanh Hoang	☐ Qi Yao
☐ Cheng Saechao	☐ Amber Acosta	☐ Kareena Rodriquez
☐ Benjamin Amparo	☐ Tasha Krongard	☐ Jennifer Lopez
☐ Heather Coronado	☐ Amanda Federico	☐ Robert Ducay
☒ Jennifer Durst	☐ Roudabeh Moraghebi	☐ Kevin Jarrett-Lee
☒ Angier Allen	☒ Paul Leung	☐ Migdalia Liboy
☒ Samuel Ling	☒ Folo Akintan	☒ Brandy Isola
☒ Li Zhao	☐ Winnie Chen	☒ Tom Nguyen
☐ Aaron Brincko	☒ Leslie Warner	☒ Fei Yu
☒ Riley Kelley	☒ Cheyenne Taylor	☐ Garvin Lum
☒ Troy Foster		☐ Tony Sengdara
		☐ Eva Lopez

Topic	Notes
1) Introductions & Objective of Meeting *Speaker:* Dr. Jeff Ribordy	Identify potential concerns for over/under utilization within the PHC network
2) Review & approve minutes from last meeting *Speaker:* Dr. Jeff Ribordy	
Underutilization Analysis Discussion Topics	
1) PCP Visit Report Owner: HA	Discuss Findings **Overall utilization performance:** The 2026 PCP visit utilization rates vary across counties, ranging from 1.6 visits PMPY to 4.4 visits PMPY. The counties that had highest visit rates were Colusa, Glenn, and Lake. Colusa demonstrated the highest utilization rate at 4.4 visits PMPY, nearly double the target. Solano County had the lowest PCP utilization rate at 1.6 visits PMPY, well below target. Placer, Nevada, and Lassen also fell below the benchmark. Despite having one of the highest visit volumes, Solano County remains among the lowest in utilization rate. All regions show an upward PCP visit trend since late 2023. Santa Rosa region currently has the highest utilization rate at approximately 2.7 visits PMPY, reflecting a 7.6% year-over-year increase. Fairfield region is the highest-performing region overall at approximately 3.0 visits PMPY, with an 8.7% increase from the previous year. Auburn region is near 2.5 visits PMPY, showing a 2.6% increase. Lowest performing regions, namely Chico and Redding, remain below target line. **County-level PCP office visit rate trends:** Overall, visit rates have increased across most counties over the reporting period, with several counties demonstrating substantial year-over-year growth and rates well above the target benchmark. Colusa recorded the highest utilization rate at approximately 4.4 visits PMPY, followed by Glenn, Del Norte, and Lake. These counties not only exceeded the target but also showed strong growth compared to the prior year. Sonoma and Sutter also remained above target. Several counties, including Solano, Placer, Nevada, Sierra, Lassen, Plumas, and Napa, remained below the target utilization rate. Solano continued to have the lowest utilization rate among counties reviewed. Moderate utilization and gradual improvement were observed in counties such as Humboldt, Butte, Modoc, Shasta, Siskiyou, Trinity, and Yuba. While some of these counties remain close to the target, year-over-year changes varied. The impact of the Woodland/Dignity contract termination is noted, which is reflected in the trend data and may have contributed to utilization changes in affected counties.

	Clinic-level PCP visit utilization: The team reviewed utilization by primary care providers for sites with less than 2.2 visits PMPY including Ampla Health Chico Medical, Shasta Comm Health Center, Solano County Health Center, and La Clinica North Vallejo. **The action items:** - QI team to investigate the 0 utilization by the provider, Center for primary care - HA team to - review % of members that had a visit out of all the assigned members - investigate very low result PCPIDs for data issues. If no data issues are found, list of the low result PCPIDs will be provided to Provider Relations. **Note:** PCP Visits Tableau dashboards are aggregated at assigned PCP level, not service provider of primary care visit.
2) Maternal vaccination rates *Speaker:* HA	Discuss Findings **Prenatal Flu Vaccinate Rate:** The overall flu prenatal vaccine rate has increased from 28% in 2024 to 34% in 2025. In 2025, members who speak Russian had the lowest rate (4%) while members who speak Spanish had the highest rate (51%) when compared to other languages. In 2025, the White population had the lowest rate (22%) while Hispanic members had the highest rate (42%). In the Redding region, Modoc had the lowest rate in 2025 (19%), which decreased from 20% in 2024, while all the other counties had increased rates. In the Eureka region, Del Norte had the lowest rate of 11%, which decreased from 13% in 2024. In the Fairfield region, Napa has the lowest rate in 2025 (30%), which decreased from 36% in 2024. In the Santa Rosa region, all the rates have increased from 2024. In the Chico and Auburn regions, Yuba (24%) and Nevada (20%) had the lowest rates, respectively. **Prenatal Tdap Vaccination Rate:** The overall TDap prenatal vaccine rate has increased from 66% in 2024 to 69% in 2025. In 2025, by language, members who speak Russian had the lowest rate (21%), and members who speak Punjabi had the highest rate (91%). By ethnicity, the White population had the lowest rate (55%), and Hispanic members had the highest rate (79%). In the Redding region, Trinity had the lowest rate in 2025 (50%), which increased from 39% in 2024, and Lassen decreased the most from 70% to 64%, while all the other counties had a slight increase or decrease. In the Eureka region, Humboldt had the lowest rate of 53%, which decreased from 55% in 2024. All the

	counties in Fairfield region and Santa Rosa region have higher-than-average rates for 2025, with Marin having the highest rate (89%). In the Chico region, Butte had the lowest rate (61%), while in the Auburn region, Nevada had the lowest rate (54%) and Sierra had 100%. **Prenatal COVID Vaccination Rate:** The overall COVID prenatal vaccine rate has stayed the same in 2025 as 2024 (3%). In 2025, by language, members who speak Punjabi, Tagalog, and Russian had the lowest rates (0%). By ethnicity, the Native Hawaiian or Other Pacific Islander population and the black population had the lowest rate (0%), and the Native American population had the highest rate (3%). In the Redding region, except for Modoc all the regions had lower than average rates for 2025. In the Eureka region, Humboldt had the highest rate of 9%, which decreased slightly from 10% in 2024. All the counties in Fairfield region and Santa Rosa region had average or lower-than-average rates for 2025. In the Chico region, Yuba had the lowest rate (0%), while in the Auburn region, Plumas and Placer had the lowest rate (3%) and Sierra had the highest rate (50%) among all counties in 2025. **Prenatal RSV Vaccination Rate:** The overall RSV prenatal vaccine rate has increased from 12% in 2024 to 20% in 2025. In 2025, by language, members who speak Russian had the lowest rate (1%), and members who speak Spanish had the highest rate (25%). By ethnicity, the Native Hawaiian or Other Pacific Islander population had the lowest rate (8%), and the Hispanic population had the highest rate (23%). In the Redding region, Lassen (5%) had the lowest rate in 2025 (5%) and Siskiyou had the highest rate of 28%. In the Eureka region, Humboldt had the lowest rate of 20%, while Lake had the highest rate (28%) among all counties. All the counties in Fairfield region and Santa Rosa region have higher-than-average rates for 2025. In the Chico region, Sutter Yuba had the lowest rate (10%), while in the Auburn region, Sierra had the lowest rate (0%).
3) TAR trend report *Speaker: QI*	Discuss Findings **TAR Volume & Trends:** In 2026, Partnership received 428,388 authorizations to date, a 8% increase from 2025, ~ 986 per 1,000 members (up 11%). April 2026 recorded the highest authorizations per 1,000 members since 2022—1,047 per 1,000 (~76K total), up 15% vs. April 2025. **TAR Volume & Trends – Community Supports:** In 2026, CS referrals ranged from a low of 37 per 1,000 members in February to a peak of 53 per 1,000 (~4,000 total) in April. **TAR Specialty Rankings:**

	Outpatient hospital services led all specialties in volume. Several of the top specialties by volume and YOY growth are labeled 'Miscellaneous', limiting visibility into specific drivers.
4) Transportation services *Speaker:* HA	Discuss Findings **NMT & NEMT Transportation Services:** For May 2026, there were 114,679 total completed trips across all counties. Shasta had the most at 17,049 while Sierra had the fewest at 86. Out of 858,720 eligible members, 13,890 members used transportation services, for an average utilization rate of 1.62 percent. Modoc led with 3.27 percent utilization, and Marin was lowest at 1.08 percent. Members who used the service averaged 8.3 trips each, with Lake highest at 10.2 and Modoc lowest at 4.4. The overall trip rate was 134 per 1,000 members, with Shasta again highest at 268 and Plumas lowest at 56. For context, May 2025 saw 111,953 trips, 1.32 percent utilization, 9.4 trips per user, and a trip rate of 124 per 1,000 members, indicating slight and steady utilization rate increase year over year as a greater share of members used the transportation service and each rider performing slightly fewer trips. **NMT & NEMT Transportation Services Demographics:** Ethnicity: Percent utilization was highest among Black or African American and American Indian or Alaska Native members, and lowest among Hispanic or Latino and Asian members. American Indian members had the highest average trips per utilizer, while Black members had the lowest. For trip rate per 1,000 members, American Indian members ranked highest and Hispanic or Latino members lowest. Language: Tagalog-speaking members had the highest percent utilization, though they accounted for a small share of total trips. Russian-speaking members had the lowest percent utilization. Tagalog speakers had the highest average trips per utilizer, and Spanish-speaking members had the lowest. For trip rate per 1,000 members, Tagalog speakers were highest, while Russian and Spanish speakers were lowest. Age: Members age 65 and older had the highest percent utilization, nearly double that of the 21-64 group and over ten times that of the 0-20 group. The 21 to 64 age group had the highest average trips per utilizer. For trip rate per 1,000 members, the 65 and older group had the highest rate overall. **NMT & NEMT Transportation Services: Trip Details:**

	From June 2025 to June 2026, most trips were between 1 and 10 miles, making up 47.9 percent of all transportation. Trips over 50 miles made up 14.3 percent but were not evenly spread across counties. Seven counties had over 40 percent of their trips exceed 50 miles, with Del Norte leading at 62.9 percent of its 31,836 trips falling into that category. In contrast, Marin County had only 0.9 percent of its nearly 36,574 trips go over 50 miles. Most transports in 2025 were completed using NMT vehicles, with 80 percent of those provided by taxis. NEMT trips, used for members needing mobility assistance, made up 23 percent of total volume, and 95 percent of those were completed using wheelchair vans. **NMT & NEMT Transportation Services: Services and Servicers:** From June 2025 to June 2026, the top ten service types by trip volume made up 77 percent of all trips. Drug Rehabilitation was the most common, alone accounting for 35.2 percent. In contrast, the 10 least common service types totaled fewer than 100 trips combined. In this past year, over 100 different transport vendors have completed member trips. The top ten vendors accounted for over 40 percent of total volume, with Lyft performing nearly three times as many trips as the second most used provider. The 10 least used vendors combined for only 190 trips this past year. **Trips completed through Kinetik Health App:** Members utilizing the mobile phone app to request and complete rides has seen a sharp increase over the past year as July 2025 only saw 282 rides performed with the app compared to July 2026 which had 6,869 rides completed through the app. Growth in mobile app usage is expected to improve rider satisfaction, streamline communication by reducing call volume, and create new opportunities to gather member feedback through in-app surveys.
5) Immunizations for adolescents	Discuss Findings **Measure Completion Description:** Percent of members turning 13 years old during the measurement year who had one Tdap vaccine, and one meningococcal conjugate vaccine and two or three doses of the HPV vaccine by their 13th birthday. Important Context: At least 1 dose of a pertussis-containing vaccine is required for entry into 7th grade in California schools. **Gender:** The gender gap was similar in all three DHCS rating regions where members identifying as female had slightly higher IMA-2 completion rates. The gap was the largest In the Rural Upper North, where females had a 34.10

	completion rate and males having a 29.96 completion rate. **Individual Vaccine Completion:** The Human Papillomavirus (HPV) vaccine is the strongest driver of members completing or not completing this series. Upon review of vaccine completion from a sampling of providers, members missing at least one HPV vaccine is the highest proportion of members missing at least one vaccine from the series. This is likely due to logistical reasons. You can give the HPV, Meningococcal and the Tdap vaccine in one visit. To complete the series, a second visit for the second HPV vaccine is required. **Summary:** To improve IMA-2 performance, priority should be given to members who have already received at least one HPV vaccine dose, as they represent the most immediate opportunity to increase series completion rates. Targeted outreach and education for members and parents should emphasize the benefits and safety of HPV vaccination while addressing age-specific and socioeconomic barriers to completion. Improving vaccine access, particularly in rural and underserved areas of the Partnership region, is also critical. While promoting annual well-care visits between ages 11 and 13 remains important, providers should be supported with timely identification of patients who have initiated the HPV vaccine series and are due for subsequent doses before their 13th birthday. Combining focused member engagement, provider reminders, and expanded vaccine access is likely to have the greatest impact on improving IMA-2 completion rates.
Overutilization Analysis Discussion Topics	
Future Agenda Items	PCP visit rates will continue to be monitored
Next Meeting Date: TBD	

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PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI DEPARTMENT UPDATE
SEPTEMBER 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** • During August's PAC meeting, the PCP QIP proposed measure set for MY2027 was reviewed and approved. • The PCP QIP team will begin specifications write-up for MY2027.
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) has begun with payment distribution being completed no later than 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** • The Perinatal Quality Dashboard was updated with Quarter 4 data and perinatal providers received their Q4 / Preliminary Reports for the 2025-26 measurement year. Most of the providers in the PQIP have connected with DataLink or are in the process of connection. DataLink is working to provide updated data to Partnership that will include capturing Estimated Date of Delivery to progress toward not needing monthly manual submissions for the PQIP timely prenatal care visits measures.
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 proposed 2027 ECM QIP measurement set will be presented to PAC this month.

HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)	**Program Overview** The Hospital QIP offers financial incentives to improve performance related to Readmissions, Advance Care Planning, Clinical Quality, Patient Safety, Operations and Efficiency, and Patient Experience **Program Update** • The HQIP 6-month Bridge period kicked off July 1 and a Kickoff webinar was held on July 14th. The proposed 2027 HQIP Measurement Set will go to PAC in September for approval. This set includes several revised measures, aligning the Substance Use Measure with HEDIS, the return of a Hepatitis B measure removal of a couple measures and a new measure encouraging hospitals to get staff certified in Advanced Life Saving in Obstetrics (ALSO) or Basic Life Saving in Obstetrics (BLSO).
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 proposed 2027 EXT QIP measurement set will be presented to PAC this month.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	**Program Overview** The Partnership Quality Dashboard (PQD) is a Tableau designed to inform, prioritize, and evaluate quality improvement efforts. Dashboards and performance metrics built into the PQD provide the ability to track and trend QIP data. **Program Update** • N/A
EREPORTS	**Program Overview** eReports is a web application that allows providers to see their quality metrics in Partnership's PCP QIP program. eReports updates twice a week for near real-time visibility to quality metrics while PQD refreshes monthly for historical trending. **Program Update** • N/A
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. **Program Update** • The ECDS/Datalink Project is transitioning from pilot to scale, with governance now established and planning underway to support expanded provider onboarding, data quality validation, and broader use of electronic clinical data for HEDIS, QIP, and future business needs. The project continues to build the infrastructure, resources, and cross-functional processes needed to support program growth while advancing Partnership's long-term ECDS strategy. Currently, 26 provider organizations have completed onboarding and are actively sending data, while 31 additional organizations are progressing through 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** • BH Non-clinical PIP submitted for the second year on 08/06/26. HSAG will validate and provide feedback no later than 10/01/26. The resubmission date is 10/27/26. • Clinical PIP final report submitted on 08/06/26. HSAG will validate and provide feedback no later than 10/01/26. The resubmission date is 10/27/26.
QUALITY MEASURE SCORE IMPROVEMENT	**Program Overview** Internal measure-focused workgroups, which bring together perspectives across Partnership's services delivery continuum with the goal of strategically improving measures that align with the strategic priorities of Partnership HealthPlan. Current Priority Measures: 1. Child and Adolescent Well Care Visits (WCV) 2. Adolescent Immunizations (IMA-2) 3. Controlling High Blood Pressure (CBP) 4. Glycemic Status Assessment for People with Diabetes (GSD) 5. Timely Prenatal Care (PPC-Pre) **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. The first drafts of toolkits for QMSI workgroups are scheduled to be completed by 9/30/2026. Going forward, this report will be reorganized to better align with shifting strategies and accountability. **Workgroup Updates** • **Pediatrics:** Developing Toolkit materials for Child and Adolescent Well Care Visits (WCV), Well Child Visits during the first 30 months of life (W30+6 and +2). • **Women's Health & Perinatal:** Developing toolkit materials for Timely Prenatal Care (PPC-Pre). • **Chronic Disease:** Developing Toolkit materials for Controlling High Blood Pressure (CBP) and Colorectal Cancer Screening (COL). • **Behavioral Health:** No new updates. Behavioral Health measures are not currently prioritized for improvement activity. The workgroup is focused on improving data completeness.
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.

- The pilot for this new training program launched on 09/08/2026 with 20 provider participants and will run through 11/17/2026.

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

Program Update
- Fall 2026 cohort kicks off 09/01/2026. There are currently 135 individuals enrolled.

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
Consumer Assessment of Healthcare Providers and Systems® (CAHPS) Program -Medi-Cal product line & Org Goals – FY 24/25 Member Experience and Access | *Org Goals – FY 25/26 Member Experience*	**Program Overview** Oversees NCQA Accreditation requirements for Member Experience (ME) 7 (Elements C and D). Conducts annual regulated CAHPS® surveys for Medi-Cal members and non-regulated surveys to assess patient experiences. Results drive improvements in care quality and member experience. **Program Updates** ***Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)*** •

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** • No new updates at this time.
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.* **Program Updates:** • ***Phase I:*** All 10 counties applied, 9 have received awards, 1 is in discussions to explore the proposed intervention. • ***Phase II:*** Proposed framework has been developed and is currently in review. • ***Phase III:*** Vendor exploration is in progress.
Preventive Care Bridge Project (Formerly: Locum Pilot Initiative)	**Overview of the Preventive Care Bridge Project** The Preventive Care Bridge Project was developed as a short-term solution to address access challenges by providing targeted locum support with the goal of improving performance on preventive care measures, specifically well-child visits and cervical cancer screenings. By proactively guiding providers to maximize the locum resources through clear onboarding, scope alignment, and data tracking, the pilot explores a potential model for supporting improved measure performance, reducing withholds and

<table>
<tr><td></td><td>sanctions associated with unmet benchmarks, and enhancing the overall member experience.

Project Update
No new updates</td></tr>
<tr><td>Mobile Mammography Program</td><td>Program Overview
Aims to boost breast cancer screening (BCS) rates for providers performing below the 50th percentile benchmark. Partnership collaborates with Alinea Medical Imaging and providers to host Mobile Mammography events, helping members complete preventive screenings.

Program Updates

<table>
<tr><th colspan="3">Event Days
07/01/2026 – 10/31/2026</th></tr>
<tr><th>Region</th><th># of Provider Event Days</th><th># of Community Event Days</th></tr>
<tr><td>Auburn</td><td>2</td><td>0</td></tr>
<tr><td>Chico</td><td>9</td><td>1</td></tr>
<tr><td>Eureka</td><td>13</td><td>0</td></tr>
<tr><td>Fairfield</td><td>4</td><td>0</td></tr>
<tr><td>Redding</td><td>8</td><td>0</td></tr>
<tr><td>Santa Rosa</td><td>4</td><td>0</td></tr>
<tr><td>Plan Wide</td><td>40</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 at this time.</td></tr>
<tr><td>Abbott Cancer Diagnostics: Promoting Colorectal Cancer Screenings</td><td>Offering Updates

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

	Providers interested in placing a care-gap order should contact their Abbott Cancer Diagnostics representative. Providers who are unsure who their representative is may contact Abbott's support line at 1-844-870-8870 or complete the online contact form at https://www.cologuardhcp.com/contact-us. Partnership's Cologuard Care-Gap Orders page continues to be available as a resource for general information. Since a minimum is no longer required for care-gap orders, Partnerships facilitated orders will be discontinued after our current offering (further details below). If you have any questions, please reach out to the Performance Improvement team at PIT@partnershiphp.org. **Partnership Facilitated Orders** • Partnership's last facilitated order launched on 07/20/2026 with a final submission date of 08/17/2026. Pre-shipment patient letters are expected to be mailed on 09/18/2026 with the kits shipping on 09/28/2026.
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 for Committee and Board approval. Scheduled review and approval dates area as follows:
	  • Internal Quality Improvement (IQI) Committee – 08/11/2026
	  • Quality Utilization Advisory Committee (Q/UAC) – 08/19/2026
	  • Physician Advisory Committee (PAC) – 09/09/2026
	  • Board of Directors – 10/28/2026

SAGE GRANT	**Program Overview** The *Systems Advancement for General EHR* (SAGE) Grant is designed to assist healthcare providers in implementing or upgrading their EHR systems, to help modernize and enhance their ability to deliver high-quality, efficient, and member-centered care. This grant will help providers overcome common barriers to EHR adoption by offering financial support and implementation guidance. The recipient of the SAGE grant, Kimaw Medical Center, signed the agreement on 12/5/2025. The first payment installment of $125,000 was initiated. The SAGE Grant team will continue to conduct regular check-ins and monitor implementation milestones. The SAGE Grant Timeline can be found here. **Program Updates** • Partnership will begin coordination activities to the July – December Progress Check-In with K'ima:w by November 2026.
D-SNP MEDICARE	**D-SNP** **Program Overview** The D-SNP Quality team is responsible for 1) Development and finalization of the Model of Care document, 2) Management of Partnership's CMS Medicare Star quality program, and 3) Developing D-SNP readiness for all Quality Improvement teams. 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.
ACTIVITY	**UPDATE**
QUALITY ASSURANCE AND PATIENT SAFETY	
ACTIVITY	**UPDATE**

Potential Quality Issues (PQI) for the period: 07/31/2026 to 08/18/2026	**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** • 19 referrals were received with 14 from Grievance and Appeals, 4 from QI Member Safety, and 1 from Utilization Management • 15 cases were processed and closed • 110 cases are currently open • Two cases were discussed at the PRC meeting in August, resulting in two Corrective Action Plans. There are nine cases pending PRC review.
Facility Site reviews (FSR) & Medical record reviews (MRR)	**Program Overview** Site Review and Medical Record Review performed for monitoring of providers. **Program Update** • No new updates

Healthcare Effectiveness Data Information Set (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	**Program Overview** HEDIS is used to evaluate clinical quality in a standardized way. This program shares performance measurement rates with the intent of improving the quality of care delivered to members. **Program Update** • The MY2025 HEDIS Annual project is complete. Partnership received its Final Audit Report from Health Services Advisory Group (HSAG) for the Managed Care Accountability Set (MCAS) measure set on 07/15/2026. The NCQA Health Plan Accreditation (HPA) audit is also complete. Partnership anticipates receiving NCQA's final MY2025 Health Plan Rating in September 15,2026.
HEDIS® Program Overall	**Program Updates** • The HEDIS Annual Summaries of Performance for the DHCS MCAS and NCQA HPA programs will be shared within Partnership, with the Physicians Advisory Committee (PAC) and the Quality Advisory Committee (QUAC), and the Board of Commissioners in August 2026. • In MY2025, MCAS measure rates were reported to HSAG/DHCS as one Plan-Wide rate for each measure. Partnership also reported county-level data to DHCS in

	MY2025. DHCS continues to its intention to use county-level data to sanction Managed Care Plans for measures in the Accountable measure set that did not perform at the Minimum Performance Level (MPL). • Completed NCQA's 2026 Health Plan Ratings (HPR) Projected Ratings process. NCQA projected HPR rating for MY2025 is 3.0 Stars, using the Child CAHPS Survey. • Prospective Medical Review Project (PMR) used to collect medical records for use as supplemental data for administrative measures such as W30 is being prepped to launch September 2026.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	**Program Overview** The State of California requires all Managed Care Plans (MCPS) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years, and reporting HEDIS and CAHPS results every year for a Health Plan Rating (HRP) score. Partnership's next HPA Renewal Survey is scheduled for 09/15/2026. **Program Update** • The NCQA Program Management Team uploaded the majority of survey documents, including the file review universes and selected delegates, to the NCQA web-based platform, Interactive Review Tool (IRT). Our consultant, Managed Healthcare Resources (MHR) has reviewed our documentation and is verifying our information completed for each requirement and all Compliance Statements were completed correctly. Submission of all finalized documents to NCQA is on 9/15/2026. • The Post HPA Renewal Survey activities will begin on 10/08/2026, when NCQA provides initial findings and outstanding issues to Partnership. The NCQA Program Management Team, along with affected Business Owners, will review and address the Initial Issues report from 10/9/2026 – 10/13/2026. A survey conference call is scheduled with NCQA on 10/14/2026 during which Partnership can clarify the outstanding issues with the surveyors before providing any additional documents by 10/19/2026. Only documents that existed prior to 9/15/2026 will be accepted as additional documentation. • Departments who participate in File Review have prepared their file universes for the applicable look-back period by completing the File Review System Universe Instruction Workbooks supplied by NCQA. The workbooks will be uploaded to NCQA's online submission portal, IRT, on or before the Renewal Survey submission date, 9/15/2026. Random file samples will be selected by NCQA and provided to Partnership on 10/19/2026. Partnership's Virtual File Review Audit is scheduled for 11/02/2026 and 11/03/2026. Selected files, including Partnership and delegate files, will be reviewed by NCQA surveyors during the Virtual Audit. A Closing Conference Call with NCQA, the Executives and all key stakeholders will also take place on

	11/03/2026, at which time NCQA will review the remaining issues (i.e. identified gaps) with Partnership.
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** • NCQA has confirmed that they will not be releasing a new set of HOA Standards and Guidelines in 2027. Partnership will be assessed against the 2026 HOA Standards and Guidelines (released in December 2025) for the May 2028 HOA Renewal Survey. Although a new set of standards will not be released, the NCQA Program Management Team must continue to monitor for Triannual Policy Updates and FAQs that may change the requirements for the 2026 HOA Standards and Guidelines. We will seek clarification from NCQA to determine if they plan to update the Implementation Plan timeframes (currently applicable through 06/30/2027) or any of the look-back periods, as this may affect the production timelines and planning for several requirements.
NCQA Health Plan Accreditation (HPA) and Health Outcomes Accreditation (HOA)	• NCQA did not release any Triannual Policy Updates in July 2026. The next updates are scheduled to be released in November 2026.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION MANAGEMENT COMMITTEE (Q/UAC)

Consent Calendar
Sept. 16, 2026
Staff deems that items on the Consent Calendar need not be discussed before approval.

		Pages
	Extended Care Quality Incentive Program (EXT QIP) CY 2027 Proposed Measure Set – *direct questions to Tony Sengdara*	47 – 49
	Pharmacy/Utilization Management TAR Timeliness, IRR and UM Rates Reports – Quarters 1 & 2 2026 – *direct questions to Stan Leung, Pharm.D, and Tony Hightower, CPhT*	51 – 63
	Grievance & Appeals' PULSE Report, Issue 22, September 2026 – *direct any questions to Latrice Innes*	65 – 78
	Quality Improvement	
	MPQP1002 – Quality/Utilization Advisory Committee	79 – 83
	MPQP1008 – Conflict of Interest Policy for QI Activities	85 – 87
	MPQP1022 – Site Review Requirements & Guidelines (with three revised attachments and one **ARCHIVED** attachment)[1]	89 – 126
	MPQP1053 – Peer Review Committee	127 – 131
	Utilization Management	
	MCUG3022 – Incontinence Guidelines	133 – 143
	MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/D-H, ICF/DD-N Facilities	145 – 151
	MCUP3115 – Community Based Adult Services	153 – 187
	MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump	189 – 193
	MPUP3078 – Second Medical Opinions	195 – 197

[1] Policy presented with Attachment E affected by Department of Health Care's All Plan Letter 26-014 Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older (July 1, 2026); ARCHIVING Attachment L – PCP Providing Urgent Care Survey Tool – because its provisions are covered by Attachments J & K (Free Standing Urgent Care Clinic and Urgent Care Clinic, respectively). Subsequent attachments move up one letter. New L & M attachments updated to delete references to the now defunct Palliative Care Quality Network (PCQN).

Proposed 2027 EXT QIP Measurement Set

Key: New Measure | Change to Measure | ~~Removed Measure~~

2026 Measures	Proposed 2027 Measures
Gateway Measures	
Gateway Measure 1: CMS Five-Star Overall Rating Points: N/A Target: 2 or more stars to be eligible for other program measures	No changes
Gateway Measure 2: California Immunization Registry (CAIR) Enrollment Points: N/A Target: CAIR enrollment required to be eligible for other program measures	No changes
Gateway Measure 3: Quality Assurance and Performance Improvement (QAPI) Plan Submission Points: N/A Target: Submission by 6/30/27: Full credit Submission between 7/1/27 - 12/31/27: 50% decrease Submission after 12/31/26, will result in gateway not met and ineligibility for other measures.	No changes
Clinical Domain	
Measure 1: Percentage of long-stay high-risk residents with pressure ulcers Points: 10 Target: Full Points: < 5.1% Partial Points: 5.1 - 5.3%	Target: Full Points: < 4.3% Partial Points: 4.3 - 4.5% 2026 Natl AVG: 4.6% 2026 CA AVG: 4.3%

Measure 2: Percentage of long-stay residents who lose too much weight Points: 10 Target: Full Points: < 4.3% Partial Points: 4.3 - 5.4%	Target: Full Points: < 4.0 % Partial Points: 4.0 - 5.1% 2026 Natl AVG: 5.2% 2026 CA AVG: 4%
Measure 3: Percentage of long-stay residents who needed and got a flu shot Points: 10 Target: Full Points: > 98.4% Partial Points: 93.5 - 98.4%	Measure 3: Percentage of long-stay residents who needed and got a flu shot *AND* successful entry into CAIR Target: Full Points: > 98.2% Partial Points: 95.6 - 98.2% 2026 Natl AVG: 95.5% 2026 CA AVG: 98.2%
Measure 4: Percentage of long-stay residents who received a vaccine to prevent pneumonia Points: 10 Targets: Full Points: > 98.5% Partial Points: 93.5 - 98.5%	Measure 4: Percentage of long-stay residents who received a vaccine to prevent pneumonia *AND* successful entry into CAIR Target: Full Points: > 98.6% Partial Points: 93.6 - 98.6% 2026 Natl AVG: 93.5% 2026 CA AVG: 98.6%
Functional Status Domain	
Measure 5: Percentage of long-stay residents experiencing one or more falls with major injury Points: 10 Target: Full Points: < 1.7% Partial Points: 1.7 - 3.2%	Target: Full Points: < 1.6% Partial Points: 1.6 - 3.1% 2026 Natl AVG: 3.2% 2026 CA AVG: 1.6%
Measure 6: Percentage of long-stay residents who have or had a catheter inserted and left in their bladder Points: 10 Target: Full Points: < 1.2% No Partial Points	Target: Full Points: < 0.8% No Partial Points 2026 Natl AVG: 0.8% 2026 CA AVG: 0.8%
Resource Use Domain	
Measure 7: Number of hospitalizations per 1,000 long-stay resident days Points: 15 Target: Full Points: < 1.83% Partial Points: 2.17 - 1.83 %	Points: 10 Target: Full Points: < 1.90% Partial Points: 2.24 - 1.90% 2026 Natl AVG: 1.90% 2026 CA AVG: 2.25%

Operations & Satisfaction Domain	
Measure 8: Health Inspection Star Rating Points: 10 Target: Full Points: 4 or more stars Partial Points: 3 stars	No changes
Measure 9: Staffing Rating Points: 15 Target: Full Points: 4 or more stars Partial Points: 3 stars	Points: 10
	ADD: Measure 10 – Health Equity Impact Analysis and Plan Facilities are required to submit an updated Health Equity Impact Analysis and Plan that addresses health disparity in at least one of the following measures listed below: • Percent of high-risk residents with pressure ulcers • Percent of residents who lose too much weight • Long-stay residents who needed and received a flu shot • Long-stay residents who received a vaccine to prevent pneumonia • Percent of residents experiencing one or more falls with major injury • Percent of residents who have/had a catheter inserted and left in bladder Points: 10 Target: Full Points No Partial Points Submit analysis and plan by August 31, 2027. Partnership will review and notify facilities if approved or rejected. Logic: To Partnership, Health Equity means everyone has a fair and just opportunity to be as healthy as possible.[30] Partnership recognizes a range of factors impact the health of the diverse communities we serve. Every patient, regardless of socioeconomic status, race, gender, or other identifying traits, deserves a quality patient experience.

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Pharmacy Treatment Authorization Request (TAR) Timeliness Report
Physician Administered Drugs
(January 1, 2026 through June 30, 2026)

Report includes only Adverse Benefit Decision (ABD) determinations resulting from medical necessity review and benefit coverage reviews.

Overall Timeliness of Denials Notification	**Quarter 1**	**Quarter 2**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	471	501	972	
Total # of requests (denominator)	471	501	972	
% compliant	**100%**	**100%**	**100%**	**95% (yes)**

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

Urgent Pre-Service *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	237	147	384	
Total # of requests (denominator)	237	147	384	
% compliant	**100%**	**100%**	**100%**	**95% (yes)**

Non-Urgent Pre-service *notification within 14 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	201	312	513	
Total # of requests (denominator)	201	312	513	
% compliant	**100%**	**100%**	**100%**	**95% (yes)**

Pharmacy
Q1 & Q2 2026

Post-Service *notification within 30 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	33	42	75	
Total # of requests (denominator)	33	42	75	
% compliant	**100%**	**100%**	**100%**	**95% (yes)**

Pharmacy TAR Approval and Denial Rates
(January 1, 2026 through June 30, 2026)

Overall Approval Rate	**Quarter 1**	**Quarter 2**	**Total**
Numerator	1,975	1,932	3,907
Denominator	2,276	2,259	4,535
Rate	**86.78%**	**85.52%**	**86.15%**

Overall Denial Rate	**Quarter 1**	**Quarter 2**	**Total**
Numerator	438	459	897
Denominator	2,276	2,259	4,535
Rate	**19.24%**	**20.32%**	**19.78%**

Pharmacy Inter-Rater Reliability (IRR) Results
(January 1, 2026 through June 30, 2026)

Pharmacy Technician IRR Results:

Quarter	**Raw Score**	**Concurrence Rate**	**Goal**	**Goal Met**
Q1	115/115	100%	90%	Yes
Q2	104/106	98%	90%	Yes
Total	**219/221**	**99%**	**90%**	Yes

Pharmacist IRR Results:

Quarter	**Raw Score**	**Concurrence Rate**	**Goal**	**Goal Met**
Q1	89/90	99%	90%	Yes
Q2	83/84	99%	90%	Yes
Total	**172/174**	**99%**	**90%**	Yes

Pharmacy
Q1 & Q2 2026

Pharmacy TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		TOTAL	
	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026
Approved	633	691	531	683	578	726	567	751	696	652	639	685	3,644	4,188
Approved as Modified	41	43	37	41	34	59	33	51	36	34	30	61	211	289
Medical Necessity Not Justified[1]	126	94	101	101	81	133	102	127	111	110	118	118	639	683
Member Not Eligible	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Other Health Insurance	36	24	29	22	32	24	21	28	20	37	20	19	158	154
Not Timely	2	2	0	0	0	0	0	0	0	0	1	0	3	2
Admin Denial[2]	174	134	142	116	161	171	164	178	174	178	151	186	966	963
Void	35	18	32	16	31	27	19	14	23	19	28	19	168	113
Total TARs	**1,047**	**1,006**	**872**	**979**	**917**	**1,140**	**906**	**1,149**	**1,060**	**1,030**	**987**	**1,088**	**5,789**	**6,392**
Working Days	21	20	19	19	21	21	22	22	21	20	21	21		
Pharmacy Technician FTE	7	8	7	8	7	7	7	7	7	7	7	7		
TARs per tech per day	7	6	7	6	6	8	6	7	7	7	7	7		
Pharmacist FTE	5	6	5	6	5	6	5	6	6	6	6	6		
TARs per pharmacist per day	10	8	9	9	9	9	8	9	8	9	8	9		

[1]Medical Necessity as defined by NCQA 2026 Standard UM1 Element A

[2] Duplicate TAR or No TAR Required

Pharmacy Appeals

Year	Total Provider Appeals	Overall Appeal Rate	Appeal Overturn Rate[3]	Appeal Upheld Rate
2026	7	1%	14% (1/7)	86% (6/7)
2025	4	0.6%	75% (3/4)	25% (1/4)

[3]Includes partially overturned appeals

Utilization Management (UM)
Q1 & Q2 2026

UM Treatment Authorization Request (TAR) Timeliness Report
Non-Behavioral Healthcare Decisions
January 1, 2026 through June 30, 2026

Report includes only Adverse Benefit Decision (ABD) determinations resulting from medical necessity and benefit coverage reviews.

Urgent Concurrent *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification timeframe (numerator)	864	985	1849	**95%**
Total # of requests (denominator)	876	996	1872	
% compliant	**98.6%**	**98.9%**	**98.8%**	**Yes**

Urgent Preservice *notification within 72 hours of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	193	204	397	**95%**
Total # of requests (denominator)	197	215	412	
% compliant	**98.0%**	**94.9%**	**96.4%**	**Yes**

Non-urgent Preservice *notification within 14 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	3953	4059	8012	**95%**
Total # of requests (denominator)	4004	4311	8315	
% compliant	**98.7%**	**94.2%**	**96.4%**	**Yes**

Post-service *notification within 30 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	130	173	303	**95%**
Total # of requests (denominator)	132	174	306	
% compliant	**98.5%**	**99.4%**	**99.0%**	**Yes**

Utilization Management (UM)
Q1 & Q2 2026

UM Treatment Authorization Request (TAR) Approval and Denial Rates
Non-Behavioral Healthcare Decisions
January 1, 2026 through June 30, 2026

Overall Approval Rate	Quarter 1	Quarter 2	Total
Numerator	58,424	58,654	**117,078**
Denominator	79,254	79,971	**159,225**
Rate	**73.72%**	**73.34%**	**73.53%**

Overall Denial Rate	Quarter 1	Quarter 2	Total
Numerator	21,778	22,239	**44,017**
Denominator	79,254	79,971	**159,225**
Rate	**27.48%**	**27.81%**	**27.64%**

Utilization Management (UM)
Q1 & Q2 2026

UM Inter-Rater Reliability (IRR) Results
Non-Behavioral Healthcare Decisions
January 1, 2026 through June 30, 2026

INPATIENT - UM Nurse Coordinator IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	367/379	96.8%	90%	Yes
Q2	406/421	96.4%	90%	Yes
Total	**773/800**	**96.6%**	**90%**	**Yes**

OUTPATIENT - UM Nurse Coordinator IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	670/676	99.1%	90%	Yes
Q2	680/692	98.3%	90%	Yes
Total	**1350/1368**	**99.67%**	**90%**	**Yes**

LTSS - UM Nurse Coordinator IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	150/154	97.4%	90%	Yes
Q2	165/173	95.4%	90%	Yes
Total	**315/327**	**96.3%**	**90%**	**Yes**

Physician UM IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	193/195	99.0%	90%	Yes
Q2	207/210	98.6%	90%	Yes
Total	**400/405**	**98.8%**	**90%**	**Yes**

Utilization Management (UM)
Q1 & Q2 2026

UM TAR Volume & Staffing
Non-Behavioral Healthcare Decisions
January 1, 2026 through June 30, 2026

Report includes data for all TARs

INPATIENT TARs – All Regions - UM Nurse Coordinators:

All Regions	January	February	March	April	May	June	TOTALS
Nurse FTE - Inpatient	26	27	25	28	28	30	**27.3**
Total TARs	5423	5110	5684	5412	5301	5585	**32,515**
Working Days	20	19	21	22	20	21	**123**
TARs per Nurse per day	**10.4**	**10.0**	**10.8**	**8.8**	**9.5**	**8.9**	**9.7**

OUTPATIENT TARs – All Regions - UM Nurse Coordinators:

All Regions	January	February	March	April	May	June	TOTALS
Nurse FTE - Outpatient	43	45	47	46	46	48	**45.8**
Total TARs	18,972	18,790	20,977	20,043	18,425	20,407	**117,614**
Working Days	20	19	21	22	20	21	**123**
TARs per Nurse per day	**22.1**	**22.0**	**21.3**	**19.81**	**20.03**	**20.25**	**20.86**

LTSS TARs – All Regions - UM Nurse Coordinators:

All Regions	January	February	March	April	May	June	TOTALS
Nurse FTE - LTC	11	11	13	13	13	15	**12.67**
Total TARs	1894	1711	1891	1819	1654	1833	**10,802**
Working Days	20	19	21	22	20	21	**123**
TARs per Nurse per day	**8.6**	**8.2**	**6.9**	**6.4**	**6.4**	**5.8**	**6.9**

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

Utilization Management (UM)
Q1 & Q2 2026

UM Treatment Authorization Request (TAR) Timeliness Report
Behavioral Healthcare Decisions
January 1, 2026 through June 30, 2026

Report includes only Adverse Benefit Decision (ABD) determinations resulting from medical necessity and benefit coverage reviews.

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

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

Non-urgent Preservice *notification within 14 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	0	0	0	**95%**
Total # of requests (denominator)	0	0	0	
% compliant	**N/A**	**N/A**	**N/A**	**N/A**

Post-service *notification within 30 calendar days of the request (NCQA standard)*	**Quarter 1**	**Quarter 2**	**Total**	**Goal/ (Goal Met)**
Total # of requests compliant with notification time frame (numerator)	0	0	0	**95%**
Total # of requests (denominator)	0	0	0	
% compliant	**N/A**	**N/A**	**N/A**	**N/A**

Utilization Management (UM)
Q1 & Q2 2026

UM Inter-Rater Reliability (IRR) Results
Behavioral Healthcare Decisions
January 1, 2026 through June 30, 2026

Behavioral Health Wellness & Recovery - UM Nurse Coordinator IRR Results:

Quarter	Raw Score	Concurrence Rate	Goal	Goal Met
Q1	30/30	100%	90%	Yes
Q2	20/20	100%	90%	Yes
Total	**50/50**	**100%**	**90%**	Yes

UM TAR Volume & Staffing
Behavioral Healthcare Decisions
January 1, 2026 through June 30, 2026

Report includes data for all TARs

Behavioral Health Wellness & Recovery TARs – All Regions - UM Nurse Coordinators:

All Regions	January	February	March	April	May	June	TOTALS
Nurse FTE (ASAM training)	2	2	2	2	2	2	**2**
Total TARs	178	160	217	192	151	173	**1071**
Working Days	20	19	21	22	20	21	**123**
TARs per Nurse per day	**4.5**	**4.2**	**5.2**	**4.4**	**3.8**	**4.1**	**4.4**

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

INPATIENT

INPATIENT TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		TOTAL	
	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026
Approved	4,974	4,477	4,560	4,176	4,497	4,421	4,414	4,306	4,657	4,161	4,598	4,420	4,614		4,548		4,603		4,448		3,907		4,665		54,485	25,961
EB Approved	3	15	1	9	2	10	2	7	5	13	4	18	10		13		4		12		10		10		76	72
IB Approved	0	8	0	34	0	157	0	20	1	70	0	29	0		0		1		4		4		8		18	318
CTC / Capped Review	1	1	0	0	0	16	1	4	0	12	1	10	1		0		0		0		0		4		8	43
Correction Received	0	1	0	5	0	3	0	0	0	0	0	0	0		0		0		0		0		0		0	9
Modified per Correction Request	3	0	1	0	3	0	1	1	2	0	2	2	0		1		2		0		0		0		15	3
TOTAL (APPROVED)	**4,981**	**4,502**	**4,562**	**4,224**	**4,502**	**4,607**	**4,418**	**4,338**	**4,665**	**4,256**	**4,605**	**4,479**	**4,625**	**0**	**4,562**	**0**	**4,610**	**0**	**4,464**	**0**	**3,921**	**0**	**4,687**	**0**	**54,602**	**26,406**
Approve as Modified	**99**	**151**	**106**	**120**	**117**	**139**	**92**	**169**	**127**	**160**	**143**	**152**	**126**		**156**		**137**		**137**		**128**		**168**		**1,536**	**891**
Admin Modification	**1**	**1**	**0**	**1**	**1**	**6**	**1**	**5**	**0**	**6**	**1**	**2**	**1**		**1**		**0**		**0**		**3**		**9**		**18**	**21**
Med Nec Not Justified	88	181	85	183	99	329	136	252	166	324	199	277	183		208		179		170		179		201		**1,893**	**1,546**
Denied by Cap Hospital	3	5	6	3	8	5	4	5	0	3	5	5	5		3		4		8		4		5		**55**	**26**
Member not Eligible	15	10	11	14	9	9	12	13	9	10	13	10	17		9		12		10		8		8		**133**	**66**
Not Timely	1	0	0	0	0	0	0	0	1	0	0	0	0		0		0		0		0		0		**2**	**0**
Other Insurance	170	219	109	236	161	257	133	224	141	190	153	185	153		158		160		149		176		247		**1,910**	**1,311**
TOTAL (MED NEC DENIALS)	**277**	**415**	**211**	**436**	**277**	**600**	**285**	**494**	**317**	**527**	**370**	**477**	**358**	**0**	**378**	**0**	**355**	**0**	**337**	**0**	**367**	**0**	**461**	**0**	**3,993**	**2,949**
Admin Denial (Duplicate TAR)	95	71	100	109	84	93	93	120	186	135	176	163	152		143		113		170		72		87		**1,471**	**691**
Admin Denial (No Auth Required)	105	114	94	127	107	162	115	170	143	135	120	159	134		134		114		127		87		100		**1,380**	**867**
Admin Denial (Void)	110	89	135	87	116	77	117	95	126	82	107	112	91		118		104		93		67		73		**1,257**	**542**
TOTAL (ADMIN DENIALS)	310	274	329	323	307	332	325	385	455	352	403	434	377	0	395	0	331	0	390	0	226	0	260	0	4,108	2,100
TOTAL (DENIALS)	**587**	**689**	**540**	**759**	**584**	**932**	**610**	**879**	**772**	**879**	**773**	**911**	**735**	**0**	**773**	**0**	**686**	**0**	**727**	**0**	**593**	**0**	**721**	**0**	**8,101**	**5,049**
Grievance Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
Overturned by Appeal	5	11	2	1	1	0	6	4	7	0	12	10	15		11		8		19		20		9		115	26
Appeal Partially Overturned	0	2	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	2
Appeal Upheld	64	67	56	5	61	0	113	17	128	0	86	31	90		66		85		123		111		23		1,006	120
TOTAL TARs	**5,737**	**5,423**	**5,266**	**5,110**	**5,266**	**5,684**	**5,240**	**5,412**	**5,699**	**5,301**	**5,620**	**5,585**	**5,592**	**0**	**5,569**	**0**	**5,526**	**0**	**5,470**	**0**	**4,776**	**0**	**5,617**	**0**	**65,378**	**32,515**
IP Nurse FTE	**22**	**26**	**22**	**27**	**22**	**25**	**24**	**28**	**25**	**28**	**25**	**30**	**26**	**27**	**26**		**28**		**26**		**26**		**26**			
Working Days	**21**	**20**	**19**	**19**	**21**	**21**	**22**	**22**	**21**	**20**	**21**	**21**	**22**	**23**	**21**	**21**	**21**	**22**	**23**	**22**	**18**	**21**	**20**	**23**		
TARs per Nurse per Day	12.42	10.43	12.60	9.96	11.40	10.83	9.92	8.79	10.86	9.47	10.70	8.87	9.78	0.00	10.20	#DIV/0!	9.40	#DIV/0!	9.15	#DIV/0!	10.21	#DIV/0!	10.80	#DIV/0!		

OUTPATIENT

OUTPATIENT TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026
Approved	11,166	10,828	11,009	10,664	12,444	12,187	13,237	10,572	12,473	9,646	12,014	10,633	12,577		12,003		12,439		13,145		9,681		10,824		143,012	64,530
EB Approved	832	955	776	964	849	1,079	938	813	939	925	1,015	856	1,182		1,060		1,113		935		675		845		11,159	5,592
CTC / Capped Review	0	0	0	0	0	0	0	0	0	0	0	0	1		0		1		0		0		0		2	0
Correction Received	3	22	3	22	6	52	4	18	11	51	6	39	10		16		8		11		23		22		123	204
Modified per Correction Request	1,752	828	1,586	566	1,888	368	1,653	648	1,640	311	1,476	517	1,574		1,301		1,187		1,167		789		642		16,655	3,238
TOTAL (APPROVED)	**13,753**	**12,633**	**13,374**	**12,216**	**15,187**	**13,686**	**15,832**	**12,051**	**15,063**	**10,933**	**14,511**	**12,045**	**15,344**	**0**	**14,380**	**0**	**14,748**	**0**	**15,258**	**0**	**11,168**	**0**	**12,333**	**0**	**170,951**	**73,564**
Approve as Modified	**262**	**235**	**203**	**245**	**203**	**281**	**190**	**233**	**217**	**241**	**223**	**233**	**260**		**226**		**212**		**219**		**192**		**211**		**2,618**	**1,468**
Admin Modification	**254**	**471**	**251**	**492**	**263**	**561**	**382**	**1,597**	**452**	**1,707**	**507**	**1,950**	**534**		**404**		**461**		**520**		**363**		**490**		**4,881**	**6,778**
Med Nec Not Justified	1,119	962	937	964	845	1,089	907	1,101	880	1,121	878	1,168	858		899		898		1,039		968		965		**11,193**	**6,405**
Denied by Cap Hospital	3	0	1	0	0	1	0	0	1	0	1	0	0		1		0		1		0		0		**8**	**1**
Member not Eligible	22	12	20	21	24	27	22	16	27	25	21	20	20		19		21		21		14		25		**256**	**121**
Not Timely	3	6	0	3	3	5	8	0	20	0	1	1	3		3		3		2		2		21		**69**	**15**
Other Insurance	423	397	347	348	42	382	400	350	385	263	413	363	449		327		39		334		306		343		**3,808**	**2,103**
TOTAL (MED NEC DENIALS)	**1,570**	**1,377**	**1,305**	**1,336**	**914**	**1,504**	**1,337**	**1,467**	**1,313**	**1,409**	**1,314**	**1,552**	**1,330**	**0**	**1,249**	**0**	**961**	**0**	**1,397**	**0**	**1,290**	**0**	**1,354**	**0**	**15,334**	**8,645**
Admin Denial (Duplicate TAR)	966	955	900	1,018	1,055	1,126	1,078	939	1,004	888	1,050	934	1,013		946		948		1,010		840		918		**11,728**	**5,860**
Admin Denial (No Auth Required)	2,739	2,816	2,218	3,012	2,471	3,337	2,151	3,289	2,208	2,874	2,058	3,151	2,200		2,090		2,233		2,534		2,499		2,760		**28,161**	**18,479**
Admin Denial (Void)	507	422	422	423	466	474	490	416	439	367	391	501	439		405		384		451		401		382		**5,177**	**2,603**
TOTAL (ADMIN DENIALS)	4,212	4,193	3,540	4,453	3,992	4,937	3,719	4,644	3,651	4,129	3,499	4,586	3,652	0	3,441	0	3,565	0	3,995	0	3,740	0	4,060	0	45,066	26,942
TOTAL (DENIALS)	**5,782**	**5,570**	**4,845**	**5,789**	**4,906**	**6,441**	**5,056**	**6,111**	**4,964**	**5,538**	**4,813**	**6,138**	**4,982**	**0**	**4,690**	**0**	**4,526**	**0**	**5,392**	**0**	**5,030**	**0**	**5,414**	**0**	**60,400**	**35,587**
Grievance Overturned	8	12	7	2	9	2	4	4	14	0	3	1	7		7		7		4		12		6		88	21
Overturned by Appeal	18	13	10	12	10	3	8	11	10	2	8	15	9		11		7		8		12		10		121	56
Appeal Partially Overturned	0	1	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	1
Appeal Upheld	57	37	34	34	28	3	35	36	33	4	37	25	25		18		21		29		35		39		391	139
TOTAL TARs	**20,134**	**18,972**	**18,724**	**18,790**	**20,606**	**20,977**	**21,507**	**20,043**	**20,753**	**18,425**	**20,102**	**20,407**	**21,161**	**0**	**19,736**	**0**	**19,982**	**0**	**21,430**	**0**	**16,812**	**0**	**18,503**	**0**	**239,450**	**117,614**
OP Nurse FTE	**38**	**43**	**40**	**45**	**42**	**47**	**42**	**46**	**43**	**46**	**43**	**48**	**44**	**47**	**44**		**44**		**44**		**46**		**46**			
Working Days	**21**	**20**	**19**	**19**	**21**	**21**	**22**	**22**	**21**	**20**	**21**	**21**	**22**	**23**	**21**	**21**	**21**	**22**	**23**	**22**	**18**	**21**	**20**	**23**		
TARs per Nurse per Day	25.23	22.06	24.64	21.98	23.36	21.25	23.28	19.81	22.98	20.03	22.26	20.25	21.86	0.00	21.36	#DIV/0!	21.63	#DIV/0!	21.18	#DIV/0!	20.30	#DIV/0!	20.11	#DIV/0!		

LTSS

LTSS TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026
Approved	1,486	1,253	1,213	1,167	1,208	1,300	1,073	1,130	1,127	1,079	1,294	1,208	1,305		1,086		1,218		1,227		967		1,356		14,560	7,137
EB / IB Approved	54	168	77	175	78	200	64	184	66	188	89	174	133		178		167		180		141		137		1,364	1,089
Correction Received	0	10	0	5	0	4	0	15	0	9	0	13	0		0		1		5		5		3		14	56
Modified per Correction Request	289	173	264	105	277	64	265	135	269	69	331	97	338		257		288		241		169		175		3,163	643
TOTAL (APPROVED)	**1,829**	**1,604**	**1,554**	**1,452**	**1,563**	**1,568**	**1,402**	**1,464**	**1,462**	**1,345**	**1,714**	**1,492**	**1,776**	**0**	**1,521**	**0**	**1,674**	**0**	**1,653**	**0**	**1,282**	**0**	**1,671**	**0**	**19,101**	**8,925**
Approve as Modified	**25**	**36**	**29**	**41**	**20**	**32**	**30**	**46**	**47**	**31**	**41**	**49**	**47**		**42**		**43**		**68**		**44**		**48**		**484**	**235**
Admin Modification	**4**	**1**	**1**	**0**	**2**	**0**	**5**	**0**	**7**	**0**	**2**	**0**	**3**		**4**		**9**		**20**		**9**		**45**		**111**	**1**
Med Nec Not Justified	32	47	28	29	26	54	27	56	41	36	35	65	28		29		24		32		17		50		**369**	**287**
Member not Eligible	2	3	2	5	2	1	3	5	6	10	3	3	4		1		4		5		0		6		**38**	**27**
Not Timely	1	0	2	1	3	1	3	0	0	0	2	0	1		1		0		0		0		0		**13**	**2**
Other Insurance	8	4	7	3	4	6	3	7	4	4	3	7	5		3		3		4		5		6		**55**	**31**
TOTAL (MED NEC DENIALS)	**43**	**54**	**39**	**38**	**35**	**62**	**36**	**68**	**51**	**50**	**43**	**75**	**38**	**0**	**34**	**0**	**31**	**0**	**41**	**0**	**22**	**0**	**62**	**0**	**475**	**347**
Admin Denial (Duplicate TAR)	100	78	64	71	70	88	64	97	72	91	97	83	71		72		88		71		82		64		**915**	**508**
Admin Denial (No Auth Required)	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		**0**	**0**
Admin Denial (Void)	210	116	126	109	146	141	127	142	130	137	123	130	171		138		139		140		130		110		**1,690**	**775**
TOTAL (ADMIN DENIALS)	310	194	190	180	216	229	191	239	202	228	220	213	242	0	210	0	227	0	211	0	212	0	174	0	**2,605**	1,283
TOTAL (DENIALS)	**353**	**248**	**229**	**218**	**251**	**291**	**227**	**307**	**253**	**278**	**263**	**288**	**280**	**0**	**244**	**0**	**258**	**0**	**252**	**0**	**234**	**0**	**236**	**0**	**3,080**	**1,630**
Grievance Overturned	0	0	1	0	1	0	1	0	0	0	1	0	1		0		0		1		1		0		7	0
Overturned by Appeal	0	0	0	0	0	0	1	0	1	0	1	3	1		1		0		1		2		1		9	3
Appeal Partially Overturned	0	1	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	1
Appeal Upheld	0	4	1	0	2	0	0	2	1	0	3	1	0		2		3		4		2		1		19	7
TOTAL TARs	**2,211**	**1,894**	**1,815**	**1,711**	**1,839**	**1,891**	**1,666**	**1,819**	**1,771**	**1,654**	**2,025**	**1,833**	**2,108**	**0**	**1,814**	**0**	**1,987**	**0**	**1,999**	**0**	**1,574**	**0**	**2,002**	**0**	**22,811**	**10,802**
LTSS Nurse FTE	**10**	**11**	**10**	**11**	**9**	**13**	**9**	**13**	**9**	**13**	**10**	**15**	**11**	**14**	**13**		**11**		**11**		**11**		**11**			
Working Days	**21**	**20**	**19**	**19**	**21**	**21**	**22**	**22**	**21**	**20**	**21**	**21**	**22**	**23**	**21**	**21**	**21**	**22**	**23**	**22**	**18**	**21**	**20**	**23**		
TARs per Nurse per Day	10.53	8.61	9.55	8.19	9.73	6.93	8.41	6.36	9.37	6.36	9.64	5.82	8.71	0.00	6.64	#DIV/0!	8.60	#DIV/0!	7.90	#DIV/0!	7.95	#DIV/0!	9.10	#DIV/0!		

SUD

Wellness & Recovery (BH) TARs

TAR STATUS	JAN		FEB		MAR		APR		MAY		JUN		JUL		AUG		SEPT		OCT		NOV		DEC		PY	CURRENT
	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026	2025	2026
Approved	123	156	78	136	53	168	110	170	97	129	44	157	121		71		47		113		52		69		978	916
EB Approved	0	0	0	0	0	1	0	0	0	0	0	0	0		0		0		0		0		0		0	1
IB Approved	36	0	51	0	92	0	34	0	61	0	97	0	42		67		97		62		60		118		817	0
Correction Received	19	7	19	19	34	38	6	14	12	15	13	14	2		11		32		8		14		20		190	107
Modified per Correction Request	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
TOTAL (APPROVED)	**178**	**163**	**148**	**155**	**179**	**207**	**150**	**184**	**170**	**144**	**154**	**171**	**165**	**0**	**149**	**0**	**176**	**0**	**183**	**0**	**126**	**0**	**207**	**0**	1,985	**1,024**
Approve as Modified	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**		**0**		**0**		**0**		**0**		**0**	**0**
Admin Modification	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**		**0**		**0**		**0**		**0**		**0**		**0**	**0**
TOTAL (MED NEC DENIALS)	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Admin Denial (Duplicate TAR)	4	12	7	3	6	8	2	5	12	6	3	2	5		1		5		6		4		11		**66**	**36**
Admin Denial (No Auth Required)	0	1	1	1	0	0	0	0	0	1	0	0	2		0		1		2		0		0		**6**	**3**
Admin Denial (Void)	0	2	1	1	2	2	1	3	1	0	0	0	3		1		5		5		1		5		**25**	**8**
TOTAL (ADMIN DENIALS)	4	15	9	5	8	10	3	8	13	7	3	2	10	0	2	0	11	0	13	0	5	0	16	0	97	47
TOTAL (DENIALS)	**4**	**15**	**9**	**5**	**8**	**10**	**3**	**8**	**13**	**7**	**3**	**2**	**10**	**0**	**2**	**0**	**11**	**0**	**13**	**0**	**5**	**0**	**16**	**0**	**97**	**47**
Grievance Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
Overturned by Appeal	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
Appeal Partially Overturned	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
Appeal Upheld	0	0	0	0	0	0	0	0	0	0	0	0	0		0		0		0		0		0		0	0
TOTAL TARs	**182**	**178**	**157**	**160**	**187**	**217**	**153**	**192**	**183**	**151**	**157**	**173**	**175**	**0**	**151**	**0**	**187**	**0**	**196**	**0**	**131**	**0**	**223**	**0**	**2,082**	**1,071**
SUD Nurse FTE	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**	**2**		**2**		**2**		**2**		**2**			
Working Days	**21**	**20**	**19**	**19**	**21**	**21**	**22**	**22**	**21**	**20**	**21**	**21**	**22**	**23**	**21**	**21**	**21**	**22**	**23**	**22**	**18**	**21**	**20**	**23**		
TARs per Nurse per Day	4.33	4.45	4.13	4.21	4.45	5.17	3.48	4.36	4.36	3.78	3.74	4.12	3.98	0.00	3.60	#DIV/0!	4.45	#DIV/0!	4.26	#DIV/0!	3.64	#DIV/0!	5.58	#DIV/0!		

Total All TAR Types	**329,721**	**162,002**
	2025	**2026 Q1 & Q2**

DATA SUMMARY FOR ALL TAR TYPES

	Year	Total Griev. Over-turned	Total Appeals	Total Appeals Over-turned	% Appeals Over-Turned	Total Appeals Partially Over-turned	% Appeals Partially Over-Turned	Total Appeals Upheld	% Appeals Upheld
	2025	95	**1,661**	**245**	14.8%	0	0.0%	1,416	85.25%
Q1 & Q2	**2026**	21	**355**	85	23.9%	4	1.1%	266	74.93%

	Year	Total	Total TARs App-roved	% App-roved	Total App. as Mod.	% App. as Mod.	Total Admin. Mod.	% Admin. Mod.	Total Med. Nec. Denials	% Med. Nec. Denials	Total Admin Denials	% Admin Denials
	2025	**329,721**	246,639	74.8%	4,638	1.41%	5,010	1.5%	19,802	6.0%	51,876	15.7%
Q1 & Q2	**2026**	**162,002**	109,919	67.9%	2,594	1.60%	6,800	4.2%	11,941	7.4%	30,372	18.7%

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GRIEVANCE & APPEALS Pulse Report

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

G&A PULSE REPORT

INSIDE THIS ISSUE

ISSUE 22 | SEPTEMBER 2026

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

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

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

2Q26 HIGHLIGHTS

OVERALL NUMBERS

In 2Q26, G&A investigated 3,152 cases. The chart below shows a breakdown of the cases investigated this quarter. Of the 2,316 cases subject to DHCS-mandated timeframes, 98.8% were closed on time and 98.7% of the acknowledgement letters were sent out on time.

2Q26 TOTAL INVESTIGATED CASES		
	# of Cases	% Total
Grievance	1,963	62.3%
Exempt	784	24.9%
Appeal	353	11.2%
State Hearing	52	1.6%
Grand Total	**3,152**	**100.0%**

KEY POINTS & TRENDS

Case Volume Trends - This quarter showed a significant increase in total case volume, rising from 2,521 cases in Q1 to 3,152 cases in Q2, a 25.1% increase overall. The largest increase was seen in standard grievances, which increased from 1,537 cases to 1,963 cases. Standard Grievances increased by 27.7%, Exempt Grievances increased by 26.2%, and appeals increased by 20.9% from 1Q26 to 2Q26. Our Transportation Services Department has experienced staffing difficulties, which is likely contributing to our increased case volume. G&A also continues to see increased volume due to Community Supports cases.

Lost State Hearing 2Q26 – We lost one (1) State Hearing in 2Q26. This case was for 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.

Community Supports – Cases related to Community Supports continue to contribute to overall case volume, increasing from 130 cases in 1Q26 to 243 cases in 2Q26, an 86.9% increase. This is primarily attributable to appeals for Medically Tailored Meals. Of the 106 cases related to Medically Tailored Meals, there were 74 appeals. This increase is likely caused by an increase in members enrolled in 2Q26. Additionally, the Community Supports team confirmed there will be additional policy clarifications that will continue to drive our case volume. Benefits like Transitional Rent and Housing Deposits only apply to members without current housing, many of the cases for these benefits are complaints about being denied for services.

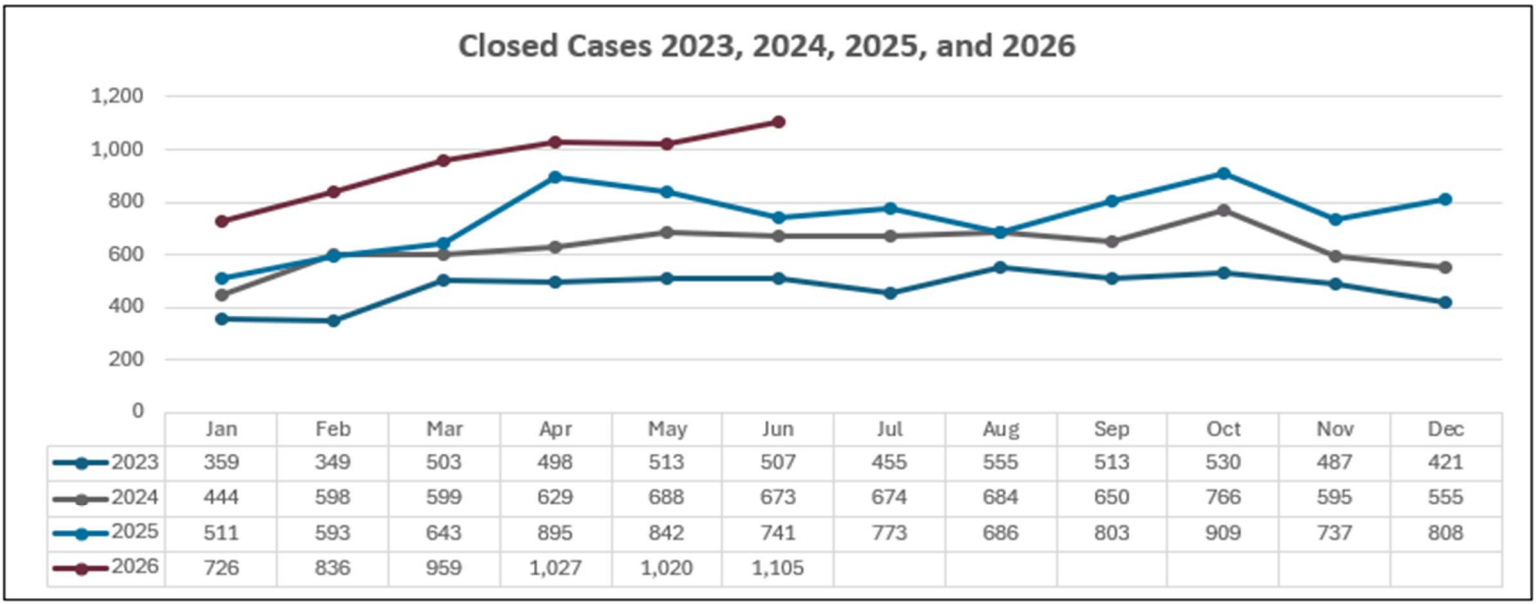
We have calculated the cases per 1,000 rates for each of the Community Supports benefits that contributed to our case volume in 2Q26, as well as the total overall below.

2Q26 Community Supports Cases by Benefit			
Benefit	# Cases	Members Enrolled	Cases per 1,000
Medically Tailored Meals	106	4,994	21.23
Housing Transition Navigation Services	50	11,263	4.44
Housing Deposits	22	454	48.46
Recuperative Care	21	1,939	10.83
Short-Term Post-Hospitalization Housing	16	1,227	13.04
Housing Tenancy and Sustaining Services	10	2,790	3.58
Transitional Rent	8	3	2,666.67
Sobering Centers	6	93	64.52
Personal Care & Homemaker	2	1,278	1.56
Day Habilitation Programs	1	1,100	0.91
Respite Services	1	632	1.58
Total	243	25,773	9.43

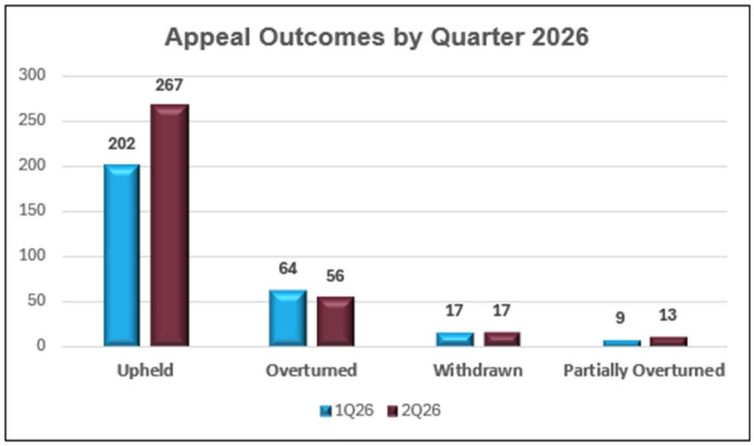
KEY STATISTICS

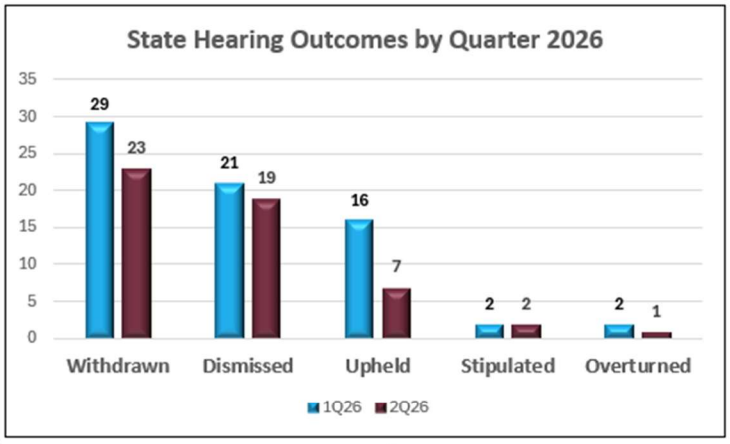
CHARTS OF KEY CASE TRENDS

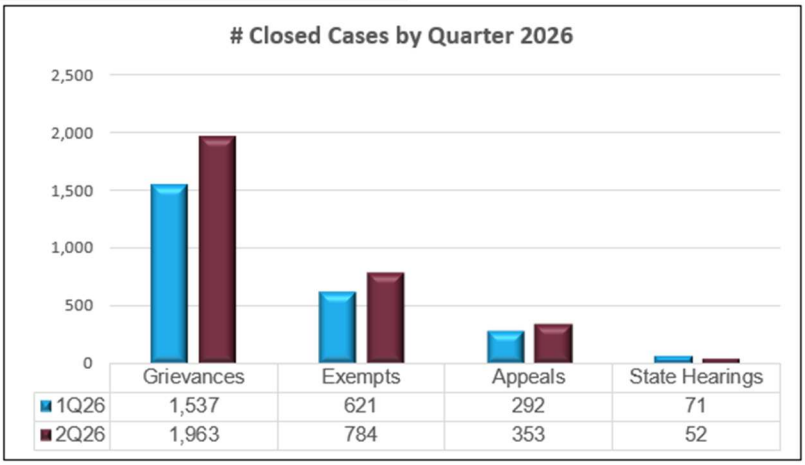
The following charts represent key data metrics used to track and trend Appeals, Grievances, and State Hearings over time.



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







	Grievances	Exempts	Appeals	State Hearings
1Q26	1,537	621	292	71
2Q26	1,963	784	353	52

STATISTICS BY REGION

CHARTS OF CASE STATISTICS BY REGION

The following charts illustrate the distribution of closed cases across each region, providing a breakdown of the total number of cases closed, the average membership, and the number of cases closed per 1,000 members for 2Q26.

2Q26 CASES PER 1,000 PARTNERSHIP OVERALL		
# of Cases	Avg Membership	Cases p/1,000
3,152	858,299	3.67

2Q26 CASES BY COUNTY AUBURN REGION			
County	# of Cases	Avg Membership	Cases p/1,000
Nevada	105	27,898	3.76
Placer	239	59,953	3.99
Plumas	23	5,268	4.37
Sierra	1	800	1.25
Total	368	93,919	3.92

2Q26 CASES BY COUNTY FAIRFIELD REGION			
County	# of Cases	Avg Membership	Cases p/1,000
Solano	381	94,508	4.03
Napa	75	26,027	2.88
Yolo	187	51,814	3.61
Total	643	172,349	3.73

2Q26 CASES BY COUNTY CHICO REGION			
County	# of Cases	Avg Membership	Cases p/1,000
Butte	332	83,090	4.00
Colusa	23	9,750	2.36
Glenn	25	12,935	1.93
Sutter	98	43,433	2.26
Yuba	102	35,752	2.85
Total	580	184,960	3.14

2Q26 CASES BY COUNTY REDDING REGION			
County	# of Cases	Avg Membership	Cases p/1,000
Lassen	29	8,084	3.59
Modoc	15	3,651	4.11
Shasta	358	63,524	5.64
Siskiyou	89	17,291	5.15
Tehama	95	28,306	3.36
Trinity	14	4,892	2.86
Total	600	125,748	4.77

2Q26 CASES BY COUNTY EUREKA REGION			
County	# of Cases	Avg Membership	Cases p/1,000
Del Norte	63	11,801	5.34
Humboldt	265	54,013	4.91
Lake	119	32,400	3.67
Mendocino	122	38,540	3.17
Total	569	136,754	4.16

2Q26 CASES BY COUNTY SANTA ROSA REGION			
County	# of Cases	Avg Membership	Cases p/1,000
Sonoma	278	102,240	2.72
Marin	114	42,329	2.69
Total	392	144,569	2.71

DEMOGRAPHICS

CHARACTERISTICS OF FILING MEMBERS

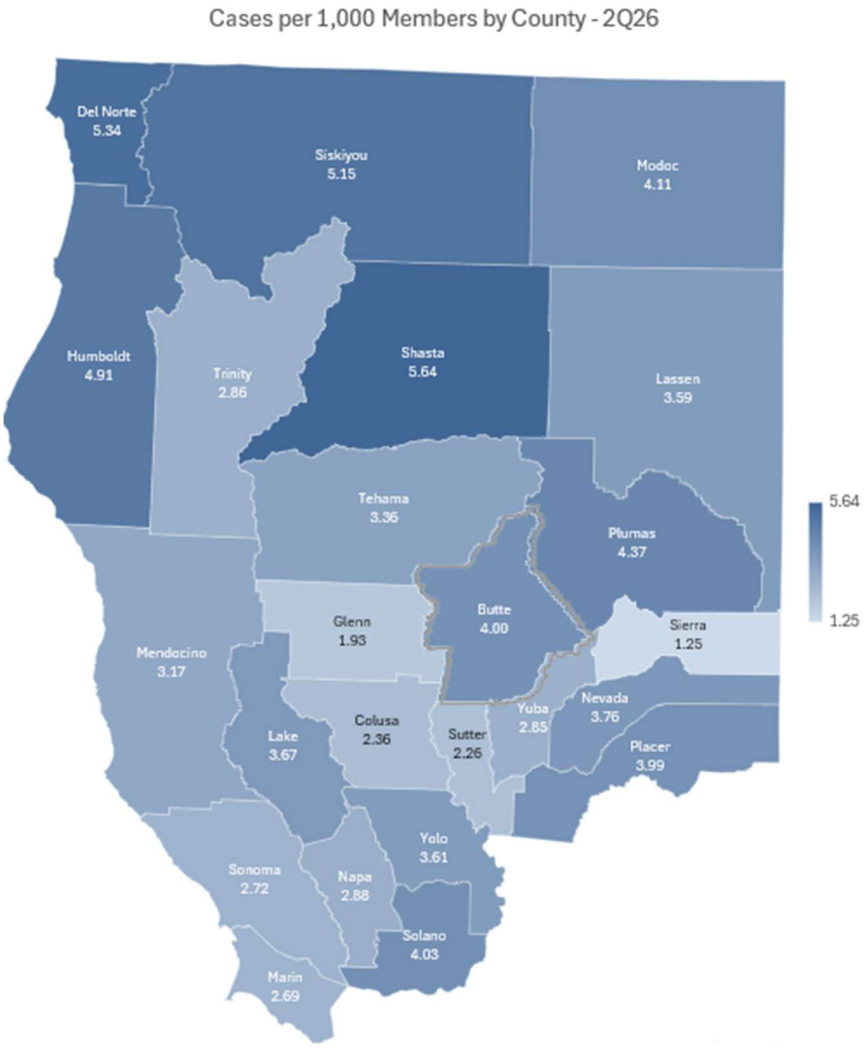
The following charts represent key demographic data of members who filed an Appeal, Grievance, or State Hearing during 2Q26.

2Q26 CASES BY GENDER		
MBR Gender	% Cases	% Membership
Female	63.1%	52.2%
Male	36.9%	47.8%
Grand Total	100.0%	100.0%

2Q26 CASES BY ETHNICITY		
Member Ethnicity	% Cases	% Membership
White	57.9%	38.2%
Other/No Response	14.9%	19.7%
Hispanic	14.6%	34.1%
Black (African American)	7.5%	3.6%
Asian	2.3%	2.4%
Native American	2.3%	1.8%
Hawaiian/Pacific Islander	0.5%	0.2%
Grand Total	100.0%	100.0%

2Q26 CASES BY AGE		
Member Age	% of Cases	% of Membership
Age 0-10	4.9%	18.6%
Age 11-19	3.5%	16.9%
Age 20-44	24.8%	33.4%
Age 45-64	42.7%	19.6%
Age 65+	24.1%	11.5%
Grand Total	100.0%	100.0%

2Q26 CASES BY LANGUAGE		
Member Language	% Cases	% Membership
English	93.7%	76.5%
Spanish	5.1%	20.0%
Other	1.0%	2.2%
Russian	0.1%	0.6%
Tagalog	0.1%	0.2%
Punjabi	0.0%	0.5%
Grand Total	100.0%	100.0%



TRANSPORTATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Transportation during 2Q26.

2Q26 STATISTICS

Transportation cases accounted for 1,637 of the total 3,152 cases closed. This represented 51.9% of all cases closed in 2Q26. This is an increase compared to the previous quarter in which 46.8% of the cases were related to transportation services. There were 1,515 Grievances (Exempt and Standard), 117 Appeals, and 5 (five) State Hearings. There were 390,526 completed trips for the reporting period. While Transportation is a main contributor to our overall case volume, transportation issues only account for 0.4% of the completed trips in 2Q26.

TRENDING ISSUES

The top five (5) providers with reported concerns in 2Q26 were Lyft (182), North Bay Transit (81), Budget Friendly (59), NorCal Transit LLC (57) and Easy Day Ride (46). Members had issues such as missed rides, driver behavior, drivers arriving late, and interruptions to care. G&A is partnering with Transportation Services to calculate the percentage of rides with concerns for the top five (5) providers. This is captured in the table below.

2Q26 Transportation Trips with Concerns by Provider			
Provider	# Cases	Trips Completed	Trips with Concerns
Lyft	182	62,929	0.3%
North Bay Transit	81	22,313	0.4%
Budget Friendly	59	7,859	0.8%
NorCal Transit LLC	57	5,849	1.0%
Easy Day Ride	46	12,372	0.4%

G&A identified multiple complaints against Transportation Services. The top three (3) complaints against the Transportation department for 2Q26 included Transportation Services' customer service, reimbursement timeframes and delays for Gas Mileage, Lodging, and/or Meals, and scheduling issues.

TRANSPORTATION SERVICES UPDATES

Transportation Services continues to use G&A data to improve provider performance, operational processes, and member satisfaction by working directly with their providers. Transportation Services has experienced staffing difficulties, which is likely contributing to the increase in volume for 2Q26. They hired 18 new staff members in June 2026, and will hire additional staff in 3Q26 to meet the staffing needs resulting from increasing utilization of this benefit. Until the new staff are onboarded and trained, G&A will likely continue to see increased transportation related concerns. One source of member dissatisfaction has been delays in reimbursements. Transportation Services has worked to improve timeliness and has confirmed reimbursements for Lodging, Meals, and Gas Mileage requests are current as of August 25, 2026.

W&R RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Wellness & Recovery (W&R) during 2Q26. It should be noted that W&R cases are measured based on the number of cases received per quarter, rather than the number of cases closed per quarter. This is due to DHCS' unique reporting of W&R cases.

2Q26 NUMBERS

Six (6) W&R cases were received and closed in 2Q26, representing 0.2% of the total concerns reported this quarter. This is the same percentage reported in 1Q26. There were no appeals reported in the first half of the year.

G&A reviews all allegations of discrimination to determine if they fall under a civil rights law. There were no W&R cases related to discrimination in 2Q26.

TRENDING ISSUES

Some members reported difficulty with program requirements. This included three (3) members reporting that their treatment provider was not assisting them in the way they expected. A member expressed frustration because the facility would not allow certain foods or transportation. The facility confirmed the member was in a medical program, which has additional rules. The member then left the program, which prevented the facility from assisting with transportation.

A member reported their treatment facility was not properly equipped to accommodate his detox. Upon investigation, it was determined that the member should have been sent to the Emergency Department (ED) for detox at a hospital prior to being admitted to the treatment facility. The original referral for services did not include the members' need for detox services. When the member arrived at the treatment facility, they were sent to the ED for detox. Partnership's Behavioral Health team assisted the member with finding additional outpatient resources for their continued treatment.

DHCS REPORTING

DHCS requires quarterly reporting of W&R cases. The below table provides the specific number of W&R cases and which case category Partnership reported to DHCS. The six (6) cases received in 2Q26 were all closed within the 30-day DHCS regulatory timeframe.

2Q26 DHCS Grievance Categories	
Access to Care	0
Quality of Care	0
Program Requirements	4
Interpersonal Relationship Issues	2
Failure to Respect Enrolee's Rights	0
Other	0

WCM RELATED

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to Whole Child Model (WCM) during 2Q26.

2Q26 STATISTICS

During 2Q26, a total of 40 WCM-related cases were closed and reported to DHCS, representing 1.3% of the total of 3,152 closed cases for this quarter. These cases are divided into 19 Appeals, 14 Standard Grievances, and seven (7) Exempt Grievances. There were no State Hearings reported in this quarter related to WCM.

TRENDING ISSUES

The top complaints reported this quarter were related to Non-Medical Transportation with 23 cases, consisting of 10 Appeals, seven (7) Grievances and six (6) Exempts. The top NMT concerns reported were driver behavior, drivers arriving late, unsafe drivers, and gas-mileage reimbursement.

There were 10 Appeal cases related to Transportation Related Expenses (TRE) and the remaining Appeals were for the following reasons: durable medical equipment (6), referral for out-of-network provider (1), treatment authorization request for gum surgery and anesthesia (1) and vision services (1).

DISCRIMINATION AGAINST WCM MEMBERS

G&A reviews all allegations of discrimination to determine if they fall under a civil rights law.

There was one (1) discrimination case reported for a WCM member during 2Q26. The member's Authorized Representative (AR) reported a provider discriminated against the member due to their disability. Upon investigation, it was determined that discrimination likely did not occur. However, a potential quality issue was discovered during the investigative process. This case was sent to the Quality Improvement department for further investigation.

ETHNICITY AND PREFERRED LANGUAGE

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

2Q26 WCM CASES BY ETHNICITY		
Member Ethnicity	**# of Cases**	**% of Cases**
White	21	52.5%
No Response	9	22.5%
Hispanic	3	7.5%
Black (African American)	2	5.0%
Other Asian	2	5.0%
Other	2	5.0%
Asian Indian	1	2.5%
Grand Total	**40**	**100.0%**

2Q26 WCM CASES BY LANGUAGE		
Member Language	**# of Cases**	**% of Cases**
English	36	90.0%
Spanish	4	10.0%
Grand Total	**40**	**100.0%**

DISCRIMINATION

REPORTING PERIOD

This section covers quarterly statistics and trends in cases related to discrimination during 2Q26. Because a member may report multiple discrimination allegations in a single Grievance, a case may fall into multiple categories. As a result, the number of concerns may exceed the total number of cases.

2Q26 DISCRIMINATION STATISTICS

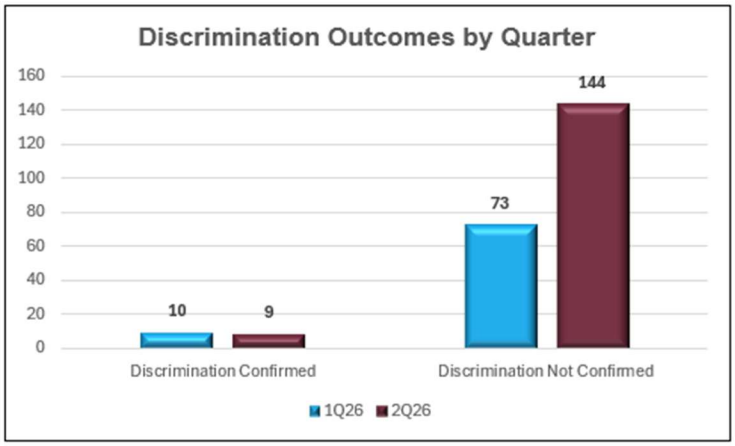
G&A changed our process for internal classification of discrimination cases when they do not fall under a protected category in 1Q26. Our reporting has been updated to only include discrimination allegations that fall under a protected category. Discrimination allegations that do not fall under a protected category are still investigated, but as a Standard Grievance.

G&A investigated 113 cases related to discrimination allegations in 2Q26. This represented 3.3% of all cases closed. Several cases alleged multiple discrimination categories.

After investigation, it was determined that discrimination likely occurred in eight (8) cases containing nine (9) discrimination categories. Disability and Race or Ethnicity were the highest concerns where discrimination was found likely, with three (3) cases each. In two (2) cases, members were requesting text-only communication with Partnership or their provider, and these requests were not accommodated. In the case against Partnership, our Transportation Department set the member up with the Transportation App (Kinetik) to set up their rides without needing to call in, but Transportation Services confirmed they were unable to accommodate text or email-only communication. Transportation Services recommended the member use an interpreter for the hearing impaired when they need to call in for services that cannot be requested through the Kinetik app.

2Q26 DISCRIMINATION TRENDS

Overall, the number of discrimination allegations has increased in number, but they continue to remain under 5.0% of total cases filed. After investigation, there were less instances where discrimination was deemed likely in this quarter compared to 1Q26.



2Q26 CASES BY CATEGORY

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

Discrimination Found Likely	
Civil Rights Category	# of Concerns
Disability	3
Race or Ethnicity	3
Language Assistance Services	1
Limited English Skills	1
Religion	1
Total	9

QUALITY ASSURANCE

INTER-RATER RELIABILITY DEFINED

The quarterly Inter-Rater Reliability (IRR) audit provides physician oversight over clinical decisions made by Partnership's Grievance Registered Nurse team. A list of cases that were not previously reviewed by a Partnership Medical Director is forwarded to Partnership's Chief Medical Officer (CMO) or designated representative, of which a sample size is selected and evaluated. The Compliance Manager and Quality & Training Supervisor complete a subsequent comprehensive review to identify opportunities for operational improvements. Due to the timing of report generation, the data discussed reflects cases closed in 1Q26.

THE RESULTS

Fifty (50) Grievances were evaluated for the 1Q26 IRR review.

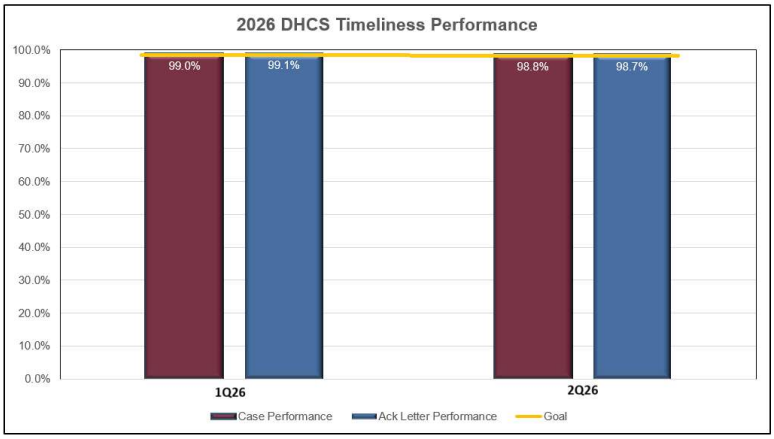
The G&A Nurse Specialists had no findings on this report.

G&A leadership identified a couple of opportunities for improvement for the remaining staff. The Grievance Case Analysts did not document their cases correctly. This includes not listing providers, listing incorrect providers, and incorrect reporting. The analysts also used incorrect DHCS categories for their cases. There were multiple instances where analysts did not send referrals within four (4) calendar days.

TIMELINESS

The target timeliness goal for closing cases and mailing acknowledgement letters is 98.3%. For 2Q26, 2,316 cases were subject to DHCS Turnaround Times (TAT). We achieved 98.8% timeliness for closing cases. The 28 cases were processed late because of delays in responses from providers, delays in sending and receiving translation requests, delays in receiving medical records and cases not being submitted by other departments timely.

There were 30 late acknowledgment letters, achieving 98.7% timeliness. Delays included internal processing challenges, delays in case induction, and issues with cases being logged incorrectly or under incorrect members.



MEMBER EXPERIENCE

REPORTING PERIOD

As required by the National Committee for Quality Assurance (NCQA), this section reports member dissatisfaction reported in the first half of calendar 2026 compared to all of calendar year 2025. The G&A department began reporting behavioral health grievances and appeals in January 2026. For more details, please reference the attached NCQA ME.7 Member Experience Threshold Reports.

OVERVIEW

There were 3,970 Grievances and Appeals closed in 1Q26 and 2Q26, compared to 6,486 in the entire year of 2025. These cases are broken into two (2) groups. Grievances accounted for 3,361 and Appeals accounted for 609. There was one (1) Second Level Grievance closed in 2025. This is no longer a case type and will not be reported on in 2026.

Partnership membership decreased by 3.6% from 901,645 to 869,061. The total number of grievances filed per 1,000 members increased to 6.88 from 6.25. For Appeals, the total number of cases filed per 1,000 members increased from 0.94 to 1.03.

G&A met the threshold for all categories of Grievances and Appeals for the first half of 2026.

Case volume has increased each quarter, even while membership has decreased. This can be attributed to the increase in Community Supports cases, staffing challenges in Transportation Services, and new training classes for Partnership departments. We will continue to monitor these trends to help improve the member experience.

GRIEVANCES

Non-Behavioral Health – Attitude and Service issues and access issues were the most frequently reported concerns, with 1,744 and 1,412 cases respectively.

Over 40.8% of the reported concerns pertained to transportation services, including missed rides, delayed driver arrivals, and scheduling inconsistencies. Commonly reported provider service concerns included poor communication, poor attitude, and treatment plan disputes.

Behavioral Health – There were 49 cases related to mental health in 1Q26 and 2Q26. Attitude and Service issues were most reported, with 35 cases.

APPEALS

Non-Behavioral Health – G&A met the threshold for all categories of Appeals for the first half of 2026. The most appealed benefits included Transportation, Durable Medical Equipment (DME), and Community Supports.

Behavioral Health – There was one (1) appeal related to mental health in 1Q26 and 2Q26. The appeal was a member reimbursement request for a stay at an inpatient mental health facility.

THE UM EXPERIENCE

REPORTING PERIOD

As required by NCQA, this section reports G&A findings about members who encountered problems with the Utilization Management (UM) processes involving authorizations or referrals in January – June 2026 compared to 2025. For more details, please reference the attached NCQA UM 1G: Member Experience-UM Threshold Report.

OVERVIEW

There were 230 reported concerns regarding the UM process from January to June 2026, compared to 426 in the entire 2025 calendar year. When comparing the first half of 2026 to all of 2025, we have met the thresholds in each category. The grievances per 1,000 rate for the first half of 2026 is 0.26. The threshold for 2026 is 0.52. If our volume continues to increase at the current pace through the remainder of the year, we will likely meet or exceed the threshold for 2026.

DISSATISFACTION WITH RAF PROCESS

Of the 230 UM concerns, 129 were associated with the Referral Authorization Form (RAF) process. Among these, 84 involved allegations that a member's primary care provider delayed submitting or processing the RAF request, resulting in delays in obtaining appointments with specialists. There were 27 cases referred to the Quality Improvement department for further investigation and review.

RAF Process	
# of Reported Concerns	
Delayed by Provider	84
Refused by Provider	20
Member dislikes overall	13
Other	5
Delayed by Partnership	4
Refused by Partnership	3
Total	129

DISSATISFACTION WITH TAR PROCESS

Members' concerns related to the Treatment Authorization Requests (TAR) process account for 101 of the 230 cases reported. The highest reported concern was members alleging their provider delayed submission of their TAR to Partnership, which was reported in 45 of the concerns. Five (5) of the cases related to the TAR process were referred to the Quality Improvement department for further investigation and review.

TAR Process	
# of Reported Concerns	
Delayed Provider	45
Delayed by Partnership	23
Member Dislikes Overall	14
Other	12
Med nec unmet by med recs	5
Refused by Provider	2
Total	101

PROVIDER FOCUSED

REPORTING PERIOD

This section highlights trends discovered from January 1, 2026, through June 30, 2026.

APPOINTMENTS

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

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

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

APPOINTMENT DELAYS WITH PROVIDERS

Primary Care Providers – During this reporting period, members submitted 88 concerns related to their primary care provider or office staff regarding difficulties accessing appointments, either in person or by phone. The highest number of cases were attributed to Jayesh Patel, MD, with seven (7) reported concerns, followed by Solano County Health Services and River Bend Medical Associates, each with four (4) reported concerns. Due to their higher volumes of reported concerns, they are subject to ongoing monitoring and corrective action, as appropriate, to ensure compliance and improve member access.

Behavioral Health – Effective September 2025, Carelon is no longer delegated for managing grievances and appeals for the er behavioral health benefit. We will now report on Behavioral Health specific providers in addition to Primary Care Physicians and specialists. Members reported difficulties obtaining appointments with two (2) behavioral health providers in the first half of 2026.

Specialists – Partnership approves access to specialists through the RAF process. High-volume and high-impact providers include cardiologists, dermatologists, ophthalmologists, orthopedists, general surgeons, and OB/GYNs. These providers are closely monitored to ensure timely appointments are available for our members. There were six (6) cases reported showing members had difficulties accessing appointments, either in person or by phone. Three (3) of the six (6) reported cases were involving a high impact provider.

MEETING CULTURAL & LINGUISTIC NEEDS

Partnership monitors our provider network to ensure it reflects and supports the cultural, ethnic, racial, gender, and linguistic diversity of our membership. During the reporting period, six (6) cases were filed against medical groups or individual providers. One (1) case was filed against a mental health provider. Four (4) cases against medical groups or individual providers were reported in the Solano region. One (1) case against medical groups or individual providers was reported in the Santa Rosa region. One (1) case against a behavioral health provider was reported in the Auburn region.

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPQP1002 (previously QP100102)</td><td colspan="3">Lead Department: Health Services
Business Unit: Quality Improvement</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Quality/Utilization Advisory Committee</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 12/1998</td><td colspan="4">Next Review Date: ~~04/14/2027~~10/14/2027
Last Review Date: ~~04/08/2026~~10/14/2026</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="3">☐ EXECUTIVE</td><td>☐ COMPLIANCE ☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="3">☐ COMPLIANCE</td><td>☐ FINANCE ☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="3">☐ 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: ~~04/08/2026~~10/14/26</td></tr>
</table>

I. RELATED POLICIES:

A. MPQP1003 – Physician Advisory Committee (PAC)
B. MPQP1004 – Internal Quality Improvement Committee
~~B.~~C. MPQP1008 – Conflict of Interest Policy for QI Activities
~~C.~~D. MPQP1016 – Potential Quality Issue Investigation and Resolution
~~D.~~E. MPQP1053 – Peer Review Committee
~~E.~~F. CMP10 – Confidentiality
~~F.~~G. CMP36 – Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

A. Health Services
B. Grievance & Appeals
C. Member Services
D. Provider Relations

III. DEFINITIONS:

A. Partnership Advantage: Effective Jan. 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 E~~e~~nrollees 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 Jan. 1, 2028 and subject to CMS and DHCS approval.

A.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The Quality/Utilization Advisory Committee (Q/UAC) is responsible for monitoring the quality of comprehensive medical care and services provided to Partnership HealthPlan of California's members. The

committee's goals are to ensure quality improvement efforts are prioritized, resources are appropriate, and processes are in place for providing quality, appropriate and safe healthcare to members. The Q/UAC reviews Partnership's Health Services departments' activities, makes recommendations, and serves as an appeal body on certain medical care issues. On occasion, the Q/UAC may review Grievance & Appeals, Member Services, and Provider Relations policies. The Q/UAC may establish inpatient and ambulatory review subcommittees as needed to accomplish its responsibilities. A ~~subcommittee~~ clinician subset of the Q/UAC serves in a confidential capacity as part of the Peer Review Committee (PRC).

The Q/UAC provides policy and other recommendations to the Physician Advisory Committee. PAC is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to Partnership members and is comprised of the Chief Medical Officer (CMO) and participating clinician representatives from primary and specialty care disciplines.

VI. POLICY / PROCEDURE:

A. Committee Structure

1. Composition

a. The Q/UAC is chaired by the CMO and comprised of formal voting representatives from community primary and specialty care practices and consumer representative(s). Licensed physicians and non-physician advanced practice clinicians (e.g., psychologists, nurse practitioners, physician assistants and certified nurse midwives) may serve on the committee. These clinician members of the committee represent licensed providers of hospitals, medical groups, and practice sites in geographic sections of Partnership's service area. The consumer representative(s) must be a consumer from one of the counties served by Partnership.

1) Committee members serve open terms and may submit resignation to the CMO or his designee.

2) Voting members with annual attendance of <50% are evaluated for termination from the Q/UAC.

b. The following Partnership staff or their delegates serve as non-voting members:

Quality/Utilization Advisory Committee Standing Members	
Department Represented	**Position Title**
Administration	Director, Grievance and Appeals
Health Services	Chief Medical Officer – Committee Chair
	Medical Director for Quality – Committee Vice Chair
	Deputy Chief Medical Officer
	Medical Director for Medicare Services
	Behavioral Health Clinical Director
	Regional and Associate Medical Director(s)
	Chief Health Services Officer
	Senior Director of Quality and Performance Improvement
	Senior Director of Care Management
	Director of Health Equity (Health Equity Officer)
	Director, Population Health Management
	Director, Enhanced Health Services
	Director(s) and Associate Director(s), Utilization Management
	Director(s) and Associate Director(s), Care Coordination
	Director, Pharmacy Services
	Manager, Member Safety - Quality Investigations

	Manager, ~~Clinical Compliance~~Member Safety – Quality Inspections
	Senior Health Educator
Provider Relations	Senior Provider Relations Rep Manager or designee

2. Minutes: Minutes are taken at all meetings. Approved minutes are submitted monthly to Regulatory Affairs and Compliance (RAC) inbox. RAC submits these minutes quarterly to the Department of Health Care Services (DHCS) and forwards the tracking documentation to the designated QI staff.
3. Chair: The CMO chairs the Q/UAC. The Medical Director for Quality serves as vice chair. When neither is available, a Medical Director or a non-Partnership clinician member of the Q/UAC acts as temporary chair.
4. Meetings: The Q/UAC meets at least ten (10) times a year with the option to add additional meetings if needed.
5. Compensation: Non-Partnership clinician and consumer committee members are eligible to receive a financial stipend for each meeting attended (unless otherwise compensated by Partnership for management responsibilities). This stipend may be in addition to other compensation when the member serves as a clinical consultant/physician adviser.
6. Voting: Only consumer and non-Partnership clinician members constitute the voting membership, with the CMO or acting chair serving in a tie breaking capacity as necessary. A quorum is 50% or more of the total voting members.
7. Confidentiality: To preserve an atmosphere promoting free and open discussion between and among committee members, each committee member signs an annual Confidentiality Agreement prepared and retained by Partnership. This agreement signifies the intent to protect individuals against misuse of information and to ensure all information, medical or otherwise, regarding patients, practitioners and providers is handled in a confidential manner.
8. Conflict of Interest: Each committee member signs an annual Conflict of Interest statement prepared and retained by Partnership.

B. Committee Responsibilities

1. Annually reviews, recommends, and approves the Utilization Management Program Description submitted by Health Services' Utilization Management department.
2. Annually reviews, recommends, and approves the Quality Improvement Program Description, Program Evaluation, and Work Plan submitted by Health Services' Quality Improvement department.
3. Annually reviews, recommends and approves the Population Health Management Strategy and Program Description and other Population Health documents as required.
4. Annually reviews, recommends and approves the Cultural & Linguistic Program Description, Program Evaluation, and Work Plan.
5. Annually reviews, recommends and approves the Care Coordination Program Description, status reports, and case management activities.
6. Annually reviews, recommends and approves ~~the Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description~~ the Health Equity and Community Reinvestment Strategy and Program Description and other Health Equity documents as required.
7. Annually reviews and makes recommendations for medical policy, new technology, and protocol changes based on guidelines and standards of practice; makes recommendations on Clinical Practice Guidelines (CPGs) and preventive health guidelines to the PAC.
8. Makes recommendations and approves Partnership policies addressing, but not limited to, quality improvement, utilization management, care coordination and health equity activities.
9. Approve and ensure implementation of evidence-based guidelines and policies of medical practice

including preventive, chronic care, and behavioral health initiatives.

10. Identifies, reviews, and recommends improvements in all areas pertaining to the quality and appropriateness of medical care. Advises staff on selection and prioritization of quality improvement activities.
11. Develops and/or approves clinical criteria used by UM staff to perform prospective and concurrent inpatient, ambulatory review or other utilization activities.
12. Reviews utilization, financial, and other staff reports that display the utilization of services and outcomes of quality within the delivery system.
13. Serves as a review body to assist in the interpretation of medical benefit coverage based on medical necessity and appropriateness issues.
14. Provides oversight of delegated utilization management and quality improvement activities.
15. Reviews performance dashboards and make recommendations for corrective action on indicators that fall below established thresholds; ensures follow-up on corrective actions where identified.
16. Reviews and provides recommendations for member-related activities including Consumer Assessment of Healthcare Providers and Systems (CAHPS®), grievances, telephone access, appointment access, availability and other member satisfaction surveys.
17. ~~Oversees the activities of its subcommittee, the Peer Review Committee (PRC), which serves as a peer review body for medical care issues. PRC members include clinician members of the Q/UAC and Partnership staff. PRC's charter is described in both MPQP1053 – Peer Review Committee and MPQP1016 - Potential Quality Issue Investigation and Resolution.~~

C. Committee Accountability
   1. The Q/UAC has oversight responsibility for the development, implementation, and effectiveness of the quality improvement and utilization management programs. The Q/UAC is accountable to the PAC, and through this body, to the Partnership Board of Commissioners on Medical Care.

D. Delegation Oversight and Monitoring
   1. Partnership may delegate~~s~~ quality improvement activities, responsibilities and committee structure.
   2. A formal agreement is maintained and inclusive of all delegated functions.
   3. Partnership conducts oversight and monitoring activities, including ~~an~~ audit~~s~~ ~~not~~ no less than annually, to ensure ~~the~~ appropriate policy and procedures are ~~in place~~maintained.~~.~~
   4. Results from Oversight and Monitoring activities shall be presented to DORS for review and approval.

VII. REFERENCES:
N/A

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer/Committee Chair

X. REVISION DATES:
Medi-Cal
06/21/00; 03/21/01; 05/15/02; 10/16/02; 09/15/04; 03/15/06; 03/21/07; 02/20/08; 03/18/09; 04/21/10; 09/19/12; 09/18/13; 04/16/14; 04/15/15; 04/20/16; 04/19/17; *06/13/18; 05/08/19; 09/11/19; 03/11/20; 09/09/20; 09/08/21; 09/14/22; 09/13/23; 09/11/24; 04/09/25; 04/08/26; 10/14/26

Partnership Advantage (effective January 1, 2028~~7~~)

Policy/Procedure Number: MPQP1002 (previously QP100102 ~~& MPQP1002~~)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Quality/Utilization Advisory Committee			☒**External Policy** ☐**Internal Policy**
Original Date: 12/1998		**Next Review Date:** ~~04/14/2027~~10/14/2027 **Last Review Date:** ~~04/08/2026~~10/14/2026	
Applies to:	☐ **Employees**	☒**Medi-Cal**	☒**Partnership Advantage**

N/A

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

PREVIOUSLY APPLIED TO:
PartnershipAdvantage
MPQP1002 - 03/21/2007 to 01/01/2015

Healthy Families
MPQP1002 - 10/01/2010 to 03/01/2013

Healthy Kids
MPQP1002- 03/21/2017 to 12/01/2016 (Healthy Kids program ended 12/01/2016)

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1008 (previously QP100108 & KK Q1201)			**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Conflict of Interest Policy for QI Activities			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1994		**Next Review Date:** ~~08/13/2026~~10/14/2027 **Last Review Date:** ~~08/13/2025~~10/14/2026		
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:** ~~08/13/2025~~10/14/2026	

I. RELATED POLICIES:

A. CMP10 – Confidentiality
B. MPQP1053 – Peer Review Committee
C. MPQP1002 – Quality/Utilization Advisory Committee
D. MPCR200 Credentials ~~ing~~ Committee and CMO Credentialing Program Responsibilities
~~D.~~E. CMP-21 – Conflict of Interest Code

II. IMPACTED DEPTS:

A. Health Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. Conflict of Interest Agreement

V. PURPOSE:

To describe the mechanism to ensure that a conflict of interest does not exist when contracted providers, who are members of Partnership HealthPlan of California (Partnership) committees, perform peer review or quality improvement activities.

VI. POLICY / PROCEDURE:

A. All non-Partnership persons involved in Partnership peer review activities or committees shall sign a conflict of interest statement annually. Signed statements are retained in Quality Improvement department files.
B. Conflict of interest is defined as any involvement in the care of the member involved in the review, any fiduciary interest or ~~fiduciary~~ relationship with the provider under review, or any other involvement in the case that may ~~impact~~ impair objectivity in performing the review. Note – a provider is a broad term that could include physicians or other direct care providers and vendors.
C. Committee members or peer reviewers with a conflict of interest in a particular case will notify the Medical Director for Quality or the Committee Chair, and excuse themselves from receiving related materials and from participating in the review.
D. Should a situation arise wherein this policy is not followed, the appropriate Committee and/or its Chair will determine appropriate action and notify the individuals(s) verbally and in writing.

Policy/Procedure Number: MPQP1008 (previously QP100108 & KK Q1201)			**Lead Department: Health Services** Business Unit: Quality Improvement
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Original Date: 04/25/1994			**Next Review Date: 08/13/202610/14/2027** **Last Review Date: 08/13/202510/14/2026**
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VII. REFERENCES:

A. Cal. Civ. Code § 43.7 – Immunity from Liability for Peer Review Activities~~N/A~~

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal
01/27/95; 10/10/97 (name change only); 12/98; 6/21/00; 05/16/01; 08/20/03; 09/15/04; 04/19/06; 04/18/07; 02/20/08; 03/18/09; 04/21/10; 08/15/12; 08/20/14; 09/16/15; 10/19/16; 11/15/17; *10/10/18; 11/13/19; 11/11/20; 11/10/21; 11/09/22; 11/08/23; 11/13/24; 08/13/25; 10/14/26

Partnership Advantage (effectiveness Jan. 1, 202~~7~~)
N/A

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

PREVIOUSLY APPLIED TO:
Partnership*Advantage*:
MPQP1008 - 04/18/2007 to 01/01/2015
Healthy Families:
MPQP1008 - 08/15/2012 to 03/01/2013 Healthy Kids: (KK QI201, MPQP1008)
04/18/07; 02/20/08; 03/18/09; 04/21/10; 08/15/12; 08/20/14; 09/16/15; 10/19/16 to 12/01/16 (Healthy Kids Program ended 12/01/2016)

PARTNERSHIP HEALTHPLAN of CALIFORNIA

CONFLICT of INTEREST AGREEMENT

As a voting member of Partnership HealthPlan of California's Peer Review Committee, Quality/Utilization Advisory Committee, Credentials Committee or any other peer review entity involved in peer review, I recognize that absence of conflict of interest is vital to the unbiased and candid decisions necessary for effective peer review activities. Therefore, I agree to report any conflict of interest, potential or confirmed, to the Medical Director for Quality or the specific Committee Chair.

As a peer reviewer with a conflict of interest regarding any matter being reviewed or brought before a committee, I will refrain from participation in or completion of said peer review. I will also refrain from casting a vote on any related issue and shall absent myself from any proceedings of the committee in which such issues are raised for consideration.

A conflict of interest is defined as any involvement in the care of the member involved in the review, any fiduciary interest in or relationship with the provider or vendor in question, or any other involvement in the case that may impair objectivity in performing the review.

Furthermore, my participation in peer review and quality improvement activities is in reliance on my belief that the absence of conflicts of interest related to these activities will be similarly ~~preserved~~ maintained by every other member of the committee or other individuals involved. I understand that Partnership HealthPlan of California is entitled to undertake such action as is deemed appropriate to ensure that this confidentiality is maintained, including action necessitated by any breach or threatened breach of this agreement.

_____
SIGNATURE

_____
PRINTED NAME

_____
DATE

_____ _____
WITNESS DATE

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1022 (previously QP100122)			**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Site Review Requirements and Guidelines			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 10/30/2002 (vs. 10/16/2002)		**Next Review Date:** ~~01/13/2027~~10/14/2027 **Last Review Date:** ~~05/13/2026~~10/14/2026		
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**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~05/13/2026~~10/14/2026	

I. RELATED POLICIES:

A. MCQP1052 - Physical Accessibility Review Survey – SR Part C
B. MPQP1016 - Potential Quality Issue Investigation and Resolution
C. ~~MCUP3101~~MPBP8007 - Screening and Treatment for Substance Use Disorders
D. MCQP1021 - Initial Health Appointment
E. MPCR601 - Fair Hearing and Appeal Process for Adverse Decisions
F. MPPR208 - Provider Notification of Provider Termination, Site Closure or Change in Location Information
G. MCQG1015 - Pediatric Preventive Health Guidelines
H. MCQG1005 - Adult Preventive Health Guidelines
I. CMP36 - Delegation Oversight and Monitoring
J. MCUG3118 - Prenatal & Perinatal Care
K. MPCR12 - Credentialing of Individual ~~dependent~~ and Private Duty Nurses Under EPSDT
L. MPCR300 – Provider Credentialing and Re-credentialing Requirements
M. MCQP1025 Substance Use Disorder (SUD) Facility Site Review and Medical Record Review
N. MCUP3044 Urgent Care Services

II. IMPACTED DEPTS:

A. Provider Relations
B. Health Services
C. Compliance
D. Grievance and Appeals

III. DEFINITIONS:

A. Primary Care Practice Site: a facility that provides services such as family medicine, internal medicine, pediatrics, and/or obstetrics and gynecology.
B. Supplemental Facility: Mobile, Satellite, School Based, and other Extension Clinics. Supplemental facilities assist in the care delivery of primary care services to geographically remote areas that lack health care services, as well as assist the underserved population in areas where there may be access to care concerns.
~~C. Free-Standing Urgent Care Provider: An outpatient facility contracted with Partnership HealthPlan of California to provide in-person visits for Urgent Care Services. These providers/facilities are not contracted to provide comprehensive primary care services and are not owned or administered by a hospital or primary care provider contracted with Partnership~~.
~~D.~~C. Free Standing Urgent Care Center: An outpatient facility contracted with Partnership HealthPlan of

California to provide in-person visits for Urgent Care Services. These providers/facilities are not contracted to provide comprehensive primary care services and are not owned or administered by a hospital or primary care provider contracted with Partnership.

~~E.~~D. Shared Medical Record Practice: Multiple PCP's see the same patients and utilize the same medical records for documentation of patient care. In a shared medical record system, medical records are not identifiable as separate records belonging to any specific provider.

IV. ATTACHMENTS:

A. Facility Site Review Tool
B. Facility Site Review Standards
C. Medical Record Review Tool
D. Medical Record Review Standards
E. Cognitive Assessment Addendum to Site Review
F. Non-Accredited Facility Site Review Tool
G. Non-Accredited Facility Review Standards
H. Private Duty Nursing Site Review Tool and Standards
I. Supplemental Facility/Mobile Unit/Street Medicine Facility Site Review Tool
J. Free Standing Urgent Care Clinic Facility Site Review Tool
K. Urgent Care Medical Record Tool
~~L. PCP providing Urgent Care Facility Site Review Tool~~
~~M.~~L. Palliative Care Facility Site Review Tool
~~N.~~M. Palliative Care Medical Record Review Tool
~~O.~~N. Master Trainer Application
~~P.~~O. Interim Review Template
~~Q.~~P. Provider Certificate

V. PURPOSE:

A. To provide primary care practice sites a comprehensive guideline for Site Review (SR) requirements and processes. A Site Review (SR) is comprised of a Facility Site Review (FSR) and a Medical Record Review (MRR). The FSR and MRR tools were developed by a collaborative coalition made up of staff from Department of Health Care Services (DHCS) and Medi-Cal Managed Care health plans (MCP). The purpose of the SR is to ensure that practicing sites have sufficient capacity to:
   1. Provide appropriate services;
   2. Carry out processes that support continuity and coordination of care;
   3. Maintain patient safety standards and practices;
   4. Operate in compliance with applicable federal, state, and local laws and regulations.

B. Findings of the SR are used to:
   1. Provide information for credentialing/re-credentialing decisions;
   2. Identify areas where education and technical assistance is needed;
   3. Identify and share best practices in patient safety, medical error prevention, and provision of quality care.

VI. POLICY / PROCEDURE:

A. Requirements
   1. **Site Review Personnel**
      The Partnership HealthPlan of California (Partnership) Chief Medical Officer (CMO) is ultimately responsible for SR activities completed by Partnership personnel. Partnership has designated a minimum of one Registered Nurse (RN) to be certified as a Master Trainer by the Department of

Health Care Services (DHCS).

a. Site Review Training and Certification

1) Partnership's Certified Master Trainer (CMT) is responsible for training, supervising and certifying Site Reviewers in addition to monitoring reviews and evaluating Certified Site Reviewers (CSR) for accuracy.
2) Site Review activities comply with the Site Reviewers' scope of practice as defined by state law, in accordance with the state licensing and certification agencies and are appropriate to the Site Reviewers' level of education and training.
3) Licensed physicians (MDs or DOs), nurse practitioners (NPs), physician assistants (PAs), clinical nurse midwifes (CNM), licensed midwife (LM), and registered nurses (RNs), are eligible to be a Site Reviewer and may perform a SR independently and sign off on the FSR and MRR tools.
4) Site Reviewers can independently make determinations regarding implementation of appropriate reporting or referral of abnormal review findings for further review.
5) DHCS will recertify the Master Trainer(s) every three years.
6) Partnership's CMT will recertify CSRs every three years. Upon certification and recertification, Site Reviewers will receive written verification of certification from Partnership.
7) MDs, DOs, NPs, PAs, CNM, LM, and/or RNs that are designated to be a CMT or CSR must meet the certification and recertification requirements outlined in the table below.

Policy/Procedure Number: MPQP1022 (previously QP100122)			**Lead Department:** Business Unit**: Quality Improvement**
Policy/Procedure Title: Site Review Requirements and Guidelines			☒ **External Policy** ☐ **Internal Policy**
Original Date: 10/30/2002 (vs. 10/16/2002)		**Next Review Date:** ~~01/13/2027~~10/14/2027 **Last Review Date:** ~~05/13/2026~~10/14/2026	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

Initial Certification Requirements	**Certified Master Trainer (CMT)**	**Certified Site Reviewer (CSR)**
Possess a current registered nurse (RN), Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), NP,PA, CNM or LM license	x	x
Be employed or subcontracted with Partnership	x	x
Have experience in conducting training in a health related field, or conducting quality improvement activities, such as medical audits, Site Reviews, or utilization management activities within the last three years.	x	
Complete 20 FSRs and 20 MRRs and one year experience as a CSR. Achieve an inter-rater score within 5% of FSR and 5% of MRR from the DHCS Nurse Evaluator.	x	
Attend didactic Site Review training or completion of DHCS Site Review training modules on the current Site Review tools under supervision of a CMT.		x
Complete 10 FSRs and 10 MRRs with a CSR or CMT.		x
Achieve an Inter-rater score of 10% in FSR and 10% in MRR with designated CMT.		x

Recertification Requirements	**Certified Master Trainer**	**Certified Site Reviewer**
Possess a current registered nurse (RN), Doctor of Medicine (MD), Doctor of Osteopathic Medicine (DO), NP, PA, CNM or LM license	x	x
Be employed or subcontracted with Partnership	x	x
Be responsible for staff training on the most current DHCS Site Review tools and standards	x	
Participate in DHCS sponsored Site Review trainings as well as Site Review Work Group (SRWG) meetings and teleconferences.	x	
Maintain CMT certification.	x	
Complete a minimum of 30 Site Reviews following initial certification or recertification. (every 3 years)	x	x
Attend DHCS sponsored inter-rater workshops in person or virtually every three years.	x	x
Achieve a 5 % variance on the MRR, on the inter-rater score as defined by the SRWG and DHCS	x	
Achieve a 10 % variance on the MRR, on the inter-rater score as defined by the SRWG and DHCS		x

b. Inter-Rater Review (IRR) Process
   1) CMT and CSR candidates must complete an inter-rater review (IRR) as part of the initial certification and the recertification process.
      a) The IRR process requires the CMT candidate to concurrently complete and score a Site Review with a DHCS Nurse Evaluator utilizing the DHCS FSR and MRR tools and standards.
      b) The IRR process requires the CSR to concurrently complete and score a Site Review with the Partnership CMT according to the DHCS FSR and MRR tools and standards.

2) If the CMT or CSR does not meet the appropriate inter-rater score variance (see chart above), he or she may repeat the process one time. The appropriate inter-rater and candidate with the failing inter-rater score will jointly assess training needs and implement a training plan prior to conducting the second inter-rater review.
   a) CMT and CSR candidates that do not meet the appropriate inter-rater variance score for the second inter-rater review must wait six (6) months to reapply for certification.

2. **Full-Scope Site Review**
A full-scope SR consists of a CSR or CMT conducting both the FSR and the MRR using the most current tools and standards required by the DHCS. (See Attachments A-D.) All PCP and Supplemental sites must comply with the Site Review requirements within DHCS APL 22-017 in order to remain in the Partnership network. Any site review concerns that reveal significant quality of care issues will be forwarded to the Chief Medical Officer (CMO) or the Medical Director of Quality for further guidance.
   a. FSR is a review of the practice's site, processes, and covers the following areas:
      1) Access/Safety
      2) Personnel
      3) Office Management
      4) Clinical Services
      5) Preventive Services
      6) Infection Control
   b. MRR areas include:
      1) Format (All sites)
      2) Documentation (All Sites)
      3) Continuity/Coordination (All sites)
      4) Pediatric Preventive (Family Practice & Pediatric sites, and OB/GYN sites if applicable)
      5) Adult Preventive (Family Practice, Adult Medicine sites, and OB/GYN sites)
      6) OB/CPSP Preventive (PCP sites that provide OB services and OB/GYN sites)
3. **Initial Site Review (SR) Process**
   a. An initial SR consists of an initial FSR and an initial MRR.
   b. The FSR is conducted first to ensure the site operates in compliance with all applicable local, state, and federal laws and regulations. Members are not assigned to providers until the site has received a passing score and all CAP items are completed and signed off. An initial FSR is not required when a new provider joins a site that has a current passing FSR score.
   c. DHCS releases sets of DHCS Site Identification (DHCS Site ID) numbers per county and Partnership issues individual ID'S to each site based on the county identification ID'S provided by DHCS. In the event of an ownership change, a new DHCS Site ID will be assigned.
      1) Pre-contracted providers who do not pass the initial FSR within two attempts may reapply to Partnership after six months.
   d. An initial MRR must be completed within 90 days of the date that members were first assigned to the site.
      1) This may be deferred an additional 90 calendar days only if the new PCP does not have enough assigned members to complete the MRR on the required minimum number of records.
      2) If after 180 days following assignment of members and the site still has fewer than the required number of medical records, a MRR on the total number of records available will be completed. Scoring on the MRR tool will be adjusted according to the number of medical records reviewed.
      3) MRR's may be conducted virtually or on-site. The virtual process must comply with all applicable Health Insurance Portability Accountability Act (HIPAA) standards at all times.

e. An Initial Site Review is required when:
   1) A new site is added to the Partnership network;
   2) A newly contracted provider assumes a site with a previous failing FSR and/or MRR score within the last three years;
   3) A site is returning to the Partnership network and has not had a passing FSR within the last three years;
   4) Identification of multiple independent practices that occupy the same site;
   5) There is a change of name or ownership of an existing provider site;
   6) A site relocation requires that Partnership must:
      a) Complete an initial FSR within 60 days of notification or discovery of the completed move;
      b) Allow existing members to continue to see the provider;
      c) New members will not be assigned to the site until the site receives a passing FSR and MRR score.

f. If Partnership expands to a new service area, the FSR portion of the initial Site Review must be completed prior to the start of new or expanding operations. Requirements are outlined as following:
   1) Five percent of the PCP sites in the new network service area, or 30 sites, whichever is greater in number;
   2) All of the remaining PCP sites in the new network service area within the first six months of expansion;
   3) All of the PCP sites in the new network service area if there are 30 or fewer PCP sites;
   4) Partnership may use site reviews of existing county MCP's as evidence of completion of the initial site reviews;
   5) Partnership must submit data and relevant information to DHCS in the format and timeframe to be specified by DHCS for expansion.

4. Supplemental Facilities-Mobile, Satellite, School Based, and Other Extension Clinics
   a. Supplemental facilities that provide primary care services will undergo an initial Site Review and a subsequent site review at least every three years thereafter, with a focus on areas relevant to the services being provided by the supplemental facilities.
5. Subsequent Site Reviews
   a. Subsequent SRs consist of a FSR and MRR at least every three years, beginning no later than three years after the initial FSR. Site Reviews may be conducted more frequently per county collaborative discussions, when determined necessary based on monitoring or evaluation, or for CAP follow up issues.

VII. Scoring

A. FSR and MRR scores are based on available documented evidence, demonstration of the criteria, and verbal interviews with site personnel. If a site reviewer chooses to review additional criteria not included on the FSR or MRR tools, the site reviewer must not include the additional criteria in the existing scoring method. Scores are based on established scoring procedures, located in the FSR and MRR tools. Sites will receive a separate score for the FSR and/ or MRR.
   1. FSR Scoring
      a. The FSR is composed of critical and non-critical elements. Critical Elements (CE) are indicated on the tool by bold and underlined text. CEs have the largest potential for adverse effects on patient health and safety and therefore, have a scored weight of two points, while non-critical elements have a scored weight of one point.
      b. The Site Reviewer will advise the practice site of any deficiencies in critical elements during the SR.
      c. A CE deficiency will automatically result in a Corrective Action Plan (CAP) for all noted

deficiencies.

d. Partnership will conduct a meeting to verify all CE's are completed.
e. The FSR tool points will differ from site to site because the "not applicable" items do not factor into the scoring where noted. All standards where review determinations result in a "N/A" (non-applicable), "R" (refusal) or "No" shall include an explanation regarding this finding.

2. MRR Scoring
   a. All MRR tool elements have a score weight of one point each
   b. The MRR score is based on a standard review of randomly selected member medical records that represents the assigned member population.
      1) For sites that only serve pediatric or adult patients, all records must be reviewed using the appropriate preventative care criteria for adults, pediatrics (pregnant under 21 years) and/or obstetrics.
      2) Pediatric preventative services are provided to members under 21 years of age in accordance with current AAP bright futures recommendations.
      3) Adults age 21 years and older, preventative services are provided in accordance with USPSTF A and B recommendations.
      4) OB/GYN acting as a PCP must provide care in accordance with American College of Obstetricians and Gynecologists (ACOG) and Comprehensive Prenatal Standards Program (CPSP).
         a) All medical records must be reviewed using the preventative care criteria for adults or pediatrics (pregnant members under the age of 21 years) and obstetrics.
         b) During the MRR review, reviewers have the option to request additional medical records for review. If the Site Reviewer chooses to review additional medical records, the scores must be calculated accordingly.
         c) If the minimum number of records is not available, Partnership will document the rationale and complete the MRR with the available records.
         d) If the site has multiple providers using the same medical record, this is considered a shared medical record system. In a shared medical record system, medical records are not identifiable as separate records belonging to any specific provider.
            i. The minimum number of records to be reviewed in a "shared" medical record relationship is determined by the number of providers at the site, unless otherwise approved by DHCS. See chart below

# Practitioners	# Medical Records to be reviewed
1-3	10
4-6	20
7 or more	30

         e) In the event that there are multiple providers in one office that do not share medical records, each provider must be reviewed separately and receive a separate score.
         f) MRR's may be conducted on-site or virtually and must comply with all HIPAA standards.
         g) The MRR total points will differ from site to site, depending on the number of physicians and types of records that are selected. The "N/A" items do not factor into the scoring where noted. All standards where review determinations result in a "N/A" shall include an explanation regarding this finding. Compliance level categories include: Exempted Pass, Conditional Pass, and Fail. See correlating table.

3. **Failing score**
   a. Contracted PCP and Supplemental sites who serve Partnership members must receive a passing

score of 80% on both the FSR and MRR to be considered passing. Sites with a score below 80% will be placed on an annual review cycle for their next review.

a. If a site fails the FSR or MRR, new members will not be assigned to the site until a CAP is initiated, completed, and closed.
b. If the site receives two consecutive failing Site Review scores (FSR or MRR), then on the third attempt the site must receive a minimum passing score on the FSR and/or MRR to remain in the Partnership provider network.
c. If the site fails on the third consecutive attempt, the site will be removed from the Partnership provider network and its members will be reassigned. Members will receive a 30-day notice.

4. **Focused Review**
   a. A focused review is a targeted review of one or more specific areas of the FSR or MRR. Partnership must not substitute a focused review for a SR. Focused reviews may be used to monitor providers between SRs to investigate problems identified through monitoring activities or to follow up on corrective actions.
   b. Site Reviewers may utilize the appropriate sections of the FSR and MRR tools for the focused review, or other methods to investigate identified deficiencies or situations.
   c. All deficiencies identified in a focused review must require the completion and verification of corrective actions according to CAP timelines.

Compliance Category	FSR Score	MRR Score
Exempted Pass	90% or above *with NO* deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control **CAP not required**	90% or above with all section scores at 80% and above **CAP not required**
Conditional Pass	90% or above with deficiencies in Critical Elements/Pharmaceutical Services or Infection Control **OR** Score of 80-89% regardless of deficiencies **CAP required**	90% and above with one or more section scores below 80% **OR** Score of 80-89% regardless of deficiencies. **CAP required**
Fail	79% and below **CAP required**	79% and below **CAP required**

5. **Corrective Action Plan (CAP) Requirements and Timelines**
   a) CAP Documentation:
      1) CAPs will be completed using a standard format and form. CAPs may be verified via document submission, virtual platform, or an on-site review per nurse reviewer discretion.
      2) The minimum elements to be included in the CAP:
         a) Specific deficiency,
         b) Corrective actions needed,
         c) CAP due dates,
         d) Instructions for CAP submission,
         e) Partnership Contact information
   b. Closed CAP documentation shall include:
      1) Documentation of problems in completing corrective actions (if any),
      2) Education and/or technical assistance provided by Partnership,
      3) Evidence of the correction,
      4) Completion and closure date, and
      5) Name and title of Site Reviewer.
      6) Timeline for CAP notification and completion:

Policy/Procedure Number: MPQP1022 (previously QP100122)			**Lead Department:** Business Unit**: Quality Improvement**
Policy/Procedure Title: Site Review Requirements and Guidelines			☒ **External Policy** ☐ **Internal Policy**
Original Date: 10/30/2002 (vs. 10/16/2002)		**Next Review Date:** ~~01/13/2027~~10/14/2027 **Last Review Date:** ~~05/13/2026~~10/14/2026	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

CAP Timeline	**CAP Action(s)**
FSR and/or MRR Survey Day	Partnership will provide the site the following: • Verbal notification of any CE findings and a signed attestation by the PCP/site designee and the MCP staff confirming that a discussion regarding CE findings occurred. (This serves as the start of the CE-CAP timeline.) • A formal written request for CAPs to address all CEs, if applicable, the day of the site visit but no later than one business day after site visit completion • The FSR and/or MRR scores the day of the site visit but no later than one business day after the site visit completion;
Within 10 Business days of the FSR and/or MRR	• PCP site must submit CAP and evidence of corrections to Partnership for all deficient CE's if applicable. • Partnership will review, approve, or request additional information on the submitted CAP(s) for all Non-CE • Partnership will provide a report to the PCP site containing FSR and/or MRR findings, along with a formal written request for CAPs for all Non-CE deficiencies. (This serves as the start of the Non-CE CAP timeline) • Partnership will provide educational support and technical assistance to sites as needed.
Within 30 calendar days of the FSR and/or MRR	Partnership will verify all aspects of the CE CAPs are completed unless an extension was granted (not to exceed 60 calendar days from the date of the FSR). • PCP site must submit a CAP for all Non-CE deficiencies to Partnership. • Partnership will provide educational support and technical assistance to sites as needed.
Within 60 calendar days from the date of the FSR and/or MRR	• Partnership will review, approve, or request additional information on the submitted CAP for non-critical findings. • Partnership will provide educational support and technical assistance to sites as needed.
Within 90 calendar days from the date of the FSR and/or MRR	• All CAPs must be closed. • The Site can request a definitive time specific extension period to complete the CAP not to exceed 120 calendar days from the date of the initial report of FSR and/or MRR findings.
Beyond 120 days from the date of the FSR and/or MRR	• Partnership will request approval from DHCS to complete a CAP review for extenuating circumstances that prevented completion of a CAP within the established timeline. • Partnership will stop assigning members to sites that do not correct Site Review deficiencies within the established CAP timelines. • Any provider that does not come into compliance with review criteria and CAP compliance within the established timelines will be removed from the network and their members will be reassigned. Members will receive a 30-day notice. • Partnership will conduct a FSR and MRR within 12 months if provider completes CAP and remains in the network.

Partnership may require a CAP regardless of score for other findings identified during the survey that require correction. See APL 22-017 page 11.

6. **Provider Certificates**
   a. Upon the completion of a passing SR score (FSR and MRR) and completed CAP, Partnership will issue a provider site certificate using the most up to date DHCS template. The certificate will contain the signature of both the Chief Medical Officer (CMO) and CMT.
   b. The provider site certification will be valid for a maximum of three years.
7. **Non-Compliance with Corrective Action Process**
   a. Providers who fail to correct deficiencies within established CAP timelines, fail to ask for an extension, or request an extension but do not turn in any CAP documentation within 90 days of the Site Review will be sent a "Notice of Overdue Corrective Action Plan" to be drafted by the CSR or CMT and signed by the CMO or Medical Director informing the site that if the CAP is not received within 30 days the site will be closed to new Partnership members.
   b. If the site does not complete the CAP within 30 days of the first notice, then a 2nd "Notice of Review" will be drafted by the CSR or CMT and signed by the CMO or Medical Director. Further escalation, such as referring to the Credentialing team. will be directed by CMO or Medical Director.
      1) Actions taken by the Credentialing team may include, but are not limited to:
         a) Reassignment of existing members
         b) Termination of the site from the provider network

      Actions taken will be effective until corrections are verified and the CAP is closed. If Partnership chooses to remove the site from the network, members will be reassigned and given a 30-day notice.
      DHCS requires health plans to remove a provider from the network regardless of survey scores if criteria is not met or deficiencies are not resolved within established CAP timeline. Refer to MPPR208 - Provider Notification of Provider Termination, Site Closure, or Change in Location (Related Policy F) for the specific procedures.
8. **Provider Appeals**
   Refer to MPCR601 - Fair Hearing and Appeal Process for Adverse Decisions (Related Policy E). If evidence of correction of deficiencies is submitted and the decision to terminate the provider from the network is reversed, Partnership will repeat a full-scope SR. If the decision is not reversed, and the provider is terminated from the network, the practice may reapply to become a network provider and Partnership will complete an initial full-scope SR.
9. **Systematic Monitoring Between SRs**
   a. Monitoring between regularly scheduled SRs will include, but is not limited to, data gathered through the following sources:
      1) Member grievances and appeals (reviewed when identified);
      2) Potential Quality Issue (PQI) information (reviewed when identified);
      3) Focused review or other on-site visit ;
      4) Healthcare Effectiveness Data and Information Set (HEDIS®) data collection (annually);
      5) Interim Review Template – see Attachment J.
   b. Problems identified through these mechanisms will require at a minimum:
      1) Informing the Provider of concern, and
      2) Issuing a CAP when a problem is verified. (Follow the above CAP process.)
   c. Interim Review Process
      1) Partnership will request a self-assessment of DHCS standards by provider site staff at the midpoint between SRs. This assessment will include all critical element criteria and previously identified deficiencies noted during the last SR.

a) The Reviewer may require an onsite Interim Review in lieu of a self-assessment based on the provider site's previous SR scores or lack of response to self-assessment.

2) Upon receipt of the provider's self-assessment, a reviewer will review the assessment and determine approval status. Any identified areas of concern will be clarified and a new CAP will be issued if required. Additional follow-up activities may include an additional site visit, referral to the CMO and/or Credentialing team.

10. As part of its monitoring and oversight of MCPs, DHCS conducts Site Reviews on randomly chosen PCP sites. Partnership collaborates with DHCS on these reviews by notifying selected sites of the upcoming review and processing any corrective action plans that result from the DHCS reviewer findings.
11. **Physical Accessibility Review Survey (PARS)**
    During the Initial Site Review and subsequent Periodic SR, a PARS review will be performed in accordance with MMCD Policy Letter 12-006. (Reference B.) This will be reviewed every three years at all sites within the Partnership Medi-Cal network. Refer to (Related Policy A) MCQP1052 - Physical Accessibility Review Survey – SR Part C.
12. **Non-Accredited Sites**
    a. In the case that the below listed contracted providers are not accredited or have not had State or Centers for Medicare and Medicaid Services (CMS) reviews conducted, Partnership will conduct an initial review prior to adding the site into the network. If the clinic remains unaccredited at the time of re-credentialing, a periodic Non-Accredited FSR will be completed at a minimum of every three years unless the site becomes accredited.
        1) Home Health Agencies
        2) Free Standing Radiology Center
        3) Community Based Adult Services (CBAS)
        4) Dialysis Center
        5) Free-standing Birthing Center
13. **Specialized Site Reviews**
    a. Obstetric Specialists (utilizes PCP FSR and MRR with a focus in OB care from DHCS Site Review Tool)
        1) Sites will need to pass an initial FSR prior to being added to the network.
        2) MRR will be conducted within 6 months of first billable claim identifying members being seen. MRR will consist of 10 medical records or number of available records based on claims.
        3) Corrective Acton Plans (CAPs) will be completed using a standard format and form. CAPs will be due within 30 days of the site review and will be verified via document submission.
    b. Free Standing Urgent Care Clinic
        1) Urgent Care Site Reviews conducted to assess the quality of care provided for facilities located within our 24 and bordering counties. Reviews will be conducted at a minimum of every three years.
        2) Sites will need to pass an initial FSR prior to being added to the network.
        3) MRR will be conducted within six (6) months of first billable claim identifying members being seen. MRR will consist of 10 medical records or number of available records based on claims.
        4) CAPs will be completed using a standard format and form. CAPs will be due within 30 business days of the site review and will be verified via document submission.
    ~~c. PCP providing Urgent Care Services for non-assigned members~~
        ~~1) PCP Providing Urgent Care Facility Site Review Tool will be utilized in addition to the PCP tool.~~
        ~~2) Initial MRR will be conducted within six (6) months of first billable claim identifying~~

~~members being seen. MRR will consist of five (5) medical records or number of available records based on claims utilizing the Urgent Care Medical Record Review tool.~~

~~3) Reviews will be conducted at a minimum of every three years and will be in addition to the PCP tool~~

~~4)~~5)~~CAPs will be completed using a standard format and form. CAPs will be due within 30 business days of the site review and will be verified via document submission.~~

~~d.~~c. Palliative Care

1) A Palliative Care report is run monthly by the Inspections Site Review Team. Once it has been identified the site has seen five (5) members, a Site Review is performed.
2) Reviews are conducted at a minimum of every three years.

~~e.~~d. Private Duty Nursing

1) Private duty nursing reviews are conducted to oversee the quality of care provided by RNs or Licensed Vocational Nurses (LVNs) for in-home medical services under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Supplemental Services (SS) Program and Private Duty patient care under DHCS-APL 26-009 Private Duty Nursing requirements. ~~APL 20-012~~.
2) The Private Duty Nurse must receive a score greater than 80% on the Private Duty Nurse tool consisting of a combined FSR and MRR tool prior to credentialing, and up to every three years for re-credentialing.
3) For an Independent Nurse Provider (INP), the site audit will be in the member's home.
4) CAPs will be completed using a standard format and form. CAPs will be due within 30 business days of the site review and will be verified via document submission.

B. **Delegation of Site Review functions**

1. Organizations or groups who have one or more DHCS Certified Site Reviewer may be determined eligible, at Partnership discretion, to perform SR functions. Eligible 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 SR functions for all PCP sites no less than every three years.
4. Results from oversight and monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.
5. Delegated organizations and/or groups will provide timely copies of all SRs conducted at the site level, within Partnership's service area, no less than semi-annually.
6. Partnership's Quality Improvement (QI) department will track all SRs conducted by the delegated entities.
7. For organizations and groups that are more than one year past due for a SR at the site level or otherwise missing a SR, the QI department will refer them to Partnership's DORS, which is managed by Partnership's compliance unit within the Administration department, for action.
8. In addition to providing Partnership copies of all SRs conducted at the site level, Partnership will ensure the delegated entity will provide timely copies and results of Site Reviews to DHCS according to DHCS standards. DHCS has processes in place for overseeing and auditing the quality of SR functions.
9. As part of the oversight process, Partnership may perform one or more repeat SRs on sites that have had the SR performed by a delegated entity.

C. **Potential Quality of Care Issues**

Potential Quality of Care Issues identified during the course of a Site Review will be processed in accordance with MPQP1016 – Potential Quality Issue Investigation and Resolution. The Site Reviewer will complete a Potential Quality Issue (PQI) Referral via the PQI Referral Intake System for follow up,

and review.

D. **Data Submission to DHCS**
SR data will be submitted by Partnership to DHCS every six months (July 31 for the period January-June and January 31 for the period July-December) in an approved format uploaded to a designated DHCS secure site. Partnership is permitted to submit data more frequently than every six months. For preoperational and expansion site reviews, Partnership must submit site review data to DHCS at least six weeks prior to site operation. Partnership will include data for SRs conducted by delegated entities in these submissions. Partnership will submit the required PHI (collected via the MRR process) in the bi-annual data submission to DHCS as required.

E. **Local Collaboration**
In an effort to streamline the regulatory process and reduce redundant SR reviews, Partnership may collaborate with other health plans having contracts with mutual providers. Partnership may accept the SR score assigned by other health plans if the DHCS tools are used and the SR is completed by appropriate certified staff. A site with a non-passing score by a collaborating health plan, that has received SR certification as addressed in of this policy, shall be considered to have a non-passing score by Partnership. Partnership may choose to repeat the FSR/MRR of a site that had passed a FSR/MRR by another health plan's reviewers.

VIII. REFERENCES:

A. California Department of Health Care Services (DHCS) All Plan Letter APL 26-014 Responsibilities for Annual Cognitive Health Assessment for Eligible Members 65 Years of Age or Older (July 1, 2026 supersedes 22-025)

~~A.~~B. DHCS ~~(~~APL~~)~~ 24-001 Street Medicine Provider: Definitions and Participation on Managed Care (Jan. 12, 2024 supersedes APL 22-023)

~~B.~~C. DHCS APL 22-017 Primary Care Provider Site Review: Facility Site Review and Medical Record Review (Sept. 22, 2022 supersedes APL 20-006)

~~C.~~D. DHCS APL 20-016 Blood Lead Screening of Young Children (revised Nov. 2, 2020 supersedes APL 18-017)

~~D.~~E. DHCS APL 26-009 ~~APL 20-012~~ Private Duty Nursing Case Management Responsibilities ~~f~~For Medi-Cal Eligible Members Under The Age Of 21 ~~(May 15, 2020~~June 1, 2026; supersedes APL 20-012)

~~E.~~F. DHCS Policy Letter 12-006 (Aug. 9, 2012 supersedes PL 11-013)

~~F.~~ G. 3 CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)

IX. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

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

XI. REVISION DATES:

Medi-Cal
8/20/03; 10/20/04; 3/15/06; 3/21/07, 3/19/08; 3/18/09; 6/17/09; 9/15/10; 3/16/11; 2/20/13; 5/15/13; 5/21/14; 11/19/14; 11/18/15; 10/19/16; 3/15/17, 10/18/17; *10/10/18; 11/13/19; 04/08/20; 06/10/20; 08/12/20; 01/13/21; 02/10/21; 03/09/22; 08/10/22; 01/11/23; 03/08/23; 03/13/24; 03/12/25; 5/13/26; 10/14/26

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

Policy/Procedure Number: MPQP1022 (previously QP100122)			**Lead Department:** Business Unit**: Quality Improvement**
Policy/Procedure Title: Site Review Requirements and Guidelines			☒ **External Policy** ☐ **Internal Policy**
Original Date: 10/30/2002 (vs. 10/16/2002)		**Next Review Date:** ~~01/13/2027~~10/14/2027 **Last Review Date:** ~~05/13/2026~~10/14/2026	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

PREVIOUSLY APPLIED TO:
Healthy Kids (Healthy Kids program ended 12/01/2016)
MPQP1022 – 2/20/13, 5/15/13; 5/21/14; 11/19/14; 11/18/15; 10/19/16 to 12/01/16
HKQP1032 – 4/18/2007 to 2/20/2013

Partnership Advantage
3/21/2007 to 11/19/2014

Healthy Families
10/01/2010 to 3/01/2013

Cognitive Assessment
Addendum to Facility Site Review Tool

PCP Name:					
PCP Site Name:	0				
Address:	0			Suite:	0
City:	0	State:	CA	ZIP:	0
Phone Number:	-				
Fax Number:	-				
Name of Individual responsible for securing & maintaining the security of medical records:				0	
Reviewers:	**First Last Name, RN DHCS-CSR**				
Date of Review:	**1/0/1900**				

	Yes	No	NA	Corrective Action (Note Date corrected as well as document correction
1. Was an annual cognitive health assessment ~~performed~~ completed for all eligible members 65 years of age ~~and~~ or older?				
Total:	0	0	0	
ADM Passed:	Yes		n/a	**Score Percentage**
CAP required:				
CAP approved:				
Guidelines for Cognitive Assessment:			**Date approved**	

Per APL ~~22-025~~26-014, PCPs ~~should~~ shall perform ~~include~~ an annual cognitive health assessment for eligible Members ~~who are~~ 65 years of age or older and who do not have Medicare Coverage, in accordance with DHCS requirements.

Documentation in the medical record should include:
- The screening tool or tools that were used.[1]
- Verification that screening results were reviewed by the Provider
- The results of the screening
- The interpretation of the results
- Details discussed with the member and/or authorized representative and any appropriate actions taken in regards to the screening results.

At least one cognitive assessment tool listed below is required.~~Acceptable patient assessment screening tools include, but are not limited to:~~

Patient Assessment Tools:
- General Practitioner Assessment of Cognition (GPCOG)
- Mini-Cog
- ~~Memory Impairment Screen (MIS) (Medicare Approved Tool)~~

Informant Tools (family members and close friends)
- Eight-~~E i g h t~~ item Informant Interview to Differentiate Aging and Dementia
- GPCOG
- Short Informant Questionnaire on Cognitive Decline in the Elderly
- ~~Quick Dementia Rating System (Medicare Approved Tool)~~

Modified Facility Site Review Survey
PCP Providing Urgent Care

Site ID:	Phone:	Fax:	Review Date:
Facility Name:		Contact Name/Title:	
Full Address:			
Reviewer Name/Title:			

Visit Purpose		Certifications		Clinic Type	
☐Initial Full Scope	☐Monitoring	☐AAAHC	☐JC	☐Primary Care	☐Community
☐Periodic Full Scope	☐Follow Up	☐CHDP	☐NCQA	☐Rural Health	☐FQHC
☐Focused Review	☐Ed/TA	☐CPSP	☐None	☐Urgent Care	☐Solo
☐Other _____		☐PCMH		☐Medical Group	☐Staff/Teaching
		☐Other _____			

Site Review Scores

	Pts. Poss.	Yes Pts. Given	No's	N/A's	CE*
I. Access/Safety	1				
II. Office Management	1				
III. Clinical Services	3				
IV. Preventive Services	12				
V. Infection Control	2				
VI. Quality Insurance Performance Improvement	6				
	25				
	Total Pts. Poss.	Total Yes Pts.	Total No Pts.	Total N/A Pts.	

Scoring Procedure

1) Add points given in each section.

2) Add total points given for all seven sections

3) Adjust score for "N/A" criteria (if needed). Subtract "N/A" points from total points possible.

4) Divide total points given by "adjusted" total points.

5) Multiply by 100 to get the compliance (percent) rate.

_____/_____=_____X100=____%
Pts. given / Total/ Adj. / Decimal Score / Comp. Rate

Compliance Rate

_____**Exempted Pass:** 90% or above (without deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control)

_____**Conditional Pass**:80-89%, or 90% and above with deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control

_____**Fail**: 79% and Below

_____CAP Required

_____Other Follow-Up

Next Review Due:_____

Modified Facility Site Review Survey
PCP Providing Urgent Care

Purpose: Site Review Guidelines provide the standards, directions, instructions, rules, regulations, perameters, or indicators for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Critical Elements have a weight of two (2) points each and non-Critical Elements have a weight of one (1) point on the site review tool. Compliance levels include: 1) Exempted Pass: 90% or above without deciencies in Critical Elements, Pharmaceutical Services, or Infection Control, 2) Conditional Pass: 80-89%, or 90% and above with deficincies in either Critical Elements, Pharmaceutical Services, or Infection Control, and 3) Fail: 79% and below.

A corrective action plan (CAP) is required for a total score less than 90%, or for a total score of 90% or above if there are deficiencies in Critical Elements, Pharmaceutical Services, or Infection Control. Compliance rates are based on total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Survey criteria to be reviewed *only* by a R.N. or physician or LPHA are labeled ""□ □ **RN/NP/CNM/LMI/MD/PA Review only".**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Explain all "N/A" and "No" (0 point) items in the comment section. Provide assistance/consultation as needed for corrective action plans, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for all seven (6) sections to determine total points given for the site.
3) Subtract all "N/A" items from total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on the total points possible.
4) Divide the total points given by the total points possible or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section.	**Step 2:** Add points given for all thirteen (6) sections. (1) Access/Safety (12) Preventive Services (1) Office Management (2) Infection Control (3) Clinical Services (6) QAPI **25 Points**
Step 3: Subtract "N/A" points from 182 total points possible. 25 (Total points possible) - 4 (N/A points) 21 ("Adjusted" total points possible)	**Step 4:** Divide total points given by 190 or by the "adjusted" points, then multiply by 100 to calculate percentage rate. Points Given / 25 or "adjusted" total or 19 / 21 =0.904 =90%

I. Access/Safety

Site Access/Safety Survey Criteria	Yes	No	N/A	wt
A. The facility has a waiting area of sufficient size to accommodate patients comfortably and to assure privacy during registration.				1
Totals				
Note: Write comments for all "No" (0 points) and "N/A" scores. 1 point possible in this section.				

Comments:

II. Office Management

Site Office Management Survey Criteria	Yes	No	N/A	wt
A. There are sufficient health care personnel to provide timely, appropriate health care services.				
22 CCR §53855; 28 CCR §1300.67.1, §1300.80 □ □				
1. Transport of emergency patients to appropriate facility. There is evidence staff has received safety training and/or has information available on emergency non-medical and emergency medical procedures.				1
Note: Write comments for all "No" (0 points) and "N/A" scores. 1 points possible in this section.				

Comments:

III. Clinical Services:

Pharmaceutical Services Criteria

Site Clinical Services Survey Criteria	Yes	No	N/A	wt
A. Drugs are handled safely and stored appropriately.				
22 CCR §75037(a-g), §75039; 21 CFR §211.137; 21 USC §351; HSC §117600-118360; 40 CFR, part 261; Current CDC Recommendations □ □				
1. Medications on site are applicable to services offered				1
Note: Write comments for all "No" (0 points) and "N/A" scores. 1 point possible on this page.				

Comments:

III. Clinical Services:

Laboratory Services Criteria

Site Clinical Services Survey Criteria (Continued)	Yes	No	N/A	wt
B. Site is compliant with Clinical Laboratory Improvement Amendment (CLIA) regulations.				
22 CCR §51211.2, §51137.2; BPC §1200-1214, §1229, §1220; 42 USC 263a; Public Law 100-578; www.cms.gov; www.fda.gov				
1. Minimum tests performed on site include: Urine HCG, hemoglobin or hematocrit, blood glucose & urine dipstick, Rapid Strep, STI collection materials. *off-site laboratory that can provide stat H & H results within 1-hour is acceptable				1
2. Lab supplies on site are applicable to survices offered				1
Note: Write comments for all "No" (0 points) and "N/A" scores. 2 points possible on this page.				

Comments:

III. Clinical Services:

Radiology Services Criteria

Site Clinical Services Survey Criteria (Continued)	Yes	No	N/A	wt
C. Site meets CDPH Radiological inspection and safety regulations.				
17 CCR §30110, §30111, §30255, §30305, §30404, §30405; https://www.cdph.ca.gov/rhb or (916) 327-5106				
1. If no radiological equipment on site, immediate access to diagnostic radiology services (plain film x-rays) with urgent results made available to member and PCP a. Chest and Limb x-rays				1
Totals:				
Note: Write comments for all "No" (0 points) and "N/A" scores. 1 point possible on this page. 3 points possible in this section.				

Comments:

IV. Preventive Services and Equipment

Site Preventive Services Survey Criteria	Yes	No	N/A	wt
A.Preventive health care services and health appraisal examinations are provided on a periodic basis for the detection of asymptomatic diseases.				
22 CCR §53851; 28 CCR §1300.67				
Examination equipment, appropriate for primary care services, is available on site:				
1. EKG machine				1
2. Nebulizer				1
3. Splinting materials				1
4. Suction machine and catheters (Recommended)				1
5. NG tubes (Recommended)				1
6. Wound irrigation supplies				1
7. Eye and Ear irrigation supplies				1
8. Eye tray				1
9. Wood's lamp for dermatologic diagnosis (Recommended)				1
10. Suture kits and materials				1
11. Dressing supplies				1
12. Pulse Oximetry				1
Note: Write comments for all "No" (0 points) and "N/A" scores. 12 points possible in this section.				

Comments:

V. Infection Control Criteria

Site Infection Control Survey Criteria	Yes	No	N/A	wt
A. Infection control procedures for Standard/Universal precautions are followed.				
8 CCR §5193; 22 CCR §53230; 29 CFR §1910.1030; Federal Register 1989, §54:23042 □ □				
1. Site has a policy or procedure for ensuring Standard/Universal precautions for infection control is followed.				1
2. Facility has a designated or qualified Infection control professional on staff.				1
Totals:				
Note: Write comments for all "No" (0 points) and "N/A" scores. 2 points possible in this section.				

Comments:

VI. Quality Assurance Performance Improvement

☐ ☐ **RN/MD only**

Site Quality Assurance Performance Improvement Survey Criteria	Yes	No	N/A	wt
1. Is there a QAPI committee which meets regularly and keeps minutes?				1
2. The QAPI committee reviewed performance standards for medical records, infection control, environment, personnel and other areas of concern.				1
3. The QAPI identified concerns, initiated corrective action plans, monitored the results of the plans, and made appropriate changes based on an analysis of the data.				1
4. The QAPI committee is aware of serious events (sentinel events, abuse allegations, privacy breaches complaints and grievances) and takes appropriate actions.				1
5. The QAPI committee has reviewed surveys, inspections, and reportssubmitted by outside agencies. Corrective action plans are available.				1
6. Is there a designated QA & PI Coordinator?				1
Totals				
Note: Write comments for all "No" (0 points) and "N/A" scores. 6 points possible in this section.				

Comments:

If more than one Reviewer, both must sign here:

Reviewer Signature: _____ **Reviewer Signature:** _____

Reviewer Name: _____ **Reviewer Name:** _____

Reviewer Title: _____ **Reviewer Title:** _____

Reviewer Comments:

Palliative Care Provider Site Review Survey

MPQP1022 – Attachment ~~ML~~ L

Health Plan	PHC	IPA		Site ID No.		Review Date		Last Review Date	

Provider Name/ Address		Phone		Fax	

Contact Person/Title		Reviewer/Title	

Visit Purpose:

_____ Initial Full Scope _____ Monitoring _____ Periodic Full Scope _____ Follow-up _____ Focused Review _____ Ed/TA _____Other _____

EHR System used:

Site Scores						Scoring Procedure	Compliance Rate
	Points Poss.	**Yes Pts. Given**	**No's**	**N/A's**		1) Add points given in each section. 2) Add total points given for all six sections. 3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 6 total points poss. 4) Divide total points given by 6 or by "adjusted" total points. 5) Multiply by 100 to get the compliance (percent) rate. _____ ÷ _____ = _____ X 100 = _____% **Points Given** / **Total / Adjusted Points** / **Decimal Score** / **Compliance Rate**	_____ **Exempted Pass: 90% or above** _____ **Conditional Pass: 80-89%** _____ **Not Pass: Below 80%** _____ CAP Required _____ Other follow-up **Next Review Due:** _____
Interview Question	**1**						
Office Management	**5**						
	6						
	Total Pts. Poss.	**Yes Pts. Given**	**No's**	**N/A's**			

Palliative Care Provider Site Review Survey

Purpose: Site Review Guidelines provide the standards for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Compliance levels include:

1) Exempted Pass: 90% or above
2) Conditional Pass: 80-89%
3) Not Pass: below 80%

A corrective action plan (CAP) is required for a total score less than 90%. Compliance rates are based on 6 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the survey. Survey criteria to be reviewed only by a R.N. or physician is labeled **RN/MD Review only**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Provide assistance/consultation as needed for CAPs, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for both sections to determine total points given for the site.
3) Subtract all "N/A" items from 6 total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 6 points.
4) Divide the total points given by 6 or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section. Example: 1 (Interview Question) 5 (Office Management)	**Step 2**: Subtract "N/A" points from 6 total points possible. 6 (Total points possible) – 1 (N/A points) 5 ("Adjusted" total points possible)
Step 3: Divide total points given by 6 or by the "adjusted" points, then multiply by 100 to calculate percentage rate. $\frac{\text{Points given}}{\text{6 or "adjusted" total}}$ or $\frac{4}{5} = 0.80 \times 100 =$ **80%**	

Palliative Care Provider Site Review Survey

Interview Questions	Yes	No	N/A	Wt.	Responses
1. How many patients are enrolled in the program?				0	Comment answer only
2. Do you provide 24/7 telephonic access to your patients? i.e. outsource after-hours calls, staff rotate taking after hours calls, etc.				1	Comment plus Y/N/N/A
3. Describe the makeup of your team. How often do you meet to discuss each patient?				0	Comment answer only
4. Is your organization a member of the Center to Advance Palliative Care (CAPC)?				0	Comment plus Y/N/N/A
5. How many physicians?				0	Comment answer only
6. How many registered nurses (RN)?				0	Comment answer only
7. How many Licensed Vocational nurses (LVN)?				0	Comment answer only
8. How many Licensed Clinical Social Workers/Masters of Social Work (LCSW/MSW)?				0	Comment answer only
9. How many managers?				0	Comment answer only
10. How many “other” types of staff?				0	Comment answer only
11. How many Chaplains?				0	Comment answer only
12. Notes				0	Comment field for notes

Total points possible 1.

Notes:

Palliative Care Provider Site Review Survey

Criteria	Office Management
1. Current Palliative Care Certifications?	Current Palliative Care Certifications? – All medical professional licenses and certifications must be current and issued from the appropriate agency for practice in California. Physician Certification Nurse Certification Advanced Certified Hospice and Palliative Social Worker (ACHP-SW) Chaplaincy Certification Personnel who are not certified have either 1 year or more of experience, OR received 12 hours didactic training or have 1 year experience in palliative care- There is a documentation on site of a proof of training or 1 year experience in palliative care, including the name of the training or program attended and who conducted the training. Proof can include a certification and copy of the training module. If caring for Pediatric Patients, then all staff caring for Pediatric Patients will have Pediatric Palliative Care Training
2. Designated administrative lead/contact? ~~(PCQN)~~ ~~a.)~~ ~~Who enters information into PCQN? One staff member or multiple?~~	Designated administrative lead/contact? ~~(PCQN) A designated administrative lead/contact is documented in personnel file, including job responsibilities. Evidence of training about the PCQN must be documented.~~ Site designates staff responsible for completing and submitting required Physician Orders for Life-Sustaining Treatment (POLST) and Edmonton Symptom Assessment System (ESAS) reporting templates to support compliance with Partnership palliative care quality reporting. ~~Document titles of staff members responsible for entering information into PCQN (no points allotted here).~~

Palliative Care Provider Site Review Survey

Office Management	Yes	No	N/A	Wt.	Site Score
Professional health care personnel have current California licenses and certifications.					
1) Current Palliative Care Certification OR if Personnel do not have certification, there is documentation of at least 1 year of experience in palliative care OR enrollment in to palliative care specific training within 3 months of working for the organization. Training MUST be completed within 6 months and be a minimum of 12 hours.					
a) Physician				1	
b) Nurse				1	
c) Advanced Certified Hospice and Palliative Social Worker (ACHP-SW)				1	
d) Chaplaincy Certification				1	
2) Designated administrative lead/contact? ~~(PCQN)~~ ~~a.) Who enters information into PCQN? One staff member, or multiple?~~ _____				1	
Yes					
No					
N/A					

Total pts possible: 5

Palliative Care Provider Medical Record Review Tool

Health Plan	PHC	IPA		Site ID No.		Review Date		Last Review Date	

Provider Name/ Address		Phone		Fax	

Contact Person/Title		Reviewer/Title	

Visit Purpose:

_____ Initial Full Scope _____ Monitoring _____ Periodic Full Scope _____ Follow-up _____ Focused Review _____ Ed/TA _____Other _____

EHR System used:

Site Scores

	Points Poss.	Yes Pts. Given	No's	N/A's	
Documentation	~~95~~ 90				
	Total Pts. Poss.	**Yes Pts. Given**	**No's**	**N/A's**	

Scoring Procedure

1) Add points given in each section.
2) Add total points given for all six sections.
3) Adjust score for "N/A" criteria (if needed), by subtracting N/A points from 95 total points poss.
4) Divide total points given by 95 or by "adjusted" total points.
5) Multiply by 100 to get the compliance (percent) rate.

_____ ÷ _____ = _____ X 100 = _____%

Points Given / **Total / Adjusted Points** / **Decimal Score** / **Compliance Rate**

Compliance Rate

_____ **Exempted Pass: 90% or above**

_____ **Conditional Pass: 80-89%**

_____ **Not Pass: Below 80%**

_____ CAP Required

_____ Other follow-up

Next Review Due: _____

Palliative Care Provider Medical Record Review Tool

Purpose: Site Review Guidelines provide the standards for the site review survey. These Guidelines shall be used as a gauge or touchstone for measuring, evaluating, assessing, and making decisions.

Scoring: Site survey includes on-site inspection and interviews with site personnel. Reviewers are expected to use reasonable evidence available during the review process to determine if practices and systems on site meet survey criteria. Compliance levels include:

1) Exempted Pass: 90% or above
2) Conditional Pass: 80-89%
3) Not Pass: below 80%

Compliance rates are based on 905 total possible points, or on the total "adjusted" for Not Applicable (N/A) items. "N/A" applies to any scored item that does not apply to a specific site as determined by the reviewer. Reviewers are expected to determine how to ascertain information needed to complete the survey. Survey criteria to be reviewed only by a R.N. or physician is labeled **RN/MD Review only**

Directions: Score full point(s) if survey item is met. Score zero (0) points if item is not met. Do not score partial points for any item. Provide assistance/consultation as needed for CAPs, and establish follow-up/verification timeline.

1) Add the points given in each section.
2) Add points given for both sections to determine total points given for the site.
3) Subtract all "N/A" items from 905 total possible points to determine the "adjusted" total possible points. If there are no "N/A" items, calculation of site score will be based on 905 points.
4) Divide the total points given by 905 or by the "adjusted" total. Multiply by 100 to calculate percentage rate.

Scoring Example:

Step 1: Add the points given in each section. Example: 87 points for Documentation	**Step 2**: Subtract "N/A" points from total points possible (905). 905 (Total points possible) – 1 (N/A points) 8994 ("Adjusted" total points possible)

Step 3: Divide total points given by 905 or by the "adjusted" points, then multiply by 100 to calculate percentage rate.

$$\frac{\text{Points given}}{\text{100 or "adjusted" total}} \quad \text{or} \quad \frac{87}{8994} = 0.9773 \times 100 = \mathbf{98.3\%}$$

Palliative Care Provider Medical Record Review Tool

Criteria	Documentation
1. Written patient specific care plan (intake, engagement visit or initial care plan)	
a. Medical History	A complete and accurate history including pre-existing medical conditions and current comorbidities needs to be present in the patients chart.
b. Medication reconciliation	Medication lists need to be addressed and updated at each visit to provide the most current information.
c. Social history	Social history is to include documentation of discussion regarding needs pertaining to patient/family support, grief, legal issues, funeral arrangements, discharge planning.
d. Emotional needs	An ongoing discussion needs to be documented in visit notes that patient and/or family member's emotional state is being discussed and addressed.
e. Spiritual concerns	Identification of patient or family member spiritual needs and/or distress and if further assessment or intervention is needed and completed.
f. Written documentation of goals of care	Documentation of collaboration between PC team and patient/family member to create a personalized plan of care so healthcare professionals know how to respond in the event that the patient is unable to speak for him/herself. This is assessed and updated throughout progression of care.
2. Does the care plan document interdisciplinary team evaluation: medical, social services, emotional and spiritual needs?	As a part of the member engagement and enrollment process a multidisciplinary comprehensive assessment is required, which includes: Medical, Social Services, Emotional and Spiritual needs. Services may be refused, but must be documented.
3. **Advance Care Plan**	
a.) Written documentation of ACP discussion	Documentation of a member of the Palliative Care (PC) team directing questions at the patient to identify 1) patient's preferences for care in the event that patient is unable to speak for him/herself and/or 2) patient's preferences about current plan of care. **(PHC Policy- MCUP3137 Attachment C, 1)**
b.) POLST completed and signed by patient and provider	Is there a POLST on File and is it signed by both the provider and the patient/Durable Power of Attorney for Health Care? This is not mandatory to maintain compliance with PHC standards, however there is a monetary bonus that is given for each POLST on file. **(no points associated with this)**
c.) Durable Power of Attorney for Health Care (DPAHC) on file?	If there is someone other than the patient making decisions regarding healthcare, a DPAHC needs to be on file. **(no points associated with this)**
4. Contact was made with member within seven days of referral	Contracted intensive palliative providers will contact members referred to their program for evaluation within 7 calendar days to arrange an evaluation and assessment.
5. Common symptoms associated with the qualifying diagnosis are consistently assessed at each visit.	Nursing discretion will be used to determine if symptoms associated with individual patient's qualifying diagnosis and comorbidities are consistently addressed and followed up on by the provider (MD, DO, NP, PA, RN)
6. Each visit type documented appropriately? (Spiritual, Medical, Social Services, etc.)	There has to be clear documentation of who is providing care at each visit.
7. Use of a Palliative Performance Score sheet or Karnofsky Performance Scale score sheet.	Documentation of a score, 70 or below, on a standardized form. Could be Palliative Performance Score sheet or Karnofsky Performance Scale score sheet.

Palliative Care Provider Medical Record Review Tool

Documentation	MR #1	MR #2	MR #3	MR #4	MR #5	Wt.	Site Score
1) Written patient specific care plan upon intake, engagement visit or initial appointment:							
a) Medical history						1	
b) Medication reconciliation						1	
c) Social history						1	
d) Emotional needs						1	
e) Spiritual concerns						1	
f) Written documentation of goals of care						1	
2) Does the care plan document interdisciplinary team evaluation: medical, social services, emotional and spiritual needs?						1	
3) **Advance Care Plan**							
a) Written documentation of ACP discussion						1	
b) POLST completed and signed by patient and provider (Y/N only)	Y/N	Y/N	Y/N	Y/N	Y/N	0	N/A
c) Durable Power of Attorney for Health Care (DPAHC) on file?	Y/N	Y/N	Y/N	Y/N	Y/N	0	N/A
4) Contact was made with member within seven days of referral						1	
5) Common symptoms associated with the qualifying diagnosis are consistently assessed at each visit.						1	
6) Each visit type documented appropriately (Spiritual, Medical, Social Services, etc.)						1	
7) Use of a Palliative Performance Score sheet or Karnofsky Performance Scale score sheet.						1	

Total pts possible this page: 60

Palliative Care Provider Medical Record Review Tool

Criteria	Documentation
8) Does the documentation reflect interdisciplinary team involvement at least monthly for each member on palliative care?	Does documentation support that each disciplinary team (Medical, Social Services, Emotional and Spiritual) is meeting with member at least monthly.
9) Visit frequency minimum is documented via face to face, telemedicine or telephonically (RN, FNP, PA, or MD)	Enrolled members must have at minimum: • One in-person or video visit by an RN every month (the RN must see the member face to face at a minimum of once every 12 weeks) • One in-person or video visit by a social worker every month • Standardized assessments of symptoms must be done approximately every 14 days. Assessments may be completed face to face, via telemedicine or telephonically
~~10) Billing matches medical record documentation?~~	
~~a) PCQN matches medical record?~~	~~The audit of PCQN documentation aligns with documentation in the medical record.~~ ~~*Dates of visits should match dates entered into PCQN, if not, NO point.~~

Palliative Care Provider Medical Record Review Tool

Documentation	MR #1	MR #2	MR #3	MR #4	MR #5	Wt.	Site Score
8) Does the documentation reflect interdisciplinary team involvement at least monthly for each member on palliative care?						1	
9) Visit frequency minimum is documented via face to face, telemedicine or telephonically (RN, FNP, PA, or MD) (5 pts possible)						5	
~~10) Billing matches medical record documentation?~~							
~~a. PCQN matches medical record?~~						~~1~~	
Yes							
No							
N/A							

Total pts possible this page: 3~~0~~5. Total pts possible this domain: 9~~0~~5

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1053				**Lead Department: Health Services** Business Unit: Quality Improvement	
Policy/Procedure Title: Peer Review Committee				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 09/17/2014			**Next Review Date:** ~~02/11/2027~~10/14/2027 **Last Review Date:** ~~02/11/2026~~10/14/2026		
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:** ~~02/11/2026~~10/14/2026	

I. RELATED POLICIES:

A. CMP10 – Confidentiality
B. MPQP1008 – Conflict of Interest Policy for QI Activities
C. MPQP1016 – Potential Quality Issue Investigation and Resolution
D. MPCR602 – Reporting Actions to Authorities
E. CMP36 – Delegation Oversight and Monitoring
F. MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines

II. IMPACTED DEPTS:

Health Services

III. DEFINITIONS:

A. Non-Physician Medical Practitioners (NPMP): NPMP's are defined as nurse practitioners (NP), physician assistants (PA), certified nurse midwives (CNM) and licensed midwives (LM).

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

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The Peer Review Committee (PRC) reviews concerns and complaints about the quality of clinical care and services provided to Partnership HealthPlan of California's (Partnership's) members and makes recommendations for actions to prevent reoccurrence of any issues. The PRC also reviews sentinel conditions identified as having quality concerns. PRC discussions and documents are protected by federal and state laws (Cal. Civ. Code §43.7.) governing confidentiality of health care peer review activities conducted in good faith.

Policy/Procedure Number: MPQP1053			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Peer Review Committee			☒ **External Policy** ☐ **Internal Policy**
Original Date: 09/17/2014		**Next Review Date: 02/11/202710/14/2027** **Last Review Date: 02/11/202610/14/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VI. POLICY / PROCEDURE:

A. Committee Structure

1. Membership
   a. The PRC is comprised of one or more licensed physicians in primary care (e.g., Family Medicine, Internal Medicine or Pediatrics), and one or more specialist physicians (e.g., OB/GYN, General Surgery) currently practicing in hospitals, medical groups, and practice sites contracted with Partnership or otherwise regularly seeing Medi-Cal members. Medi-Cal population experienced physicians who have retired from practice within the last two years are also eligible to serve on the PRC. There will be a minimum of three external physician members on the PRC. There is no upper limit to the number of standing members on the PRC.
   b. NPMPs as defined in MPQG1011 who are currently practicing within Partnership's service area may also serve as PRC members. There is no defined number of any type of NPMP who may serve on the PRC.
   ~~b.~~c. The PRC's external clinicians are a subset of the voters of the Quality/Utilization Advisory Committee. As a confidential body, however, the PRC does not report case specifics to the Q/UAC, which is a Brown Act committee. PRC caseload numbers are reported in aggregate by quarter twice each year to both the Q/UAC and the Physician Advisory Committee (PAC).
   ~~c.~~d. Partnership staff physicians are also voting members of the PRC and include, but are not limited to, the Chief Medical Officer, the Deputy Chief Medical Officer, the Medical Director for Quality, the Behavioral Health Clinical Director, the Medical Director for Medicare Services, and Regional and Associate Medical Directors, as assigned by the CMO.
   ~~d.~~e. Additional Partnership non-voting staff attending and supporting the PRC include ~~the Senior Director of Health Services;~~ the Director of Pharmacy or designee; the Director of Health Equity; and members of the Member Safety Quality Inspection and Quality Investigation teams.~~Quality Assurance & Member Safety and Clinical Quality & Member Safety teams.~~
   ~~e.~~f. Members serve open terms and may elect to resign at any time by formally advising the chair.
   ~~f.~~g. Members with annual attendance of < 50% may be barred from future participation in the PRC.
2. Chair: The Chief Medical Officer (CMO) chairs the PRC. When the CMO is unavailable, the Medical Director for Quality is the designated chair. A Regional or Associate Medical Director acts as the temporary chair when needed. The role of the Chair is to assure that all quality matters and concerns are evaluated thoroughly, that there is adequate input to the discussion, that a reasonable effort is made to obtain the facts of the matter, and that matters are fully investigated and any required actions are completed. The Chair must ensure that the process follows protocol; is always fair and unbiased; and, that any providers under scrutiny are afforded due process, receiving adequate notifications and opportunities to respond to the concerns under investigation.
3. Meetings: The PRC meets at least quarterly and on an as-needed basis.
4. Dual Capacity: External physicians and NPMPs are also voting members of the Quality/Utilization Advisory Committee (Q/UAC).
5. Compensation: External members are eligible to receive a financial stipend for each Q/UAC **or** PRC meeting attended to compensate them for travel time and time away from work.
6. Voting: Internal and external physician and NPMP members constitute the voting membership, with the Chair serving in a tie breaking capacity as necessary. A quorum is not required for a meeting to occur, except where formal action needs to take place or in instances where the Chair determines that a quorum is necessary. In this case, the PRC's quorum is comprised of more than 50% of the voting membership. The Chair may not be counted for purposes of a quorum.
   a. NPMPs may vote to score providers and/or systems only in areas in which they possess subject matter expertise. For example, CNMs and LMs may vote only in cases involving obstetrics. Nurse Practitioners and PAs may vote only in cases involving their area(s) of practice, such as outpatient primary care, hospital care, pediatrics, internal or family medicine.

7. Confidentiality: To preserve an atmosphere promoting free and open discussion between and among committee members, each external member signs an annual Confidentiality Statement prepared and retained by Partnership. This statement signifies the intent to protect individuals against misuse of information and to ensure that all information, medical or otherwise, regarding patients, practitioners and providers is handled in a confidential manner. Partnership staff are governed by similar confidentiality policies, as required elements of employment.
8. Conflict of Interest: The integrity of the Peer Review process requires prevention of input and decision making where a conflict of interest exists. All non-Partnership clinicians taking part in the peer review process, including those on the PRC, are required to adhere to Partnership's Conflict of Interest (MPQP1008) policy. Each external PRC member signs an annual Conflict of Interest Statement prepared and retained by Partnership. Partnership staff are governed by similar conflict of interest policies.

B. Committee Responsibilities
1. The PRC will carefully review the clinical care in all situations in which a quality of care concern has been raised and forwarded for committee review. See MPQP1016 - Potential Quality Issue Investigation and Resolution for details of this process.
2. The PRC will evaluate the quality concern related to clinical care and determine whether there is sufficient evidence that the involved practitioner failed to provide care within generally accepted standards.
3. Minutes are maintained according to the Confidentiality policy CMP10.
4. External Peer Review
   a. Circumstances that require external review:
      1) Referral for "medical specialist review" when the PRC membership does not include members with adequate expertise or training to fully evaluate the quality of care concern.
      2) The PRC cannot make a determination and requests external review.
      3) An individual whose case is under review requests external peer review.
      4) When dealing with potential litigation that might affect a provider's contracted status.
      5) When dealing with ambiguous or conflicting recommendations from internal reviewers, or when there does not appear to be a strong consensus for a particular recommendation.
5. Subcommittees: Complex or specialized peer review issues may be reviewed by a PRC subcommittee. These subcommittees meet on an *ad hoc* basis when cases identified through the peer review process require specialized peer review. A minimum of three clinicians are assigned to any peer review subcommittee. A minimum of 50% of subcommittee members must participate to take action. The notes, findings, and recommendations of the peer review subcommittee are presented to the next regular peer review meeting for deliberation. The principles of evaluation, confidentiality and recommended rating are the same as for the PRC as a whole. *Ad hoc* subcommittees may be created at the discretion of the CMO or PRC. There are two standing subcommittees:
   a. Medication Safety Subcommittee: This subcommittee evaluates potential quality issues referred by the Quality department related to appropriate use of opioid medications in patients with a diagnosis of chronic pain. Members of this subcommittee will include at least one specialist board certified in pain management and one behavioral health provider.
   b. Substance Use Services Subcommittee: This subcommittee evaluates potential quality issues referred by the Quality department related to the provision of services related to the treatment of Substance Use Disorder (SUD). The subcommittee will be chaired by the Behavioral Health Clinical Director and include at least one outside specialist experienced in addiction treatment or in addiction medicine.

C. Confidentiality
1. As specified in State statute (Cal. Civ. Code §43.7.), peer review activities are not subject to

discovery. The members of the PRC and the records associated with its reviews and actions shall be afforded all of the immunity, protection and privileges under California law. A practitioner under review shall be afforded all rights and protections under California law. The PRC and the CMO shall take all reasonable steps to protect the confidentiality of the committee's deliberations, reviews and actions, including all information obtained at all stages of the investigation, review and decision making process. Any confidential health information obtained during the course of peer review investigations shall be protected from loss, tampering, alteration and unauthorized or inadvertent disclosure of information.

D. Indemnification
   1. Partnership will indemnify, defend and hold harmless the members of the PRC from and against losses and expenses (including attorneys' fees, judgments, settlement and other costs, direct or indirect) incurred or suffered by reason or based upon any threatened, pending or completed action, suit, proceeding, investigation or other dispute relating or pertaining to any alleged act or failure to act within the scope or quality assessment activities as a member of the PRC. Partnership will retain the responsibility for the sole management and defense of any such claims, suits, investigations or other disputes against PRC members, including, but not limited to, selection of legal counsel to defend against any such actions. The indemnity set forth herein is expressly conditioned on the PRC member's good-faith belief that his or her actions and/or communications are reasonable and warranted and in furtherance of Partnership's peer review, quality assessment, or quality improvement responsibilities.~~,~~ In no event will Partnership indemnify a member for acts of omissions taken in bad faith or in pursuit of the member's private economic interests.

E. Oversight
   1. The PRC is accountable to Partnership's Board of Commissioners on Medical Care.

F. Delegation Oversight and Monitoring
   1. Partnership may delegate Potential Quality Issue (PQI) investigation, including PRC oversight.
   2. A formal agreement is maintained and inclusive of all delegated functions.
   3. Partnership will review related policies and procedures and annual summary reports of findings and actions taken as a result of the PQI review process and provide feedback as part of Partnership's annual oversight audit.
   4. Results from Oversight and Monitoring activities shall be presented to the Delegation Oversight Review Sub-Committee (DORS) for review and approval.

VII. REFERENCES:

A. Cal. Civ. Code §43.7 ~~.~~ Immunity from Lliability; Mmental Hhealth Pprofessional Qquality Aassurance Ceommittees; Pprofessional Ssocieties, Mmembers or Sstaff; Ppeer Rreview or Iinsurance Uunderwriting Ceommittees; Hhospital Ggoverning Bboard

https://leginfo.legislature.ca.gov/faces/codes_displaySection.xhtml?lawCode=CIV&sectionNum=43.7.

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer or designee

X. REVISION DATES:

Medi-Cal
09/17/14; 11/19/14; 01/20/16; 3/16/16; 3/15/17,* 06/13/18; 05/08/19; 5/13/20; 5/12/21; 06/08/22; 06/14/23; 02/14/24; 02/12/25; 02/11/26; 10/14/26

Policy/Procedure Number: MPQP1053			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Peer Review Committee			☒ **External Policy** ☐ **Internal Policy**
Original Date: 09/17/2014		**Next Review Date: 02/11/202710/14/2027** **Last Review Date: 02/11/202610/14/2026**	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

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

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

PREVIOUSLY APPLIED TO:
N/A

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCUG3022 (previously UG100322)</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Incontinence Guidelines</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 07/24/1994</td><td colspan="4">Next Review Date: ~~02/11/2027~~10/14/2027
Last Review Date: ~~02/11/2026~~10/14/2026</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALS</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~02/11/2026~~10/14/2026</td></tr>
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I. RELATED POLICIES:

MCUP3041 – Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Certificate of Medical Necessity (CMN) Form: Incontinence Supplies Medical Necessity Certification Form *DHCS 6187*
B. Incontinence supplies: ~~Medicaid defines incontinence supplies as~~ ~~m~~Medically necessary products used to manage urinary and/or bowel incontinence, typically including disposable briefs (adult diapers), protective underwear (pull-on products), underpads, belted undergarments, shields, liners, pads and reusable underwear.
C. Medical Practitioner: For the purposes of this policy, the medical practitioner is a physician, nurse practitioner or physician assistant.

IV. ATTACHMENTS:

A. Partnership Maximum/ Average Benefit Incontinence Guidelines
B. Incontinence Supplies Medical Necessity Certification form (DHCS 6187)

V. PURPOSE:

To outline the process by which coverage of incontinence supplies is an available Medi-Cal benefit to Partnership Health Plan of California Members. Incontinence supplies are a Medi-Cal benefit that must be prescribed by the physician, nurse practitioner, or physician assistant (medical practitioner) who is currently responsible for the care of the Member and has evaluated the Member's bladder and bowel incontinence within the past year. All Members with a diagnosis of incontinence should be evaluated by the current medical practitioner to determine whether consultation with a specialist is indicated.

VI. GUIDELINE / PROCEDURE:

A. TREATMENT AUTHORIZATION REQUEST (TAR) PROCESS
   1. A TAR is required for all incontinence supplies*. The TAR must contain documentation regarding the Member's history of incontinence, along with information regarding the medical necessity for the

*See VI.A.3 for two code exceptions.

supplies ordered.

2. For incontinence supplies over $165 per month (including sales tax), a state mandated Incontinence Supplies Medical Necessity Certification Form *DHCS 6187* (Attachment B) must accompany the TAR and will include the following information:
   a. Medical condition / diagnosis causing bowel and bladder incontinence
   b. Type of urinary / bowel incontinence
   c. Evaluation and treatments attempted and outcomes (including urologist assessment or reports)
   d. Documentation of the reasons why other options (pharmacologic, drugs, behavioral techniques or surgical interventions) are not appropriate to decrease or eliminate incontinence
   e. Prognosis for controlling incontinence
   f. Brief summary of the incontinence therapeutic intervention plan
   g. Explanation if medical practitioner orders supplies in **excess** of the thresholds listed in Attachment A and information regarding medical necessity for the additional use
3. Codes A4335 and A6250 for skin wash and skin cream do not require a TAR unless they are ordered above normal supply limit. (See Attachment A for supply limits.) However, providers are encouraged to include these items on the incontinence supply TAR as the authorization will be valid for one year and the provider will be able to submit claims electronically without attaching the prescription each month. If these items are not included on the incontinence supply TAR, then the provider must submit a paper claim and attach a prescription form with each submission.
4. The requested item must be the lowest cost medically appropriate item to meet the Member's medical needs.
5. If the Member has chronic, non-treatable incontinence as confirmed by the primary care practitioner or a urologist, the TAR can be approved for up to one (1) year.
6. If the approval is granted for an interval greater than 30 days, the provider of service has the responsibility to verify that the Member remains eligible for Medi-Cal coverage with Partnership on a monthly basis and in NO instance will Partnership reimburse for supplies in excess of a 60 day supply dispensed at any one time. (For Example: If Partnership approves supplies for a one-year time frame, the provider will NOT be reimbursed for the entire year at one time. Billings are to occur incrementally on a monthly basis as the Member's eligibility status may change.) See Attachment A for supply limits.
7. Incontinence supplies such as disposable briefs (diapers), liners, underpads, etc. over $165 per month (including sales tax) require a completed Incontinence Supplies Medical Necessity Certification Form *DHCS 6187* (CMN form) (see Attachment B) submitted with the TAR.
8. Incontinence supplies $165 per month or less require a TAR with the prescription attached, but do not require the CMN form.
9. Note that the "NU" code modifier is NOT to be used for disposable incontinence supplies.

B. Incontinence supplies for Members in a skilled nursing facility (SNF) and Intermediate Care Facility (ICF)/Developmentally Disabled (DD) or ICF are part of the facility per diem rate and are not billable separately to Partnership. Incontinence supplies for Members in ICF/DD- Habilitative (H) or ICF/DD- Nursing (N) are not part of the facility per diem and are separately billable to Partnership. Incontinence supplies for Members in ICF/DD-H or ICF/DD-N can be approved for up to one (1) year. The same requirements as per VI.A.7 apply.

C. Incontinence supplies for Members under age five may be covered under the Medi-Cal for Kids & Teens benefit (formerly Early & Periodic Screening, Diagnostic and Treatment (EPSDT)) Services benefit ~~(now referred to as Medi-Cal for Kids and Teens)~~ where the incontinence is due to a chronic physical or mental condition, including cerebral palsy and developmental delay, and at an age when the child would normally be expected to achieve continence.

D. The CMN form (Attachment B) must be dated within 12 months of the date of service on the claim and must be signed by the Member's current medical practitioner.

Guideline/Procedure Number: MCUG3022 (previously UG100322)		**Lead Department: Health Services** **Business Unit:** Utilization Management
Guideline/Procedure Title: Incontinence Guidelines		☒**External Policy** ☐**Internal Policy**
Original Date: 07/24/1994	**Next Review Date: ~~02/11/2027~~10/14/2027** **Last Review Date: ~~02/11/2026~~10/14/2026**	
Applies to: ☒ **Medi-Cal**		☐ **Employees**

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Incontinence Medical Supplies (*incont*); List of Contracted Incontinence Absorbent Products; List of Contracted Incontinence Creams and Washes; List of Incontinence Medical Supplies Billing Codes
B. Department of Health Care Services (DHCS) California Children's Services (CCS) Numbered Letter (NL) 11-1223 Authorization for Purchase of Incontinence Medical Supplies (12/19/2023)
C. Welfare & Institutions Code, Section 14125.4

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES: 01/01/96; 04/28/00; 06/20/01; 04/21/04; 02/16/05; 03/15/06; 08/20/08; 11/18/09; 07/21/10; 06/20/12; 08/20/14; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 11/13/19; 02/12/20; 06/10/20; 09/09/20; 02/10/21; 05/12/21; 08/11/21; 08/10/22; 09/13/23; 10/09/24; 02/12/25; 02/11/26; 10/14/26

*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.

****

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

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

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

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

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

PARTNERSHIP MAXIMUM/AVERAGE BENEFIT- INCONTINENCE GUIDELINES

Billing Code (HCPCS)	Description	UOM	Medi-Cal Quantity Limits	Monthly Quantity
Disposable Incontinence Products (Briefs/Diapers) ~~*(See Notes 1, 2)*~~				
Adult Sizes				
T4521	Adult sized disposable incontinence product, brief/diaper, **small**	each	200 in a 27-day period	225 /month
T4522	Adult sized disposable incontinence product, brief/diaper, **medium/regular**	each	192 in a 27-day period	216 /month
T4523	Adult sized disposable incontinence product, brief/diaper, **large**	each	216 in a 27-day period	243 /month
T4524	Adult sized disposable incontinence product, brief/diaper, **extra-large (XL) and double extra-large (XXL)**	each	192 in a 27-day period	216 /month
T4543	Adult sized disposable incontinence product, protective brief/diaper, **triple extra-large (XXXL) or above**	each	200 in a 27-day period	225 /month
Youth Size				
T4533	**Youth sized** disposable incontinence product, brief/diaper	each	200 in a 27-day period	225 /month
Pediatric Sizes				
T4529	Pediatric sized disposable incontinence product, brief/diaper, **small/medium**	each	200 in a 27-day period	225 /month
T4530	Pediatric sized disposable incontinence product, brief/diaper, **large**	each	200 in a 27-day period	225 /month

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PARTNERSHIP MAXIMUM/AVERAGE BENEFIT- INCONTINENCE GUIDELINES

Billing Code (HCPCS)	Description	UOM	Medi-Cal Quantity Limits	Monthly Quantity
Disposable Incontinence Products (Protective Underwear/Pull-Ons) ~~*(See Notes 1, 2)*~~				
Adult Sizes				
T4525	Adult sized disposable incontinence product, protective underwear/pull-on, **small**	each	120 in a 27-day period	135 /month
T4526	Adult sized disposable incontinence product, protective underwear/pull-on, **medium**	each	120 in a 27-day period	135 /month
T4527	Adult sized disposable incontinence product, protective underwear/pull-on, **large**	each	120 in a 27-day period	135 /month
T4528	Adult sized disposable incontinence product, protective underwear/pull-on, **extra-large (XL) and double extra-large (XXL)**	each	120 in a 27-day period	135 /month
T4544	Adult sized disposable incontinence product, protective underwear/pull-on, **triple extra-large (XXXL) or above**	each	120 in a 27-day period	135 /month
Youth Size				
T4534	**Youth sized** disposable incontinence product, protective underwear/pull-on	each	200 in a 27-day period	225 /month
Pediatric Sizes				
T4531	Pediatric sized disposable incontinence product, protective underwear/pull-on, **small/medium**	each	200 in a 27-day period	225 /month
T4532	Pediatric sized disposable incontinence product, protective underwear/pull-on, **large**	each	200 in a 27-day period	225 /month

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PARTNERSHIP MAXIMUM/AVERAGE BENEFIT- INCONTINENCE GUIDELINES

Billing Code (HCPCS)	Description	UOM	Medi-Cal Quantity Limits	Monthly Quantity
Disposable Liners/Shields/Pads/Undergarments *(See Note ~~1~~2)*				
T4535	Disposable liners	each	180 in a 27-day period if only one product type billed. 300 in a 27-day period if two or more product types billed.	202 or 338 /month
T4535	Disposable shield	each		202 or 338 /month
T4535	Disposable pad	each		202 or 338 /month
T4535	Disposable undergarment (belted or beltless)	each		202 or 338 /month
Disposable Underpads ~~*(See Note 2)*~~				
T4541	Incontinence product, disposable underpad, **large size** (core mat area size equal to or greater than 676 sq. in.)	each	120 in a 27-day period	135 /month
T4542	Incontinence product, disposable underpad, **small size** (core mat area size less than 676 sq. in.)	each	120 in a 27-day period	135 /month
A4554	Disposable underpads, breathable	each	None *Restricted to patients using low air flow beds.* TAR required	—
Incontinence Reusable Pants (Any Size)				
T4536	Incontinence product, protective underwear/pull-on, reusable, **small, medium, large, XL, XXL**	each	2 units per claim, one claim per calendar month and 12 claims in a 12 month period	2 /month
Reusable waterproof sheeting				
T4537	Reusable waterproof sheeting	each	2 per year	—
Incontinence Skin Care *(See Note ~~2~~3)*				
A4335	Incontinence wash	ml	2880 ml in an 81-day period	1081 /month
A6250	Incontinence cream/ointment	g/ml	1620 g/ml in an 81-day period.	608 /month

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PARTNERSHIP MAXIMUM/AVERAGE BENEFIT- INCONTINENCE GUIDELINES

Note 1: If justification is provided, liners, shields, pads and disposable undergarments ~~Disposable Briefs/ Diapers and Disposable Protective Underwear/ Pull-Ons~~ may be mixed and matched, not to exceed 300 total units in a 27-day period or 338/ month. Medical justification must be stated in Section C, field 12 on the DHCS form 6187, Incontinence Supplies Medical Necessity Certification, which is Attachment B to this policy. Please reference the following link for quantity limits:
List of Incontinence Medical Supply Billing Codes

~~**Note 2:** The "NU" code modifier is NOT to be used for disposable incontinence supplies.~~

Note ~~2~~3: Skin Cream and Skin Wash Codes A4335 and A6250 do not require a TAR unless they are ordered above normal frequency limit. However, providers are encouraged to include these items on the incontinence supplies TAR as the authorization will be good for one year and the provider will be able to submit claims electronically without attaching the prescription each month. If these items are not included on the incontinence supply TAR, then the provider must submit a paper claim and attach a prescription form with each submission.

Additional Notes:

- The "NU" code modifier is NOT to be used for disposable incontinence supplies.
- Kimberly-Clark Products are not a Medi-Cal Benefit.
- Enuresis Alarm Pads are a covered benefit as described in policy MCUP3013 Durable Medical Equipment (DME) Authorization.

INCONTINENCE SUPPLIES MEDICAL NECESSITY CERTIFICATION

SECTION A: Incontinence Provider Information

1. Contact Person	2. Contact Telephone Number	3. Contact Fax Number

SECTION B: Patient Information

4. Patient Name– Last, First, Middle (as appears on card)

5. Medi-Cal ID Number	6. Gender	7. Date of Birth (mm/dd/yy)	8. Age
	Male ☐ Female ☐		

9. Type of Residence

☐ Home ☐ Board and Care ☐ ICF/DD-H ☐ ICF/DD-N ☐ Other _____

SECTION C: Documentation Supporting Medical Necessity

Note: If necessary, include supporting documentation on an attachment

10. Does the patient **meet the Code 1 Restriction**? Yes ☐ No ☐

If yes, indicate the primary and secondary diagnosis name and ICD-10-CM codes.

_____

_____

_____

If no, provide clinical evidence and describe in detail the medical conditions and/or extenuating circumstances to support the medical necessity.

_____

_____

_____

_____

11. Have any **previous treatments** (for example, drug therapy, behavioral techniques, and/or surgical intervention) to manage symptoms of incontinence been tried and failed or been partially successful? Yes ☐ No ☐

If yes, describe treatment(s), treatment results, and patient's responsiveness.

_____

_____

_____

_____

If no, explain reasons why other treatments are not appropriate to decrease or eliminate incontinence.

_____

_____

_____

_____

SECTION C: Documentation Supporting Medical Necessity (Continued)

12. Is this patient **prescribed multiple absorbent product types** to be used during the same time period? Yes ☐ No ☐
If yes, explain in detail the need for multiple varieties of supplies.

13. Does this request include a billing code that **requires prior authorization?** Yes ☐ No ☐
If yes, list billing code(s) and supporting documentation of medical need.

14. Does the patient require a quantity that **exceeds the quantity limits** for any of the supplies needed? Yes ☐ No ☐
If yes, list billing code(s), provide clinical evidence and describe in detail the acute medical condition and/or extenuating circumstances for increased need for additional quantities.

15. Does the patient require supplies (except creams and washes) that **exceed the $165 per month allowable**? Yes ☐ No ☐
If yes, provide a detailed explanation to support the need for supplies exceeding $165 per month.

16. Does this request have an attachment for additional supporting documentation? Yes ☐ No ☐

NOTE: Medical justification must be complete and thorough to process this request. If necessary, provide the supporting documentation and any additional information on an attachment.

SECTION D: List All Prescribed Product Types (For example, briefs, protective underwear, etc.)

17. Complete the table below for the supplies prescribed. Enter the last date of service (DOS) if previously billed.

Billing Code	Product Type	Last DOS	Daily Usage	Unit Cost	Monthly Usage	Monthly Cost	Total Units

18. This prescription is valid for _____ months. **NOTE:** The maximum allowed is 12 months. The physician's signature date below must be within 12 months of the date of service on the claim.

SECTION E: Physician's Attestation, Signature and Date (Physician's Use Only)

By my signature below, I verify that I have physically examined the patient within the last 12 months and certify to the best of my knowledge that the information contained in this form is true, accurate and complete. I have prescribed the items on this form and will maintain a copy of this prescription in the beneficiary's medical record to meet Medi-Cal documentation requirements.

19. Physician's Name	20. Physician's National Provider Identifier
21. Physician's Business Address (number, street) City	ZIP Code
22. Physician Telephone Number	23. Physician's Signature / 24. Date

INCONTINENCE SUPPLIES MEDICAL NECESSITY CERTIFICATION INSTRUCTIONS

SUBMISSION REQUIREMENTS: This form must accompany each Treatment Authorization Request (TAR) and must contain <u>all</u> supplies needed for the time period, not just supplies needing a TAR.

SECTION A: Incontinence Provider Information

1. Enter the name of the individual to contact for TAR questions.
2. Enter the phone number where the contact person can be reached.
3. Enter the fax number to receive information.

SECTION B: Patient Information

4. Enter the patient's last name, first name and middle initial.
5. Enter the Medi-Cal Identification Number.
6. Check the appropriate box.
7. Enter the complete date as 2-digit month, 2-digit day, and 2-digit year.
8. Enter the patient's current age.
9. Check the appropriate box.

SECTION C: Documentation Supporting Medical Necessity

10. – 15. An answer to each question is required. Depending on the response further explanation to support medical justification is required and if needed may be included on an attachment.
    NOTE: Medical justification must be complete and thorough in order to process the request.
16. Indicate if an attachment is included with this form.

SECTION D: List All Prescribed Product Types

17. This table must include **<u>all</u> supplies prescribed** for this patient's use during the number of months covered by this prescription.
    - Billing Code - Enter the HCPCS billing code for each supply item. Refer to the *List of Incontinence Medical Supplies Billing Codes*
    - Product Type – For each billing code enter the corresponding product type name (for example, cream, wash, disposable brief, protective underwear, pad, liner and underpad). Do not list brand name.
    - Last DOS – Enter the last date of service if product type was previously billed.
    - Daily Usage – Enter the estimated number of units the patient will use daily
    - Monthly Usage – Enter the estimated number of units the patient will use monthly.
    - Monthly Cost – Enter the estimated monthly cost for this supply, including markup and sales tax (unit cost multiplied by the monthly usage plus markup and sales tax)
    - Total units – Enter the total number of units for each supply item prescribed (monthly usage multiplied by the total number of months covered by this prescription).
18. Enter the number of months covered by this prescription. The maximum allowed is twelve (12) months.

SECTION E: Physician's Attestation, Signature and Date (Physician's Use Only)

NOTE: This section must be completed by the attending physician. The physician's personal signature in ink and date of signature is required. Signatures stamped, printed or initials are not acceptable.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3058 (previously UG100358)				**Lead Department:** Health Services **Business Unit**: Utilization Management	
Guideline/Procedure Title: Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities				☒ **External Policy** ☐ **Internal Policy**	
Original Date: 03/19/2003			**Next Review Date:** ~~01/14/2027~~10/14/2027 **Last Review Date:** ~~01/14/2026~~10/14/2026		
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:** ~~01/14/2026~~10/14/2026	

I. RELATED POLICIES:

A. MCUG3038 Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Subacute or Skilled) Facilities

B. MCUP3041 Treatment Authorization Request (TAR) Review Process

C. MPTP2501 Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)

~~C.~~D. CLPM15 Claims Processing and Payment Standards for Partnership

II. IMPACTED DEPTS:

A. ~~Health Services~~Care Coordination

B. Claims

C. Member Services

III. DEFINITIONS:

A. BH: Bed Hold

B. Developmentally Disabled (DD): Throughout this document, the term "developmentally disabled" is used to match current California Code of Regulations (CCR) language. However, it is acknowledged that this terminology is not person-centered and does not align with more contemporary language such as "people with intellectual and other developmental disabilities."

C. Intermediate Care Facilities (ICF): A health facility/home that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care.

D. ICF/DD: Intermediate Care Facilities for the Developmentally Disabled. The ICF/DD Home living arrangement is a Medi-Cal Covered Service offered to individuals with intellectual and developmental disabilities who are eligible for services and supports through the Regional Center service system.

E. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative

F. ICF/DD-N: Intermediate Care Facilities for the Developmentally Disabled/Nursing

G. Form HS 231: State of California Department of Health Care Services form entitled "Certification for Special Treatment Program Services"

H. LOA: Leave of Absence

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

J. Regional Centers: Nonprofit private corporations that contract with the Department of Developmental Services to provide or coordinate services and supports for individuals with developmental disabilities throughout California. Partnership Members with intellectual and developmental disabilities are

identified through coordination with the Regional Centers and in the course of utilization and case management services. Regional Centers providing services in Partnership's service area are as follows:

1. Alta California Regional Center provides services in Alpine, Colusa, El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, and Yuba counties.
2. Far Northern Regional Center provides services in Butte, Glenn, Lassen, Modoc, Plumas, Shasta, Siskiyou, Tehama and Trinity counties
3. Golden Gate Regional Center provides services in Marin county
4. North Bay Regional Center provides services in Solano, Napa, and Sonoma counties
5. Redwood Coast Regional Center provides services in Del Norte, Humboldt, Lake, and Mendocino counties

IV. ATTACHMENTS:

A. Bed hold/TAR Process
B. Bed Hold & Change of Status Report

V. PURPOSE:

To delineate the medically necessary criteria for admission and continuing care in an ICF/DD for Partnership HealthPlan of California Members.

VI. GUIDELINE / PROCEDURE:

A. As a Managed Care Plan (MCP), Partnership provides all medically necessary covered services for Members residing in or obtaining care in an ICF/DD facility/home, including home services, professional services, ancillary services, and transportation services. Partnership also provides the appropriate level of care coordination, as outlined in DHCS All Plan Letter (APL) 26-012 ~~(APL) 24-011~~ and in adherence to DHCS contract requirements and the DHCS Population Health Management (PHM) Policy Guide.

B. Utilization Review: ICF/DD, ICF/DD-H and ICF/DD-N Facilities

1. Federal regulations require California to provide a program of independent professional review of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled/Habilitative (ICF/DD-H), and Intermediate Care Facilities for the Developmentally Disabled/Nursing (ICF/DD-N) that provide services to Medi-Cal recipients. This process is referred to as utilization review. Its purpose is to control unnecessary utilization of services by evaluating patient needs and the appropriateness, quality and timeliness of service delivery.
2. Patient Placement Requirements
   a. Only individuals with predictable, intermittent skilled nursing needs, which can be arranged for in advance, are appropriate for ICF/DD-H and ICF/DD-N placement. Recipients who require skilled nursing procedures "as needed" are not appropriate for ICF/DD-H and ICF/DD-N placement.
   b. Please refer to policy MCUG3038 Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care (LTC) Facilities
3. Per Diem Services
   a. Services covered under the daily rate of an ICF/DD, ICF/DD-H and ICF/DD-N include:
      1) Services of the direct care staff
      2) Services of the facility's interdisciplinary team
      3) Services of qualified intellectual disabilities professional
      4) Case conference reviews
      5) Development of service plans
      6) In-service training of direct care staff and consultation on individual recipient needs

7) Transportation services (see policy MPTP2501- Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
8) Equipment and supplies necessary to provide appropriate care
9) Room and Board

4. ICF/DD-H/DD-N TAR Submission
   a. Submitting with a Treatment Authorization Request (TAR):
      1) Completed new TAR form 20-1
      2) Submit form HS 231 with initial and reauthorization TARs within 15 business days from date of service.
   b. Certification Period:
      1) For the ICF/DD-H or ICF/DD-N level of care, form HS 231 must be certified by the Regional Center director or designee.
      2) Certification may be granted for a period of twelve months at a time.
      3) The Regional Center director or designee assesses new patients within a reasonable amount of time.
      4) When the certified period expires, the Member must be re-assessed and a new form HS 231 must be filled out and signed by the Regional Center director or designee.
5. Readmission and New Certification:
   a. ICF/DD-H or ICF/DD-N Member who is discharged and subsequently readmitted must be re-assessed. A new form HS 231 must be filled out and submitted with a new TAR.

C. Leave of Absence
1. Leave of Absence Qualifications
   a. A leave of absence (LOA) may be granted to a recipient in an ICF/DD-N or ICF/DD-H in accordance with the recipient's individual plan of care and for the specific reasons outlined below:
      1) A visit with relatives or friends
      2) Participation by developmentally disabled recipients in an organized summer camp for developmentally disabled persons
2. Leave of Absence Maximum Time Period
   a. If the LOA is an overnight visit (or longer) to the home of relatives or friends, the time period is restricted as follows:
      1) Developmentally disabled recipients can receive a leave of absence for relatives/friend visits or summer camp for up to seventy-three (73) days per calendar year.
         a) A physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled.
      3) These limits are in addition to bed hold days ordered by the attending physician for each period of acute hospitalization for which the facility is reimbursed for reserving the patient's bed (bed hold) as described below.

D. Bed Hold (BH) Qualifications
1. Partnership covers the stay when a recipient residing in a ICF/DD facility/ home is admitted to an acute care hospital setting, a post-acute care setting such as a skilled nursing facility (SNF), or a rehabilitation facility, and then requires a return to an ICF/DD Home. Providers must bill bed hold (BH) days (see Attachment B). Reimbursement for bed hold days is limited to a maximum of seven (7) days per hospitalization, subject to the following:
   a. The attending physician must order the acute hospitalization.
   b. The ICF/DD facility/home must hold a bed vacant when requested during the entire hold period, maximum of 7 days for each bed hold period, except when notified in writing by the attending physician that the patient requires more than seven days of hospital care. The facility is then no longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days.

2. General Leave of Absence and Bed Hold Requirements
   a. General requirements for LOA and BH are outlined below:
      1) Day of departure is counted as one day of LOA/BH, and the day of return is counted as one day of inpatient care.
      2) Facility holds the bed vacant during LOA/BH
      3) LOA or BH (hospitalization) is ordered by a licensed physician
      4) Recipient's return from LOA/BH must not be followed by discharge within 24 hours
      5) LOA/BH must terminate on a recipient's day of death
      6) Facility claims must identify the inclusive dates of leave
3. Additional Leave of Absence Requirements
   a. Requirements specific to LOA are listed below:
      1) Provisions for LOAs are part of the individual program plan for recipients in an ICF/DD, ICF/DD-H, or ICF/DD-N.
      2) Re-admission TAR's are not necessary for recipients returning from a leave of absence if a valid TAR covering the return date exists.
      3) Payment will not be made for the last day of leave if a recipient fails to return from leave within the authorized leave period.
      4) Recipient's records maintained in an ICF/DD, ICF/DD-H, or ICF/DD-N must show the address of the intended leave destination and inclusive dates of leave.
   b. Payment will not be made for any LOA days exceeding the maximum number of leave days allotted by these regulations per calendar year.
   c. At the time of admission, if a recipient has not been an inpatient in any custodial/long term care facility for the previous two months or longer, the recipient is eligible for the full complement of leave days as specified by these regulations.
4. Patient Failure to Return from Leave of Absence
   a. If recipients have used their total leave days, they may still be allowed a leave of absence during the same calendar year. However, the facility will not receive reimbursement for those authorized leave days.

VII. REFERENCES:

A. Title 42 Code of Federal Regulations (CFR) Sections 483.400 – 483.480
B. Title 22 California Code of Regulations (CCR) Section 51535
C. California Department of Developmental Services (DDS) Guidelines
D. Medi-Cal Provider Manual/Guidelines: Utilization Review: ICF/DD, ICF/DD-H and ICF/DD-N Facilities *(util review)*; Leave of Absence, Bed Hold, and Room and Board *(leave)*; TAR for Long Term Care: 20-1 Form *(tar ltc)*
E. Lanterman Developmental Disabilities Services Act
F. DHCS APL 26-012 ~~APL 24-011~~ Intermediate Care Facilities for Individuals w~~W~~ith Developmental Disabilities - Long Term Care Benefit Under Managed Care ~~Standardization and Transition of Members to Managed Care (09/16/2024)~~ (06/10/2026)
G. DHCS Population Health Management Guide
H. DHCS form HS 231 Certification for Special Treatment Program Services

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

Guideline/Procedure Number: MCUG3058 (previously UG100358)		**Lead Department: Health Services** **Business Unit:** Utilization Management
Guideline/Procedure Title: Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities		☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/19/2003	**Next Review Date: 01/14/202710/14/2027** **Last Review Date: 01/14/202610/14/2026**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

*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

REGULATOR APPROVAL:
DHCS – last approved on 4/2/2025 for APL 24-011
DHCS – approved on 9/23/2024 for APL 23-023

****

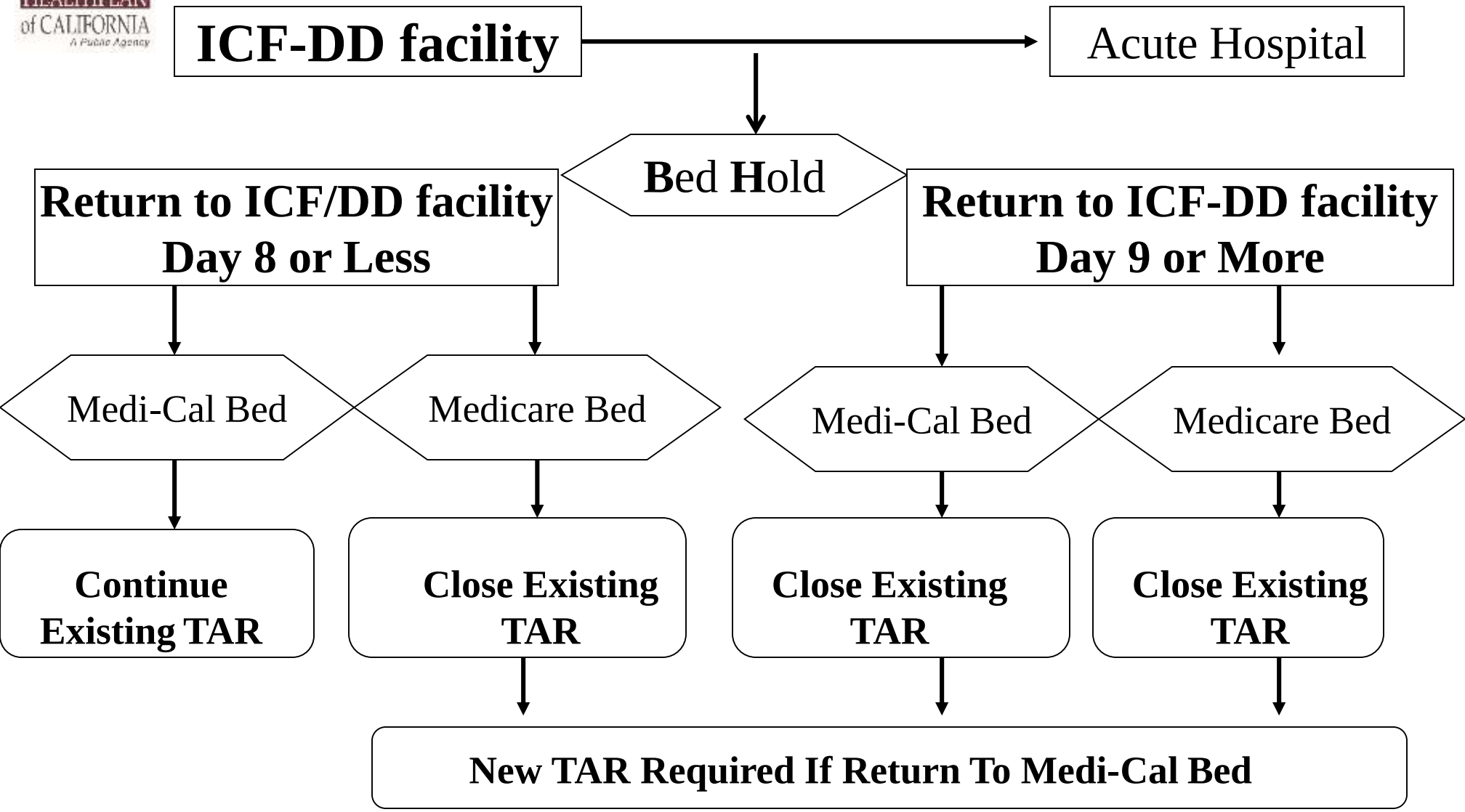
In accordance with the California Health and Safety Code, Section 1363.5, this policy was developed with involvement from actively practicing health care providers and meets these provisions:

- 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.

Bed Hold / TAR Process After Acute Hospitalization



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

MCUG3038 Attachment A 01/14/2026
MCUG3058 Attachment B 01/14/2026

BED HOLD & CHANGE OF STATUS REPORT

FACILITY NAME: _____

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

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

Fax to **707 - 863 - 4118**

REMARKS:

NO.	

LEGEND:

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

Prepared By: _____

Telephone #: _____

Fax #: _____

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3115</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Community Based Adult Services</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 10/17/2012
(Effective 07/01/2012)</td><td colspan="4">Next Review Date: ~~11/12/2026~~10/14/2027
Last Review Date: ~~11/12/2025~~10/14/2026</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>☒ QUAC</td><td></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="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/12/2025~~10/14/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
C. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
D. CGA024 – Medi-Cal Member Grievance System
E. MPCR700 – Assessment of Organizational Providers
F. MPCR500 – Ongoing Monitoring of Sanctions ~~and Interventions~~

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

A. Community Based Adult Services (CBAS): An outpatient facility-based program that delivers skilled nursing care, social services, therapeutic activities, personal care, family/caregiver training and support, nutrition services and transportation to qualified beneficiaries.
B. Developmentally Disabled (DD): Throughout this document, the term "developmentally disabled" is used to match current California Code of Regulations (CCR) language. However, it is acknowledged that this terminology is not person-centered and does not align with more contemporary language such as "people with intellectual and other developmental disabilities."
C. Emergency Remote Services (ERS): Temporary provision of CBAS services in a care setting other than the CBAS center, such as an alternative location in the community, at the doorstep of the participant's home, or via telehealth, including telephone and virtual video conferencing, as clinically appropriate, to allow for immediate response to a Member's need when an emergency restricts or prevents them from receiving services at their CBAS center.
D. Intermediate Care Facilities (ICF): A health facility/home that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care.
E. ICF/DD-H: Intermediate Care Facilities for the Developmentally Disabled/Habilitative

IV. ATTACHMENTS:

A. CBAS Individual Plan of Care (IPC) Form (DHCS 0020)

Policy/Procedure Number: MCUP3115		Lead Department: Health Services Business Unit: Utilization Management
Policy/Procedure Title: Community Based Adult Services		☒ External Policy ☐ Internal Policy
Original Date: 10/17/2012	**Next Review Date: 11/12/202610/14/2027** **Last Review Date: 11/12/202510/14/2026**	
Applies to:	☒ Medi-Cal	☐ Employees

V. PURPOSE:

Effective July 1, 2012, Partnership HealthPlan of California assumed responsibility to provide benefits for the services provided at Community Based Adult Service (CBAS) agencies. Under an interagency agreement, the CBAS Program is administered among the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and the California Department of Aging (CDA). CDPH licenses Adult Day Health Care (ADHC) centers and CDA certifies them for participation in the Medi-Cal Program. The purpose of this policy is to define the process required to access CBAS services.

VI. POLICY / PROCEDURE:

A. CBAS Objectives
   1. The primary objectives of the CBAS program are to:
      a. Restore or maintain optimal capacity for self-care to frail elderly persons or adults with disabilities; and
      b. Delay or prevent inappropriate or personally undesirable institutionalization
      c. The program stresses partnership with the participant, the family and/or caregiver, the primary care provider (PCP), and the community in working toward maintaining personal independence.

B. Eligibility Criteria
   1. To be eligible for CBAS services through Partnership HealthPlan of California, the person must be at least 18 years of age. They must be an eligible Member of Partnership's Medi-Cal program.
   2. The Member must also meet all the following criteria:
      a. Must have one or more chronic or post-acute medical, cognitive, or mental health conditions.
      b. A physician, physician assistant, nurse practitioner or other health care provider has, within his/her scope of practice, requested CBAS services for the person.
      c. The person requires ongoing or intermittent protective supervision, skilled observation, assessment or intervention by a skilled health provider to improve, stabilize, maintain, or minimize deterioration of the medical, cognitive or mental health condition.
      d. The person requires CBAS services that are individualized and planned to support the individual and his or her family or caregiver in the living arrangement of his/her choice and to avoid or delay the use of institutional services, including but not limited to, hospital services, inpatient mental health services or placement in a nursing or intermediate care facility for the developmentally disabled providing continuous nursing care.
      e. Any person who is a resident of an Intermediate Care Facility for the Developmentally Disabled/Habilitative (ICF/DD-H) shall be eligible for CBAS care services if that resident has disabilities and a level of functioning that are of such a nature that without supplemental intervention through CBAS care, placement to a more costly institutional level of care would likely occur.
   3. Medical Necessity Criteria
      a. Except for participants residing in an ICF/DD-H, authorization or reauthorization of a CBAS Treatment Authorization Request (TAR) shall be approved only if the participant meets all of the following medical criteria:
         1) The participant has one or more chronic or post-acute medical, cognitive, or mental health conditions that are identified by the participant's personal health care provider as requiring one or more of the following, without which the participant's condition will likely deteriorate and require emergency department visits, hospitalization or other institutionalization:
            a) Monitoring
            b) Treatment

c) Intervention

2) The participant's network of daytime health care support is insufficient to maintain the individual in the community, demonstrated by at least one of the following:
   a) Participant lives alone and has no family or caregivers available to provide sufficient and necessary care or supervision
   b) Participant resides with one or more related or unrelated individuals, but they are unwilling or unable to provide sufficient and necessary care or supervision to the participant
   c) Participant has family or caregivers available, but those individuals require respite in order to continue providing sufficient and necessary care or supervision to the participant.
   d) A high potential exists for the deterioration of the Participant's medical, cognitive, or mental health condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization if CBAS services are not provided.
3) The Member meets the criteria for Emergency Remote Services (ERS) as defined in Section VI.F below.

C. CBAS Authorization Process
1. Initial Request: A request for initiation of CBAS services may come from one of the following sources:
   a. Community Based Adult Services Center
   b. A licensed physician, physician assistant, nurse practitioner or other health care provider within their scope of practice and board certification
   c. Nursing Facility
   d. Hospital
   e. Individual Member
   f. Family member
   g. Community Based Organization
   h. Partnership's internal report with CBAS indicator
   i. Partnership's Care Coordination staff
2. To recommend a Member for CBAS services, all other requesting entities besides the CBAS center itself must refer to the CBAS center. This inquiry may be done verbally or in writing. The following information should be included at the time of the request:
   a. Member's Name
   b. Identification Number
   c. Date of Birth
   d. Contact Information of Member, caregiver and referring agent. (Name, address, phone number)
   e. Reason the Member needs CBAS services
   (Specific information may vary by the requesting entity)

D. TAR Submission
1. The CBAS agency will begin their Multidisciplinary Team assessment process and complete the Individualized Plan of Care (IPC), (see Attachment A). When the evaluation and IPC is complete and CBAS staff determines the Member to be appropriate for services, the CBAS agency must electronically submit a TAR to Partnership. The TAR must include the codes and description of the services to be provided and a copy of the IPC, with anticipated level of service, as well as any other clinical documentation available (i.e. History and Physical).
2. An initial face-to-face review is not required when Partnership or DHCS or its contractor(s) determine that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses. Partnership determines that a Member is

eligible to receive CBAS, and that the receipt of CBAS is clinically appropriate, based on review of the IPC and clinical information submitted with the TAR.

a. If Partnership or DHCS or its contractor(s) cannot determine that an individual is eligible to receive CBAS and that the receipt of CBAS is clinically appropriate based on information that the plan possesses, then the initial eligibility determination for the CBAS benefit will be performed through a face-to-face review by a registered nurse with level of care determination experience, using a standardized tool and protocol approved by DHCS.

3. Partnership will approve, modify or deny the requested CBAS services within seven ~~five~~ (7~~5~~) calendar~~business~~ days of receipt of the TAR, in accordance with Health and Safety Code 1367.01. Decisions for requests on behalf of Members in a hospital or Skilled Nursing Facility (SNF) whose discharge plan includes CBAS, or who are at high risk for admission to a hospital or SNF (e.g., an expedited or urgent request) will be made within 72 hours of receipt of the TAR, in accordance with CMS Letter Number 11-W100193/9 (CalAIM) Special Terms and Conditions (STCs). If the TAR is approved, the facility will be notified via copy of the authorization.
4. If the TAR is modified or denied, a Notice of Action (NOA) letter will be sent to the Member and CBAS provider.
5. If the plan does not have sufficient information to make a determination, Partnership will extend the time frame one time by up to 14 calendar days. The Member and the CBAS provider are notified immediately in writing of the extension and what additional information is required to complete the review. If no additional requested information is received, the TAR may be denied via the NOA letter. The letter will include appeal rights and responsibilities.
6. CBAS providers can contact Partnership at (800) 863-4155 with all inquiries related to CBAS eligibility determinations, authorization requests, and care planning. The call will be triaged to the appropriate department, where the appropriate assigned Case Manager/Care Team will be identified and notified for follow-up. Partnership will coordinate with CBAS providers for the timely exchange of coordination of care information, including but not limited to:
   a. Updates to Member's IPC and/or discharge plan
   b. Reports of incidents that threaten the welfare, health, and safety of the Member
   c. Significant changes in the Member's condition

E. Reassessment and Reauthorization

1. Eligibility for ongoing receipt of CBAS is determined at least every six months through the reauthorization process or up to every twelve months for individuals determined by Partnership to be clinically appropriate.
2. A CBAS center requests reassessment and submits a request to begin the CBAS reassessment process.
   a. Examples:
      1) Prior authorization end date is approaching
      2) Due to a change in level of service
3. A TAR is created and sent to Partnership with an IPC and a Level of Service recommendation.
4. Partnership receives the prior authorization request from the CBAS center, which includes a completed IPC and level of service recommendation. Partnership will handle the recommendation through existing TAR process which includes:
   a. Partnership will approve, modify or deny prior authorization request within seven~~five~~ (7~~5~~) calendar~~business~~ days, in accordance with Health and Safety Code 1367.01.
   b. If Partnership cannot make a decision within seven~~five~~ (7~~5~~) calendar ~~business~~ days, a 14-day pend letter will be sent to the Member and center.
   c. Partnership notifies the center within 24 hours of the decision. The plan notifies the Member within 48 hours of the decision.
5. Denial in services or reduction in the requested number of days for services of ongoing CBAS by

DHCS or by Partnership requires a face-to-face review.

a. Process must be completed in accordance with the Health and Safety Code 1367.01 and ensure timelines are met.

6. CBAS services continue.

F. Emergency Remote Services (ERS)

1. Pursuant to the CalAIM 1115 waiver authorized by Centers for Medicare and Medicaid Services (CMS) in January of 2022, CBAS Emergency Remote Services (ERS) are available to Members who are approved and participate in services delivered by a CBAS center.
   a. ERS are defined as the temporary provision of CBAS services in a care setting other than the CBAS center, such as an alternative location in the community, at the doorstep of the participant's home, or via telehealth, including telephone and virtual video conferencing, as clinically appropriate, ~~-~~to allow for immediate response to a Member's needs when an emergency restricts or prevents them from receiving services at their CBAS center.
2. Prior to delivery or approval of ERS services, CBAS centers are required to complete the necessary two-step process for obtaining approval from the California Department of Aging (CDA).
   a. Prior to authorizing CBAS ERS services, Partnership shall track and ensure contracted CBAS providers have completed the approval process as required.
   b. Partnership shall regularly check the CDA website for updated CBAS and ERS letters.
3. Effective October 1, 2022, CBAS providers are required to provide ERS when Members experience ~~emergencies~~ unique circumstances as defined below:
   a. Public Emergency: The CBAS center is located in a region that is impacted by S~~s~~tate or local disaster(s) as determined by DHCS or Partnership, regardless of whether formally declared. Partnership will allow for the provision of ERS prior or subsequent to an official public health emergency declaration, as determined by DHCS or Partnership. These public emergencies may include, but are not limited to: earthquakes, floods, fires, power outages, epidemic/infectious disease outbreaks such as COVID-19, Tuberculosis, Norovirus, etc. ~~and/or~~
   b. Personal Emergency: The Member enrolled in CBAS is experiencing a time-limited serious illness or injury, crisis or care transition, which temporarily prevents or restricts ~~affects~~ their ability to ~~safely and appropriately participate in~~ receive CBAS ~~-~~services in-person at the CBAS center location, subject to approval by Partnership. For the purposes of ERS, DHCS has defined this as:
      1) Serious illness or injury that prevents the Member from receiving CBAS services within the facility and that providing medically necessary services/supports to the Member would protect life, address or prevent significant illness or disability, and/or alleviate pain.
      2) Crisis means that the Member is experiencing or threatened with intense difficulty, trouble or danger. Examples of personal crises include the sudden loss of a caregiver, neglect or abuse, loss of housing, etc.
      3) Care transitions occur when the Member is moving to or from care settings such as returning to home or another community setting after a hospital or nursing facility stay.
4. Members who are hospitalized or admitted to a skilled nursing facility (SNF) are not eligible for ERS services while they are admitted or in those facilities.
5. ERS provided during a care transition shall address service gaps and Member/caregiver needs but should not duplicate responsibilities assigned to intake or discharging entities.
6. To request ERS services:
   a. The Registered Nurse and Social Worker at the CBAS center must first assess the emergency and make updates to the Member's IPC above (Attachment A).
   b. If there is no active TAR on file for CBAS services, the CBAS provider must submit a new TAR to Partnership requesting ERS services along with:
      1) A copy of the Member's IPC

2) Documentation of the Public and/or Personal Emergency need(s) necessitating ERS services
3) Anticipated time/duration of ERS services

c. If there is already an active TAR on file for CBAS services, the CBAS provider must submit a TAR modification request to Partnership requesting ERS services along with:
1) An updated copy of the Member's IPC
2) Documentation of the Public and/or Personal Emergency need(s) necessitating ERS services
3) Anticipated time/duration of the ERS services

d. During the TAR review process for ERS services, Partnership staff shall work collaboratively with contracted CBAS providers regarding the method of ERS services.

7. ERS services are time-limited and may be authorized for up to three (3) consecutive months for Members who are experiencing a public or personal emergency.
a. Members may choose to cease ERS services at any time.
b. For Members who may require ERS beyond the initial three (3) consecutive months:
1) The CBAS center shall complete a new assessment documenting the continued need for remote/telehealth delivery of CBAS services and supports at least every three (3) months. A TAR modification request shall be submitted to Partnership requesting a continuation of ERS along with the Member's updated IPC for review.

8. Through the TAR review process for ERS services, Partnership shall coordinate with the CBAS center(s) to ensure that Members have their service and support needs met throughout the duration of ERS services.

G. CBAS Facility Selection
1. The Member may choose any CBAS Center as long as it is within the selected facility's time and distance criteria for transportation.

H. Reduction in Services or Discharge from CBAS Services
1. If a Member is going to experience a reduction in CBAS or ERS services, the CBAS center must submit an updated IPC to Partnership.
2. If the Member will be discharged from a CBAS center, the CBAS center must update the Member's IPC and/or complete a discharge plan for the Member. A copy of the revised IPC and/or discharge plan must be submitted to Partnership for review. The discharge plan must include the following:
a. The Member's name and ID number
b. The name(s) of the Member's physician(s)
c. If applicable, the date the NOA denying authorization for CBAS was issued
d. If applicable, the date the CBAS benefit will be terminated
e. Specific information about the Member's current medical condition, treatments, and medications
f. Potential referrals for medically necessary services and other services or community resources that the Member may need upon discharge
g. Contact information for the Member's case manager
h. A space for the Member or the Member's representative to sign and date the discharge plan or IPC
3. If a Member has already been discharged, the CBAS center must submit the updated IPC and/or discharge plan to Partnership within 30 days.
4. Partnership shall review the IPC and/or discharge plan to determine if the Member has additional needs.
a. For Members that possess additional needs, Partnership shall make a referral to appropriate care coordination or case management services.
b. Members who are discharged from a CBAS program involuntarily may file a grievance with Partnership or request a fair state hearing or independent medical review within 180 calendar days of the date of the involuntarily discharge.

1) A Member who receives a written notice of action has the right to file an appeal and/or grievance under State and Federal Law.
2) A CBAS participant may file a grievance with Partnership as a written or oral complaint as described in Partnership policy CGA024 Medi-Cal Member Grievance System. The Member or their authorized representative may file a grievance at any time that they experience dissatisfaction with the services or quality of care provided to them.

I. Unbundled Services
1. If a Member is determined to be eligible for CBAS services but there is no CBAS facility in the Member's service area, the Member may choose to attend a CBAS facility of their choice. If there is no CBAS facility available, Partnership will assist in arranging for those individual services that are Partnership benefits and make appropriate referrals to other agencies for the unbundled services that are not Partnership benefits.
2. Unbundled CBAS covered services are limited to the following:
   a. Professional Nursing Services
   b. Nutrition
   c. Physical Therapy
   d. Occupational Therapy
   e. Speech and Language Pathology Services
   f. Nonmedical Emergency Transportation (NEMT) and Non-Medical Transportation (NMT), only between the Member's home and the CBAS unbundled service Provider; and
   g. Non-specialty Mental Health Services (NSMHS) and Substance Use Disorder (SUD) services that are covered services

J. Quality and Monitoring
1. Licensing & Program Oversight: Under an interagency agreement, the CBAS Program is administered among the Department of Health Care Services (DHCS), the California Department of Public Health (CDPH), and the California Department of Aging (CDA). CDA certifies licensed Adult Day Health Care (ADHC) centers as Medi-Cal CBAS providers. CDA is responsible for initial certification of new CBAS centers as Medi-Cal providers, certification renewal, providing on-going training and technical assistance to centers, and initiating adverse certification actions against centers that are substantially out of compliance with program requirements.
   a. Partnership's Provider Relations department shall review All Center Letters (ACL) issued by the CDA and ensure that contracted CBAS providers are meeting all requirements issued in those letters.
2. Credentialing: Partnership's Provider Relations department is responsible for ensuring that all CBAS providers are licensed pursuant to CDA and DHCS regulations, and verifying center credentials (see policy MPCR700 Assessment of Organizational Providers). Pursuant to Partnership policy MPCR500 Ongoing Monitoring and Interventions, Partnership's CBAS providers shall be monitored monthly to ensure they remain free of Medi-Cal and Medicare sanctions and maintain a valid and unrestricted license.
   a. In addition, Partnership's Network Services department shall review and monitor the CDA website for updates to contracted CBAS providers licensing and/or ERS approval status.
   b. Partnership's Network Services department shall update Partnership Health Services staff when or if a CBAS provider loses their license(s) or ERS approval(s).
   c. Partnership Provider Relations and Health Services departments will be responsible for providing written notification and training (if necessary) when substantive updates to CBAS-related policies and procedures are made.
3. In collaboration with Health Services (HS) staff, Partnership's Network Services department shall monitor the documentation and reporting requirements of CBAS providers, including but not limited to IPCs, discharge plans, on-going assessments, progress notes, discharge plans,

timely completion of the CBAS Emergency Remote Services Initiation Form (CEIF or CDA 4000), etc.

4. Reporting: CBAS centers shall remit to Partnership all DHCS and/or CDA required reporting pursuant to the templates and frequencies requested by Partnership.
5. In addition to DHCS Quarterly reporting, Partnership Health Services staff shall monitor and track available performance and/or quality measures made available on the on the CDA website, such as the CBAS dashboard, to track, trend and/or evaluate CBAS provider performance and outcomes.

K. Darling vs. Douglas Settlement
1. Members who were considered Members under the DHCS Darling vs Douglas litigation and were determined not to be eligible for CBAS services will continue to receive these services as stipulated in the settlement agreement.

VII. REFERENCES:

A. Welfare and Institutions Code, Sections 14525 and 14526.1
B. California Health and Safety Code Section 1367.01
C. California Department of Aging (CDA) CBAS Branch All Center Letter (ACL) #19-02 Implementation of New CBAS Individual Plan of Care (IPC) (*Amended* 03/19/2019)
D. Medi-Cal Provider Manual/ Guidelines: Community-Based Adult Services (CBAS) *(community)*
E. DHCS All Plan Letter (APL) 25-013 "Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage" (09/18/2025)
F. DHCS APL 22-020 *Revised* Community-Based Adult Services Emergency Remote Services (11/02/2022)
G. DHCS APL 21-011 *Revised* Grievance and Appeal Requirements, Notice And "Your Rights" Templates (08/31/2022)
H. California Department of Aging (CDA) CBAS Branch All Center Letter (ACL) 22-04 *Revised* Launch of New CBAS Emergency Remote Services (ERS) (10/03/2023)
I. Centers for Medicare and Medicaid Services (CMS) Letter Number 11-W-00193/9 (CalAIM) Special Terms and Conditions (STCs) (*Amended* 11/28/2014)

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

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

*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

REGULATOR APPROVAL:
DHCS approved on 11/12/2025 for MOR.0254
DHCS approved on 11/07/2025 for MOR.0253
DHCS approved on 8/9/2023 for R.0218
DHCS approved on 4/4/2023 for R.0215

DHCS approved on 3/30/2023 for R.0216
DHCS approved on 3/14/2023 for R.0217
DHCS approved on 2/6/2023 for APL 22-020

****

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

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
DEPARTMENT OF HEALTH CARE SERVICES
INDIVIDUAL PLAN OF CARE
DHCS 0020 (REV 07/2019)

Center Name:	**Provider # (NPI):**
Participant Name:	
Date of Birth (MM/DD/YY):	CIN:
Gender: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female	
Managed Care Plan Name:	
Dates of Service: From: _____ To: _____	Planned Days/Week (#_____)
TAR Control Number (TCN):	

(1) TREATMENT AUTHORIZATION REQUEST (TAR) AND ELIGIBILITY

☐ Initial TAR ☐ Reauthorization TAR ☐ Change TAR

TB Clearance Date (initial TAR only): _____

If this is a reauthorization TAR, the participant's condition would likely deteriorate if the CBAS services were denied. ☐ Yes ☐ No ☐ N/A

☐ The individual meets all CBAS eligibility and medical necessity criteria and one or more of the following CBAS medical criteria categories as set forth in the current Medi-Cal 1115(a) Demonstration Waiver, entitled California Medi-Cal 2020:

- ☐ **Category 1**: Nursing Facility Level A (NF-A) or above
- ☐ **Category 2**: Organic, acquired or traumatic brain injury and/or chronic mental disorder
- ☐ **Category 3**: Alzheimer's disease or other dementias at moderate to severe level
- ☐ **Category 4**: Mild cognitive impairment including Alzheimer's disease or other dementias
- ☐ **Category 5**: Individuals who have developmental disabilities

(2) DIAGNOSES AND ICD CODES

Diagnosis	ICD Code	Diagnosis	ICD Code
1.		**2.**	
3.		**4.**	
5.		**6.**	
7.		**8.**	
9.		**10.**	
11.		**12.**	
13.		**14.**	

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

Diagnosis	ICD Code	Diagnosis	ICD Code
15.		**16.**	
17.		**18.**	
19.		**20.**	

(3) MEDICATIONS

☐ No medications or supplements

ACTIVE PRESCRIPTIONS		OVER-THE-COUNTER MEDICATION AND/OR SUPPLEMENTS
1.	**2.**	
3.	**4.**	
5.	**6.**	
7.	**8.**	**1.**
9.	**10.**	**2.**
11.	**12.**	**3.**
13.	**14.**	**4.**
15.	**16.**	**5.**
17.	**18.**	**6.**
19.	**20.**	**7.**
21.	**22.**	**8.**
23.	**24.**	**9.**
25.	**26.**	**10.**

Center administers participant's prescribed medication(s) ☐ Yes ☐ No
Participant self-administers prescribed medication(s) at center ☐ Yes ☐ No

(4) ACTIVE PERSONAL MEDICAL/MENTAL HEALTH CARE PROVIDER(S)

NAME	PROVIDER SPECIALTY	ADDRESS	PHONE

COMMUNITY-BASED CBAS ADULT SERVICES

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

(5) ADL/IADLs

Independent: able to perform for self with or without device

Needs Supervision: no physical help required but needs to be monitored, even with device

Needs Assistance: physical help or cueing required, even with device

Dependent: unable to do for self, even with physical help, cueing or device

ADLs	INDEPENDENT	NEEDS SUPERVISION	NEEDS ASSISTANCE	DEPENDENT
Ambulation	☐	☐	☐	☐
Bathing	☐	☐	☐	☐
Dressing	☐	☐	☐	☐
Self-Feeding	☐	☐	☐	☐
Toileting	☐	☐	☐	☐
Transferring	☐	☐	☐	☐

IADLs	INDEPENDENT	NEEDS SUPERVISION	NEEDS ASSISTANCE	DEPENDENT
Accessing Resources	☐	☐	☐	☐
Hygiene	☐	☐	☐	☐
Meal Preparation	☐	☐	☐	☐
Medication Mgmt.	☐	☐	☐	☐
Money Mgmt.	☐	☐	☐	☐
Transportation	☐	☐	☐	☐

(6) CURRENT ASSISTIVE/ADAPTIVE DEVICES

☐ None

☐ Wheelchair ☐ Walker ☐ Gait Belt ☐ Crutches ☐ Hoyer Lift ☐ Cane

☐ Dentures ☐ Glasses or Other Vision Aids ☐ Orthosis/Prothesis

☐ Hearing Device ☐ Augmentative and Alternative Communication (AAC) Device

☐ Specialized Eating Equipment/Utensils

☐ Respiratory Equipment (specify): _____

☐ Other (specify): _____

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

(7) CONTINENCE INFORMATION

☐ Continent

☐ Incontinent of bladder: ☐ Occasionally ☐ Frequently ☐ Always

☐ Incontinent of bowel: ☐ Occasionally ☐ Frequently ☐ Always

☐ External/internal catheter ☐ Ostomy

☐ Other (specify): _____

(8) NUTRITIONAL INFORMATION

☐ Body Mass Index (BMI) _____ ☐ Underweight ☐ Normal ☐ Overweight ☐ Obese

☐ BMI Not Known ☐ Feeding tube ☐ Special/therapeutic diet (specify): _____

☐ Difficulty chewing and/or swallowing ☐ Needs dietary counseling and education

☐ Other (specify): _____

(9) LIVING ARRANGEMENT/HOUSEHOLD COMPOSITION AND NON-CBAS LONG TERM SUPPORT SERVICES (if known)

LIVING ARRANGEMENT/HOUSEHOLD COMPOSITION

Type of Residence:

☐ Personal Residence (house/apartment)

☐ Community Care Licensed Facility (e.g., Residential Care Facility)

☐ Other Congregate Living

☐ ICF/DD-H ☐ Homeless/Temporary Shelter

☐ Other (specify): _____

Household Composition:

☐ Alone ☐ Relative (specify): _____ ☐ Non-relative (specify): _____

This space intentionally left blank.

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

SUPPORT SERVICES (IN ADDITION TO CBAS)

☐ Not known ☐ None

☐ IHSS (In Home Supportive Services) (Number of Hours/Month: _____)

☐ Care Management Program: ☐ MSSP ☐ Regional Center

☐ Other (specify): _____

☐ Veterans Administration Services (specify): _____

☐ Home Delivered Meals ☐ Friendly Visitor/Senior Companion/Peer Counselor

☐ Telephone Reassurance ☐ Transportation

☐ Representative Payee ☐ Conservatorship ☐ Other (specify): _____

(10) OTHER HEALTH SERVICES (if known)

WITHIN THE PAST 6 MONTHS

☐ None

☐ Not Known

☐ Emergency Department Visit(s)

visits: _____

Explain: _____

☐ Medical Hospitalization(s)

times admitted: _____

Explain: _____

☐ Psychiatric Hospitalization(s)

times admitted: _____

Explain: _____

☐ Nursing Facility

Explain: _____

☐ Home Health Services

☐ Currently receiving

Explain: _____

COMMUNITY-BASED CBAS ADULT SERVICES

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

OTHER HEALTH SERVICES (if known) Continued

WITHIN THE PAST 6 MONTHS

☐ Hospice Care

☐ Currently receiving

Explain: _____

☐ Mental Health Outpatient Services

☐ Currently receiving

Explain: _____

☐ Other (specify): _____

(11) RISK FACTORS (check all that apply at time of IPC completion)

INTERNAL/CLINICAL RISK FACTORS

☐ None

☐ Mental Illness

☐ Substance Use/Abuse

☐ Cognitive Impairment

☐ Polypharmacy (6+)

☐ Medication Mismanagement

☐ ADL Functional Limitations (3+)

☐ High Fall Risk

☐ Chronic Pain

☐ Frailty

☐ Wandering/Exit-Seeking Behavior

☐ Significant Sensory Impairment

☐ Other (specify): _____

EXTERNAL RISK FACTORS/SOCIAL DETERMINANTS OF HEALTH

☐ None

☐ At Risk When Home Alone

☐ Limited or No Social Supports/Family

☐ Caregiver Stress/Inconsistency

☐ IHSS Inconsistency

☐ Social Isolation/Loneliness

☐ Emergency Department (ED) visit within 30 days

☐ Hospitalization (unplanned) within 60 days

☐ Unstable or Unsafe Housing

☐ Homeless/history of homelessness

☐ Financial Insecurity/Poverty/Lack of Resources

☐ Food Insecurity

☐ Lack of Transportation to Medical Visits

☐ Limited Health Literacy

☐ Language/Communication Barriers

☐ Other (specify): _____

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

(12) NEEDS/GOALS/DESIRED OUTCOMES EXPRESSED BY PARTICIPANT OR AUTHORIZED REPRESENTATIVE DURING ASSESSMENT PROCESS	
1.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH	
2.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH	
3.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH	
4.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH	
5.	
Indicate during which of the following assessments the participant expressed his/her need/goal/desired outcome: ☐ NUR ☐ SS ☐ ACT ☐ PT ☐ OT ☐ SPEECH ☐ RD ☐ MH	
Additional Information: Use space to include any additional explanations about participant needs/goals/desired outcomes, including the participant's strengths and abilities.	

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

(13) CORE SERVICES		
PROFESSIONAL NURSING SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

PROFESSIONAL NURSING SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

3. Need/Problem

Treatment(s)/Intervention(s)	Frequency	Goal(s)

4. Need/Problem

Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

PERSONAL CARE SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

SOCIAL SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

SOCIAL SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
3. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
4. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

THERAPEUTIC ACTIVITIES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

THERAPEUTIC ACTIVITIES – PHYSICAL THERAPY MAINTENANCE PROGRAM **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

THERAPEUTIC ACTIVITIES – OCCUPATIONAL THERAPY MAINTENANCE PROGRAM **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

(14) ADDITIONAL SERVICES		
PHYSICAL THERAPY **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

OCCUPATIONAL THERAPY
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

SPEECH THERAPY
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem

Treatment(s)/Intervention(s)	Frequency	Goal(s)

2. Need/Problem

Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

REGISTERED DIETICIAN SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

BEHAVIORAL HEALTH SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

TRANSPORTATION SERVICES
Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____

1. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
2. Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

(15) SIGNIFICANT CHANGES SINCE PREVIOUS IPC (For reauthorization TARs only)

(16) ADDITIONAL INFORMATION (include critical history/information not included in this IPC and relevant to the authorization of this TAR)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

(17) SIGNATURES OF MULTIDISCIPLINARY TEAM AND PROGRAM DIRECTOR

Signatures of the Multidisciplinary Team (MDT)

Pursuant to section 14529 of the Welfare and Institutions Code, signing below certifies agreement with the treatments designated in the IPC that are consistent with the signer's scope of practice.

PRINTED NAME	SIGNATURE	DATE OF SIGNATURE
	RN	
	SW	
	AC	
	PT	
	OT	

By signing below I certify that I have reviewed and concur with this IPC.

PRINTED NAME	SIGNATURE OF THE PRIMARY/PERSONAL HEALTH CARE PROVIDER OR CBAS CENTER PHYSICIAN	DATE OF SIGNATURE
☐ Primary/Personal Health Care Provider	☐ CBAS Center Physician	

By signing below, I certify the following: (1) all assessments have been completed and the participant meets all CBAS eligibility and medical necessity criteria as specified in this IPC effective on this date: _____ (NOTE: The TAR will not be approved for CBAS services prior to this date); (2) information contained in this IPC is the result of an MDT person-centered planning process and is documented in the center records; and (3) services scheduled in this IPC will be provided, unless otherwise noted in the health record, after approval of the participant's CBAS eligibility and TAR, and after the participant or authorized representative has signed the CBAS Participation Agreement (Form CDA 7000), no later than the first day of enrollment, consenting to services.

PRINTED NAME	SIGNATURE	DATE OF SIGNATURE
	Program Director	

Privacy Statement: The information requested on this form is required by the Department of Health Care Services, Fee-for-Service or Managed Care Plans, for the purpose of adjudication of TARS for CBAS services. Failure to provide this mandatory information may result in denial of the TAR for CBAS services.

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

Please use this page to document additional Box 13 and 14 services.

_____ SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

Please use this page to document additional Box 13 and 14 services.

_____ SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

Participant Name:	
Dates of Service: From: _____ To: _____	CIN:

Please use this page to document additional Box 13 and 14 services.

_____ SERVICES **Addresses participant needs/goals/desired outcomes identified in Box 12 #(s) _____**		
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)
Need/Problem		
Treatment(s)/Intervention(s)	Frequency	Goal(s)

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MPUP3059 (previously UP100359)</td><td colspan="2">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Negative Pressure Wound Therapy (NPWT) Device/Pump</td><td colspan="2">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 10/15/2003</td><td colspan="3">Next Review Date: ~~04/08/2027~~10/14/2027
Last Review Date: ~~04/08/2026~~10/14/2026</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: ~~04/08/2026~~10/14/2026</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3013 - Durable Medical Equipment (DME) Authorization
B. MCUG3134 - Hospital Bed/ Specialty Mattress Guidelines
C. MCUG3007 - Authorization of Ambulatory Procedures and Services
D. MCUP3041 - Treatment Authorization Request (TAR) Review Process

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Negative Pressure Wound Therapy (NPWT) - Involves applying continuous or intermittent topical negative pressure to a special dressing positioned in the wound cavity or over a flap or graft. The pressure distributing wound dressing helps remove fluids from the wound and stimulates the growth of healthy granulation tissue.

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 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. N/A

V. PURPOSE:

To define the clinical indications for NPWT [also known as Negative Pressure Wound Therapy or Vacuum-Assisted Closure (VAC)] system to improve wound healing in an outpatient setting for Partnership HealthPlan of California Members.

Policy/Procedure Number: MPUP3059 (previously UP100359)			**Lead Department: Health Services** **Business Unit:** Utilization Management
Policy/Procedure Title: Negative Pressure Wound Therapy (NPWT) Device/Pump			☒**External Policy** ☐**Internal Policy**
Original Date: 10/15/2003		**Next Review Date:** ~~04/08/2026~~10/14/2027 **Last Review Date:** ~~04/08/2025~~10/14/2026	
Applies to:	☐ **Employees**	☒ **Medi-Cal**	☒ **Partnership Advantage**

VI. POLICY / PROCEDURE:

A. Initial ~~Coverage~~ Authorization:
A Treatment Authorization Request (TAR) must be submitted for NPWT pumps and supplies.
Partnership will ~~approve~~ authorize ~~the use of~~ NPWT when either ~~criteria in~~ Section VI. ~~on~~ A.1. or A.2. criteria ~~is~~ are met AND InterQual® Durable Medical Equipment (DME) criteria are ~~met~~ satisfied. NPWT Treatment Authorization Requests (TARs) are reviewed in one-month increments.

1. Ulcers and Wounds in the Home Setting:
   a. The patient has one of the following chronic ulcers or wounds, present for at least two weeks despite appropriate wound care: Stage III or IV pressure ulcer, a neuropathic (diabetic) ulcer, venous or arterial insufficiency ulcer or mixed etiology ulcer.
   b. A complete wound therapy program described below by criterion 1) and criteria 2), 3), or 4) as applicable depending on the type of wound, should have been tried or considered and ruled out prior to application of NPWT.
      1) For all chronic ulcers or wounds, the following components of a wound therapy program must include a minimum of all of the following general measures, which should either be addressed, applied, or considered and ruled out prior to application of NPWT.
         a) Documentation in the patient's medical record of evaluation, care, and wound measurements by a licensed medical professional, and
         b) Application of dressings to maintain a moist wound environment, and
         c) Debridement of necrotic tissue if present, and
         d) Evaluation of and provision for adequate nutritional status
      2) For Stage III or IV pressure ulcers:
         a) The patient has been appropriately turned and positioned, and
         b) The patient has used a group 2 or 3 (e.g. low air loss mattress) support surface for pressure ulcers on the posterior trunk or pelvis
         c) The patient's moisture and incontinence have been appropriately managed
      3) For neuropathic (for example, diabetic) ulcers:
         a) The patient has been on a comprehensive diabetic management program, and
         b) Reduction in pressure on a foot ulcer has been accomplished with appropriate modalities.
      4) For venous insufficiency ulcers:
         a) Compression bandages and/or garments have been consistently applied, and
         b) Leg elevation and ambulation have been encouraged.
2. Ulcers and Wounds Encountered in an Inpatient Setting:
   a. When NPWT is initiated in an inpatient setting, the NPWT device is included in the per diem payment and is not separately reimbursable. ~~by the treating physician, i~~It will be covered upon discharge for the first month if no Exclusions from Coverage apply (see section VI.C. below).
   b. NPWT ~~applied~~ initiated in an inpatient setting and continued after discharge will be reviewed ~~as~~ according to the ~~a~~ Continued Coverage ~~request~~ criteria in Section VI.D., rather than as an initial request ~~(see section VI.D. below)~~.

B. Documentation:

1. A written order for the negative pressure wound therapy pump and supplies must be signed and dated by the treating physician and obtained by the supplier prior to delivery of the item. Written order must include:
   a. Patient history, previous treatment regimens (if applicable), and current wound management orders
   b. Any concurrent measurements to support the need for NPWT
   c. Duration of the time the patient is expected to require the NPWT

2. Documentation of the treatment plan must also be submitted with the TAR to include the following:
   a. Detailed wound evaluation, including quantitative wound measurements and documentation of ~~of wound presence of~~ granulation and necrotic tissue characteristics including wound length and width (surface area), and depth, and amount of wound exudate (drainage)
   b. Comorbid conditions
3. Documentation of wound status indicating progress of healing must be entered at least weekly (using quantitative measurements described in VI.B.2.a. above). The supplier of the equipment and supplies must obtain from the treating clinician an assessment of wound healing progress, based upon the wound measurement as documented in the patient's medical record.

C. Exclusions from Coverage:
A NPWT will be denied as not medically necessary if one or more of the following are present:
1. The presence in the wound of necrotic tissue with eschar, if debridement is not attempted;
2. Untreated osteomyelitis within the vicinity of the wound
3. Cancer present in the wound
4. The presence of a fistula to an organ or body cavity within the vicinity of the wound
5. Exposed vasculature, nerves, anastomosis or organs

D. Continued Coverage:
1. For wounds and ulcers described under VI.A. above, once placed on an NPWT, in order for coverage to continue, a licensed medical professional must do the following:
   a. On a regular basis,
      1) Directly assess the wound(s) being treated
      2) Supervise or directly perform the dressing changes
   b. On at least a weekly basis, document changes in the ulcer's dimensions and characteristics.
2. If criteria D.1.a.1) and 2) are not met, continued coverage of this therapy will be denied as not medically necessary.

E. When Coverage Ends:
1. For wounds and ulcers described under VI.A. or VI.C. above, NPWT will be denied as not medically necessary with any of the following, whichever occurs earliest:
   a. Criteria D.1.a.1) and 2) cease to occur, or
   b. In the judgment of the treating physician, adequate wound healing has occurred to the degree that NPWT may be discontinued, or
   c. Any measurable degree of wound healing has failed to occur over a one-month period of treatment. There must be documented in the patient's medical records quantitative measurements of wound characteristics including wound length and width (surface area), and depth, serially observed and documented, over a specified time interval. The recorded wound measurements must be consistently and regularly updated and must have demonstrated progressive wound healing from month to month, or
   d. Four (4) months (including the time NPWT was applied in an inpatient setting prior to discharge to the home) have elapsed using a NPWT in the treatment of any wound.
2. Coverage beyond four (4) months will be given individual consideration on a case-by-case basis. If the wound has not shown progress over the prior month, a patient assessment must be completed by the clinician managing the wound. Documentation should include an evaluation for factors and medical conditions impeding wound healing, such as diabetes, poor nutritional status or infection, with submission of recent, relevant labs (complete blood count [CBC], comprehensive metabolic panel [CMP], albumin, wound cultures, hemoglobin A1C [HbA1c]).

F. Supplies Covered:
1. Coverage is provided up to a maximum of 15 dressing kits per wound per month unless there is documentation that the wound size requires more than one dressing kit for each dressing change.
2. Coverage is provided up to a maximum of 10 canister sets per month unless there is documentation

evidencing a large volume of drainage (greater than 90 ml of exudate per day.) For high volume exudative wounds, a stationary pump with the largest capacity canister must be used. Excess utilization of canisters related to equipment failure (as opposed to excessive volume drainage) will be denied as not medically necessary.

3. Amounts greater than 15 dressing kits per wound per month or 10 canister sets per month in the absence of documentation clearly explaining the medical necessity of the excess quantities will be denied as not medically necessary.

VII. REFERENCES:

A. Medi-Cal Provider Manual/ Guidelines: Durable Medical Equipment (DME): Other DME Equipment (*dura other*) refer to section on Negative Pressure Wound Therapy (NPWT) Devices
B. InterQual® DME Equipment Criteria – Negative Pressure Wound Therapy (NPWT) Pump
C. Centers for Medicare & Medicaid Services (CMS) Standards: Local Coverage Determination (LCD) L33821 Negative Pressure Wound Therapy Pumps 01/01/2024 or any subsequent updates published by CMS.

VIII. DISTRIBUTION:

A. Partnership Department Directors
B. Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2028~~7~~)
04/09/25; 04/08/26; 10/14/26

Medi-Cal
10/20/04; 10/18/06; 08/20/08; 10/01/10; 04/18/12; 04/15/15; 04/20/16; 04/19/17; *06/13/18; 04/10/19; 05/13/20; 04/14/21; 05/11/22; 05/10/23; 05/08/24; 04/09/2025; 04/08/26; 10/14/26

*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 MPUP3059 (Healthy Kids program ended 12/01/2016)
10/18/06; 8/20/08; 10/01/10; 04/18/12; 04/15/15; 04/20/16 to 12/01/2016

PartnershipAdvantage:
MPUP3059 - 10/18/06 to 01/01/2015

Healthy Families:
MPUP3059 - 10/01/2010 to 03/01/2013

****

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

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

disclosed to the provider and/or enrollee upon request

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

<table>
<tr><td colspan="4">Policy/Procedure Number: MPUP3078</td><td colspan="3">Lead Department: Health Services
Business Unit: Utilization Management</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Second Medical Opinions</td><td colspan="3">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 04/20/2016 – Medi-Cal</td><td colspan="4">Next Review Date: ~~11/12/2026~~10/14/2026
Last Review Date: ~~11/12/2025~~10/14/2026</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>☐ P & T</td><td colspan="3">☒ QUAC</td></tr>
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</table>

I. RELATED POLICIES:

A. MCUP3124 – Referral to Specialists (RAF) Policy
B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
C. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
D. CGA024 – Medi-Cal Member Grievance System

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services
D. Grievance and Appeals

III. DEFINITIONS:

A. Urgent Request: A request for medical care or services where application of the timeframe for making routine or non-life threatening care determinations:
   1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, ***or***
   2. In the opinion of a licensed health care practitioner, with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the indications and process for Second Medical Opinions.

VI. POLICY / PROCEDURE:

A. When a second medical opinion is requested by a Member, a Member's authorized representative and/ or health professional, the request will be reviewed. The Member does not need permission from Partnership HealthPlan of California (Partnership) for a second opinion from a network provider. If there is no provider in the Partnership network who can provide the second opinion, a prior authorization will be required and if approved, Partnership will pay for the second opinion from an approved out-of-network provider who is certified by Medi-Cal. Reasons for second opinions include, but may not be limited to the following:

1. The Member has questions concerning the reasonableness or necessity of a recommended surgical procedure or treatment.
2. The Member questions the diagnosis or course of treatment for a condition that threatens loss of life, limb, bodily function or impairment, including but not limited to a serious chronic condition.
3. The diagnosis is in doubt due to conflicting test results, or the treating practitioner is unable to make an accurate diagnosis of the situation.
4. The current treatment plan is not improving the medical condition within an appropriate period of time for the known diagnosis.
5. The Member has attempted to follow the course of treatment or consulted with the initiating professional and still has serious doubts about the diagnosis or treatment plan.

B. An appropriately qualified health care professional, qualified to render a second opinion, is considered to be a primary care provider or specialist acting within the scope of practice and who possesses a clinical background including training and expertise related to the particular illness, disease or condition associated with the request for a second opinion.

C. The plan reserves the right to limit a Member's choice of provider for the second opinion from within the network/contracted providers when there is a qualified professional available. The Member shall be referred to an out-of-network ~~outside the network to a~~certified Medi-Cal ~~certified~~ provider when ~~there is not~~ a qualified network/contracted professional is not available (see discussion of out of network referrals in policy MCUP3124 Referral to Specialists [RAF] Policy.) Note that any out of network treatments recommended would be subject to the treatment authorization (TAR) process as per policy MCUP3041 Treatment Authorization Request (TAR) Review Process.

D. Timeframes for out-of-network second opinions will be as follows:
1. If a Member's request requires an urgent review, a determination will be made within 72 hours after receipt of the request.
2. For a non-urgent request, the Member will be notified within ~~5 business~~seven (7) calendar days as to whether or not the provider ~~he/she~~they requested for a second opinion was approved.

E. If a Member's request for a second opinion is not granted by the primary care provider, the Member may contact ~~the~~ a Grievance Coordinator at Partnership HealthPlan and file a grievance in accordance with Partnership policy CGA024 Medi-Cal Member Grievance System.

F. If the health plan denies a request for a second opinion, the Member will be notified in writing of the reasons for the denial, the Member's right to appeal or file a grievance, and information on how to file an appeal and how to file a grievance.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment III, Section 2.3.C.

B. National Committee for Quality Assurance (NCQA) ~~2026~~ Guidelines ~~(Effective July 1, 2025)~~ UM Factor 5 Timeliness of UM Decisions, Element D Interim: Policies and Procedures

VIII. DISTRIBUTION:

A. Partnership Provider Manual

B. Partnership Department Directors

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

X. REVISION DATES:

Medi-Cal:

04/20/16 initial; 04/19/17; *06/13/18; 08/14/19; 08/12/20; 08/11/21; 08/10/22; 09/13/23; 09/11/24; 11/12/25; 10/14/26

Policy/Procedure Number: MPUP3078		**Lead Department: Health Services** **Business Unit:** Utilization Management
Policy/Procedure Title: Second Medical Opinions		☒**External Policy** ☐**Internal Policy**
Original Date: 04/20/2016 – Medi-Cal	**Next Review Date:** ~~11/12/2026~~10/14/2027 **Last Review Date:** ~~11/12/2025~~10/14/2026	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

*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.

Note – Policy initially developed under the Healthy Kids Program 11/16/2005

PREVIOUSLY APPLIED TO:
Healthy Kids – MPUP3078, KK UM115 (Healthy Kids program ended 12/01/2016):
11/16/05; 11/21/07; 11/19/08; 10/01/10; 08/19/15; 04/20/16 to 12/01/2016

Healthy Families:
MPUP3078 - 10/01/2010 to 03/01/2013

****

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

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

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

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Synopsis of Changes to Discussion Policy MPPRGR210

Below is an overview of the policy that will be discussed at the Sept. 16, 2026 Quality/Utilization Advisory Committee (Q/UAC).
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]

☒ **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	

Policy Number & Name	**Page #**	**Summary of Revisions** (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
Policy Owner: Provider Relations – *Presenter: Aaron Brincko, MPH, Director of Provider Relations*			
MPPRGR210 – Provider Grievance – *CLEAN copy begins on p. 205*	201 – 207	**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** – 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.	All Departments

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

Synopsis of Changes to Discussion Policy MPPRGR210

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	External Documentation (Notice required outside of originating department)
		VI. B. 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 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.	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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<tr><td colspan="3">Policy/Procedure Number: MPPRGR210</td><td colspan="3">Lead Department: Provider Relations</td></tr>
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<tr><td colspan="2">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: ~~10/13/202/2027~~10/14/2027
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I. RELATED POLICIES:

A. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
B. MPQP1053 – Peer Review Committee
C. MPQP1016 – Potential Quality Issue Investigation and Resolution
D. CGA024 – Medi-Cal Member Grievance System
E. CLPM-41 Claims Provider Dispute Resolution Mechanism
F. CMP38 Escalation and Corrective Action

II. IMPACTED DEPTS:

~~A. **Provider Relations**~~
~~B.~~A. Health Services

III. DEFINITIONS:

A. Network Provider: any Provider or entity that has an Agreement with Partnership and receives Medi-Cal funding directly or indirectly to order, refer, or render Covered Services to Partnership members.
B. Provider Dispute Resolution (PDR): The process by which a provider's written notice to the plan challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted or contested or seeking resolution of a billing determination or disputing a request for reimbursement of an overpayment is resolved.
~~A.~~C. Provider Grievance: A formal written~~For the purposes of this policy, a Provider Grievance is defined as an~~ expression of dissatisfaction submitted by a Network Provider related to Partnership's policies, processes, procedures, or administrative actions, with the exception of decisions regarding claims or service authorizations~~from a provider that, after exhausting all Plan appeal processes, requests to have their complaint, appeal or dispute submitted to the Provider Grievance Review Committee for final review of the medical or pharmacy decision or how the Plan implemented a regulatory requirement~~. A provider grievance may be submitted after ~~all~~any applicable Partnership reconsideration, appeal, or dispute resolution processes have been exhausted.

IV. ATTACHMENTS:

A. N/A

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) ~~proces~~process. Claims payment disputes, overpayment disputes, and other

Policy/Procedure Number: MPPRGR210		Lead Department: Provider Relations	
Policy/Procedure Title: Provider Grievance		☒ **External Policy** ☐ **Internal Policy**	
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Applies to:	☒ **Medi-Cal**	☐ **Employees**	☐ **Partnership Advantage**

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. ~~and claims related dispute shall exhaust the PDR process prior to being addressed as a provider grievance. resolved through that process.~~

Providers not contracted with ~~Partnershi~~Partnership are not eligible to submit provider grievances.

~~To describe the process for resolving provider grievances related to determinations of medical or pharmacy decisions made by Partnership HealthPlan of California, the Plan's implementation of DHCS Regulatory or other State and Federal requirements, or contractual disputes between the Health Plan and providers. The provider grievance process is not applicable to provider appeals filed on behalf of members and as such, is separate and distinct from the member grievance and appeal process. A provider may request a grievance after all applicable Partnership Appeal processes have been exhausted.~~

VI. POLICY / PROCEDURE:

A. The Partnership HealthPlan of California, ~~(Partnership)~~ Chief Executive Officer is ultimately responsible for the provider grievance process and has primary responsibility for maintenance, review, formulation of policy changes and procedural improvements of the grievance review system. The CEO is assisted by the Partnership Chief Medical Officer, Chief H~~h~~ealth Services Officer, Chief Operating Officer, and ~~Senior~~ Director of Provider Relations. The provider grievance process is managed and monitored by the Provider Relations department.

B. INTAKE:

1. Informal complaints and requests for routine assistance are addressed by the Provider Relations team, with assistance from other staff as needed. Formal written acknowledgements or resolutions are generally not necessary for these matters but are available if requested.
   a. ~~If a provider expresses~~Provider concern(s), ~~these~~ should first be addressed ~~attempt to be resolved within~~through the impacted department's internal resolution policies and procedures. The Provider Relations team will connect the caller to the appropriate department to address the issue and respond ~~as appropriate~~appropriately.
2. If unable to resolve, upon receipt, Provider Relations shall review and categorize the grievance to determine:
   a. Appropriate internal routing
   b. Level of urgency
   c. Required escalation
   d. Applicable resolution timeframe
3. Providers have 180 calendar days from the incident date to report any concerns to the Provider Relations team via the Provider Grievance Intake form or formal written notice to prgrievances@partnershiphp.org.

C. REVIEW / RESOLUTION

1. ~~The life cycle of a provider grievance can take up to~~Provider Grievances shall be resolved within sixty (60) business days ~~for final formal resolution by the Executive Committee.~~.
   a. If a provider submits a formal written grievance, Provider Relations team shall acknowledge receipt of a provider grievance within five (5) business days of submission.
   b. If the Provider Relations team is unable to adjudicate the grievance within thirty (30) business days, the grievance may be submitted to the executive committee for final review.
   c. The E~~e~~xecutive C~~c~~ommittee will review and determine final decision of the grievance within fifteen (15) business days of the escalation.
   d. The provider is formally notified within fifteen (15) business days of the Committee's decision.
2. Partnership shall make reasonable efforts to resolve grievances at the lowest appropriate level and within the shortest timeframe practicable.

~~1. Providers must be given an opportunity to have their grievance heard and evaluated. Two mechanisms, an informal and a formal grievance procedure, have been established for that purpose.~~

~~2.~~

~~3. Informal grievances may be registered by the provider, by telephone, letter or visit to the Partnership office. The provider should contact the Provider Relations department to register a grievance. The grievance is immediately recorded. If a satisfactory solution has not been reached through discussion with the parties within ten (10) working days after an informal grievance is registered, the grievance automatically becomes a formal grievance.~~

~~4. Formal grievance is filed in writing at the Partnership offices or by mail within 45 working days of the determination or action that is the subject of the grievance. There is a fifteen (15) working day resolution period during which time the Partnership staff proposes a resolution to the provider. If the proposed resolution is not satisfactory, the provider may request in writing a Provider Grievance Review Committee (PGRC) hearing.~~

~~5. The PGRC will meet within forty-five (45) working days of receipt of the written provider request for a meeting. PGRC decisions are binding unless reversed by Partnership's Board of Commissioners.~~

~~6. The Provider Grievance Review Committee (PGRC) has been established to provide a formal grievance mechanism.~~

~~7. The PGRC consists of the members of the Peer Review Committee (PRC) who are not Partnership medical directors, excluding any members of the PRC who have a potential conflict of interest. Potential conflict of interest for provider grievances includes being a member of the active medical staff on a hospital if the hospital is the grieving party and otherwise working for a hospital or institution if the grieving party is a physician on the active medical staff of that hospital or institution. PGRC will meet on the same date as the Peer Review Committee.~~

~~8. The Committee's meeting is documented in minutes. The provider and Partnership are advised in writing of the Committee's decision within ten (10) working days of the meeting.~~

~~9. Providers appealing utilization management or pharmacy decisions on behalf of members must follow the procedure outlined in Health Services policy MCUP3037, Appeals of Utilization Management/Pharmacy Decisions prior to filing a request for a PGRC hearing.~~

~~10. Providers retrospectively appealing a decision to deny or limit payment for a service based on application of UM criteria, for which the member is not financially responsible, should first submit an appeal (which is not on behalf of a member, but on behalf of the billing provider), with additional documentation responding to the reason for the initial denial or limitation. A provider grievance may not be filed until an initial appeal has been completed, which the provider disagrees with.~~

3. If during the review process, ~~the executive committeePGRC determines~~it is determined that a provider may be deficient in rendering or managing care, or problem areas are discovered, a Potential Quality Issue (PQI) referral is made to the Quality Improvement (QI) department via the PQI Referral Intake System. ~~this information is referred to the Performance Improvement Clinical Specialist as a Potential Quality Issue (PQI);~~ See MPQP1016 - Potential Quality Issue Investigation and Resolution.

~~11.~~4. The plan or the plan's capitated provider shall not discriminate or retaliate against a provider (including but not limited to the cancellation of the provider's contract) because the provider filed a ~~contracted~~ provider grievance ~~or a non-contracted provider grievance~~.

VII. REFERENCES:

A. ~~California~~ Department of Health Care Services (~~DHCS) All Plan Letter (APL) 21-011 Grievance and~~DHCS) All Plan Letter (APL) 21-011 Grievance and ~~Appeal Requirements~~Appeal Requirements, Notice and "Your Rights" Templates (*revised* Aug. 31, 2022,~~Aug. 31, 2021~~ *supersedes* APL 17-006)

B. National Committee for Quality Assurance (NCQA) Guidelines (effective July 1, 2026~~4~~) UM 7 Element C, Written Notification of Non-Behavioral Healthcare Appeal Rights/Process ~~and Element I, Written Notification of Pharmacy Appeal Rights/Process~~

~~B.~~C. DHCS All Plan Letter (APL) 26-006 Skilled Nursing Facility Workforce Quality Incentive Program (March 30, 2026)

Policy/Procedure Number: MPPRGR210		Lead Department: Provider Relations	
Policy/Procedure Title: Provider Grievance		☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1994		**Next Review Date:** ~~11/03/2027~~10/14/2027 **Last Review Date~~:~~:** ~~11/04/2026~~10/14/2026	
Applies to:	☒ **Medi-Cal**	☐ **Employees**	☐ **Partnership Advantage**

VIII. DISTRIBUTION:

A. Partnership Provider Manual
B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

~~Senior~~ Director of Provider Relations

X. REVISION DATES:

Medi-Cal: 08/23/1996, 10/10/1997, 03/29/2000, 07/24/2000, 09/13/2000, 07/17/2002, 11/17/2003, 2/11/2004, 02/09/2005, 03/08/2006, 07/11/2007, 03/12/2008, 04/08/2009, 07/08/2009, 08/11/2010, 08/10/2011, 08/08/2012, 08/14/2013, 08/13/2014, 08/12/2015, 08/10/2016, 08/09/2017, 08/08/2018, 01/09/2019, 01/08/2020, 08/12/2020, 08/11/2021, 08/10/2022, 08/09/2023, 08/14/2024, 04/08/2026, 10/14/2026

PREVIOUSLY APPLIED TO:

N/A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

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I. RELATED POLICIES:

A. MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions
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II. IMPACTED DEPTS:

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IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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Policy/Procedure Number: MPPRGR210		Lead Department: Provider Relations	
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B. INTAKE:

1. Informal complaints and requests for routine assistance are addressed by the Provider Relations team, with assistance from other staff as needed. Formal written acknowledgements or resolutions are generally not necessary for these matters but are available if requested.
   a. Provider concern(s), should first be addressed through the impacted department's internal resolution policies and procedures. The Provider Relations team will connect the caller to the appropriate department to address the issue and respond appropriately.
2. If unable to resolve, upon receipt, Provider Relations shall review and categorize the grievance to determine:
   a. Appropriate internal routing
   b. Level of urgency
   c. Required escalation
   d. Applicable resolution timeframe
3. Providers have 180 calendar days from the incident date to report any concerns to the Provider Relations team via the Provider Grievance Intake form or formal written notice to prgrievances@partnershiphp.org.

C. REVIEW / RESOLUTION

1. Provider Grievances shall be resolved within sixty (60) business days.
   a. If a provider submits a formal written grievance, Provider Relations team shall acknowledge receipt of a provider grievance within five (5) business days of submission.
   b. If the Provider Relations team is unable to adjudicate the grievance within thirty (30) business days, the grievance may be submitted to the executive committee for final review.
   c. The Executive Committee will review and determine final decision of the grievance within fifteen (15) business days of the escalation.
   d. The provider is formally notified within fifteen (15) business days of the Committee's decision.
2. Partnership shall make reasonable efforts to resolve grievances at the lowest appropriate level and within the shortest timeframe practicable.
3. If during the review process, it is determined that a provider may be deficient in rendering or managing care, or problem areas are discovered, a Potential Quality Issue (PQI) referral is made to the Quality Improvement (QI) department via the PQI Referral Intake System. See MPQP1016 - Potential Quality Issue Investigation and Resolution.
4. The plan or the plan's capitated provider shall not discriminate or retaliate against a provider (including but not limited to the cancellation of the provider's contract) because the provider filed a provider grievance.

VII. REFERENCES:

A. Department of Health Care Services (DHCS) All Plan Letter (APL) 21-011 Grievance and Appeal Requirements, Notice and "Your Rights" Templates (*revised* Aug. 31, 2022, *supersedes* APL 17-006)

B. National Committee for Quality Assurance (NCQA) Guidelines (effective July 1, 2026) UM 7 Element C, Written Notification of Non-Behavioral Healthcare Appeal Rights/Process

C. DHCS All Plan Letter (APL) 26-006 Skilled Nursing Facility Workforce Quality Incentive Program (March 30, 2026)

VIII. DISTRIBUTION:

A. Partnership Provider Manual

B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:
Director of Provider Relations

X. REVISION DATES:
Medi-Cal: 08/23/1996, 10/10/1997, 03/29/2000, 07/24/2000, 09/13/2000, 07/17/2002, 11/17/2003, 2/11/2004, 02/09/2005, 03/08/2006, 07/11/2007, 03/12/2008, 04/08/2009, 07/08/2009, 08/11/2010, 08/10/2011, 08/08/2012, 08/14/2013, 08/13/2014, 08/12/2015, 08/10/2016, 08/09/2017, 08/08/2018, 01/09/2019, 01/08/2020, 08/12/2020, 08/11/2021, 08/10/2022, 08/09/2023, 08/14/2024, 04/08/2026, 10/14/2026

PREVIOUSLY APPLIED TO:
N/A

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Grand Analysis: Network Access

Assessment of Network Adequacy

Standards for Network Management

Availability of Practitioners

- Primary Care Practitioners
- Specialty Care Practitioners

Accessibility of Services

- Primary Care Practitioners
- Specialty Care Practitioners

Assessment of Network Adequacy

NET Grand Analysis Report

NET 1, Elements B and C - Availability of Practitioners

- Provider to Member Ratios
- Geographic Distribution of Practitioners

NET 2, Elements A and C - Access to Care

- Timely Access
  - Third Next Available (3NA) Appointment
  - Provider Telephone Accessibility

NET Grand Analysis

NET 3, Element A and B – Assessment of Member Experience Accessing the Network & Opportunities to Improve Access to Non-Behavioral Healthcare Services

- Member Grievances
- CAHPS Composite Scores
- Out-of-Network Referrals

Practitioner Ratios

Primary Care:

Practitioner Ratios: Primary Care – Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure: Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	1,185	903,499	Primary Care Practitioner to Member (adult and children)	1:762	1:≤ 2,000	MET
Family or General Practice	664	903,499	Family or General Practice Practitioner to Member (adult and children)	1:1,361	1:≤ 2,000	MET
Pediatrics	264	283,146	Pediatricians to Members (children)	1:1,073	1:≤ 2,000	MET
Internist	257	620,353	Internists to Members (adult)	1:2,414	1:≤ 3,000	MET

Partnership met the standard for all Primary Care Practitioners

Practitioner Ratios

Specialty Care:

Practitioner Ratios: High Volume Specialists - Standards and Performance Goals						
Practitioner Type	**Practitioner Count**	**Membership**	**Measure Ratio**	**Results**	**Performance Goal**	**Goal Met?**
Obstetrics/Gynecology	581	371,707	OB-GYN to Member	1:640	1: ≤ 5,000	MET
Cardiology	505	903,499	Cardiologist to Member	1:1,789	1: ≤ 10,000	MET
General Surgery	442	903,499	General Surgery to Member	1:2,044	1: ≤ 10,000	MET
Orthopedic	393	903,499	Orthopedic Surgeon to Member	1:2,299	1: ≤ 10,000	MET
Ophthalmology	275	903,499	Ophthalmologist to Member	1:3,285	1: ≤ 10,000	MET
Dermatology	220	903,499	Dermatologist to Member	1:4,107	1: ≤ 15,000	MET

Partnership comfortably met the provider ratio standards for all high-volume specialist providers.

Geographic Distribution

Primary Care:

Geographic Distribution of Primary Care – Standards and Performance Goals				
Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Primary Care Practitioner Overall	1 within 10 miles or 30 minutes from the member's residence	96.8%	≥ 95%	MET
Family Medicine or General Practitioner	1 within 10 miles or 30 minutes from the member's residence	99.8%	≥ 95%	MET
Pediatrician	1 within 10 miles or 30 minutes from the member's residence	97.2%	≥ 95%	MET
Internal Medicine	1 within 10 miles or 30 minutes from the member's residence	96.2%	≥ 95%	MET

Partnership met the plan-wide geographic distribution of "Primary Care Practitioner Overall" standard and the individual performance standard for each PCP specialty.

Geographic Distribution

Geographic Distribution of Primary Care by County – Standards and Performance Goals						
Region	**County**	**Specialty Type**	**Standard: Geographic Distribution**	**Result**	**Performance Goal**	**Goal Met?**
	Lassen	Internal Medicine	1 within 10 miles or 30 minutes	83.3%	≥ 95%	Not MET
		Family Practice		90.1%		Not MET
		Pediatrics		83.3%		Not MET

A breakdown of the data at the county level shows Lassen County as not meeting the time or distance standard for primary care for both children and adults. Out of 7,879 Partnership members in Lassen County, 779 do not meet the time or distance standard despite the Family Practice to member ratio in Lassen County being 1:1,313.

This is indicative of a rural county, where the population is widely dispersed, and the providers are in, or near, towns and cities.

Geographic Distribution

Specialty Care:

Geographic Distribution of Specialty Care – Standards and Performance Goals				
High Volume Practitioner Type	**Standard: Geographic Distribution**	**Results**	**Performance Goal**	**Goal Met?**
Cardiology	Standard: % of members whose residence is within a distance (miles) or time (minutes) from a specialist's office. Rural = 60 miles or 90 minutes Small= 45 miles or 75 minutes Medium= 30 miles or 60 minutes	100%	≥90%	MET
Dermatology		99.7%	≥90%	MET
General Surgery		100%	≥90%	MET
Obstetrics/Gynecology		99.7%	≥90%	MET
Ophthalmology		99.3%	≥90%	MET
Orthopedics		99.7%	≥90%	MET
High Impact Practitioner Type		**Results**	**Performance Goal**	**Goal Met?**
Oncology/Hematology		97.3%	≥80%	MET

The geographic distribution of all High Volume and High Impact Specialties met the access standard plan wide.

Geographic Distribution

Geographic Distribution of Specialty Care – Standards and Performance Goals						
Region	**County**	**Specialty Type**	**Standard: Geographic Distribution**	**Result**	**Performance Goal**	**Goal Met?**
Redding	Modoc	Ophthalmology	Rural standard: % of members' residence is 60 miles or 90 minutes from a specialist's office.	14.5%	≥ 90%	Not MET
	Modoc	Hematology/Oncology		0.8%	≥ 80%	Not MET
	Siskiyou	Hematology/Oncology		69.6%	≥ 80%	Not MET
	Lassen	Ophthalmology		86.5%	≥ 90%	Not MET
Eureka	Del Norte	Hematology/Oncology		5.7%	≥ 80%	Not MET

When the data is broken down to the county level, four rural counties did not meet the time or distance standard for specialty care access. Modoc, Siskiyou, Lassen, and Del Norte are sparsely populated and have an insufficient population to sustain a practice for many specialties.

Timely Access

Primary Care:

Third Next Available (3NA) Survey Findings

Region	Median Days for Established PCP Appointment					Percentage of Clinics Meeting PCP Standards			
	Adult ≤ 10 bus. days	Peds ≤ 10 bus. days	Newborn ≤ 48 hrs.	Urgent ≤ 48 hrs.		Adult	Peds	Newborn	Urgent
Auburn	2	2	1	0		76.7%	82.5%	92.3%	83.0%
Chico	2	2	1	0		86.0%	90.9%	97.2%	96.8%
Eureka	3	3	1	0		74.6%	82.7%	82.1%	93.8%
Fairfield	5	3	1	0		75.6%	71.1%	85.3%	94.0%
Redding	3	4	1	0		89.4%	93.1%	84.6%	93.8%
Santa Rosa	4	3	1	1		76.7%	87.8%	85.3%	90.4%
Plan Average	**3**	**3**	**1**	**0**		**79.8%**	**84.7%**	**87.8%**	**92.0%**
					Goal	≥ 90%	≥ 90%	≥ 90%	≥ 90%
					Goal Met?	Not MET	Not MET	Not MET	MET

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.

Timely Access

Specialty Care:

Third Next Available (3NA) Survey Findings					
	Average Days for Specialty Care Appointment Access			Percentage of Clinics Meeting Standards	
Region	Non-Urgent ≤ 15 bus. days	Urgent ≤ 48 hrs.		Non-Urgent ≤ 15 bus. days	Urgent ≤ 48 hrs.
Auburn	14.3	2.8		86.4%	64.7%
Chico	11.5	8.5		80.4%	76.5%
Eureka	7.3	2		91.9%	80.6%
Fairfield	13.3	2		76.4%	83.6%
Redding	9	5.7		79.2%	78.7%
Santa Rosa	13.5	7.7		69.0%	80.4%
Plan Average	**11.5**	**4.8**		**80.6%**	**77.4%**
			Goal	≥ 80%	≥ 90%
			Goal Met?	MET	Not MET

As a Plan, we met the 2025 goal for non-urgent specialty care appointments however, we did not meet the 2025 goal for urgent specialty care appointments

Timely Access

2025 Third Next Available (3NA) Survey Findings						
	Percentage of Clinics Meeting Specialty Care Appointment Standards ≤15 business days					
Region	**Cardiology**	**Dermatology**	**General Surgery**	**Obstetrics Gynecology**	**Ophthalmology**	**Orthopedic Surgery**
Auburn	80%	100%	100%	100%	100%	100%
Chico	80%	100%	100%	80%	100%	100%
Eureka	100%	100%	88%	71%	100%	100%
Fairfield	57%	75%	100%	85%	77%	83%
Redding	100%	33%	100%	87%	85%	83%
Santa Rosa	60%	0%	100%	90%	50%	75%
Plan Average	**79.5%**	**68%**	**98%**	**85.5%**	**85.3%**	**90.2%**
Goal	**≥ 80.0%**	**≥ 80.0%**	**≥ 80.0%**	**≥ 80.0%**	**≥ 80.0%**	**≥ 80.0%**
Goal Met?	Not MET	Not MET	MET	MET	MET	MET

Cardiology and Dermatology fell below the established median 15-day appointment goal.
A closer look at the region level shows additional specialties not meeting the standard

Member Access Grievances

In 2024, there were a total of 5,477 grievances submitted by our members. The analysis attributes 42% of all cases to Access.
In comparison to the 2025 reporting period, there were a total of 5,638 grievances submitted by our members. The analysis attributes 46% of all cases to Access.

Grievances Reporting Period: Annual 2024 vs 2025								
	Previous Period: 2024			Current Period: 2025				
NCQA Category	Grievances	Avg Mship	Grievances p/1,000	Grievances	Avg Mship	Grievances p/1,000	Threshold	Threshold Met?
ACCESS	2,567	905,570	2.83	2,570	901,645	2.85	3.12	Yes

Partnership met the established 3.12 grievances per 1,000 member threshold, having 2.85 grievances per 1,000 members in 2025.

Member Access Grievances

Primary Care

Region	Appt. Availability	Office Availability	Telephone Availability	Total
Auburn	36	0	17	53
Chico	18	1	5	24
Eureka	22	0	4	26
Fairfield	30	0	7	37
Redding	12	1	4	17
Santa Rosa	18	0	1	19
Totals	136	2	38	176

Specialty Care

Region	Appt. Availability	Office Availability	Telephone Availability	Total
Auburn	2			2
Chico	6			6
Eureka	1			1
Fairfield	4			4
Redding	2			2
Santa Rosa	1			1
Totals	16			16

CAHPS Composite Scores
Adult

	ADULT CAHPS Composite	2023-2024 (15.3% Response Rate) Sample Size 3,375 Total Returns 510	2023 Percentile Rate	Partnership Benchmark	PHC Benchmark Met?	2024-2025 (15.3% Response Rate) Sample Size 3,375 Total Returns 511	2024 Percentile Rate	Partnership Benchmark	PHC Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	74.0%	7th	≥ 33rd	No	74.5%	5th	≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	68.1%	<5th	≥ 33rd	No	74.0%	11th	≥ 33rd	No

The Adult Composite score for getting needed care and getting care quickly both increased slightly, however, both failed to meet the benchmark.

CAHPS Composite Scores
Child

	CHILD CAHPS Composite	2023-2024 (16.1% Response Rate) Sample Size 4,125 Total Returns 659	MY 2023 Percentile Rate	Partnership Benchmark	Benchmark Met?	2024-2025 (15.8% Response Rate) Sample Size 5,00 Total Returns 783	MY 2024 Percentile Rate	Partnership Benchmark	Benchmark Met?
Composite Measure	Getting Needed Care (% Always or Usually)	77.1%	14th	≥ 33rd	No	77.9%	13th	≥ 33rd	No
	Getting Care Quickly (% Always or Usually)	78.9%	9th	≥ 33rd	No	80.0%	13th	≥ 33rd	No

The child composite score for Getting Needed Care and Getting Care Quickly experienced a slight increase, However, both measures failed to meet the benchmark.

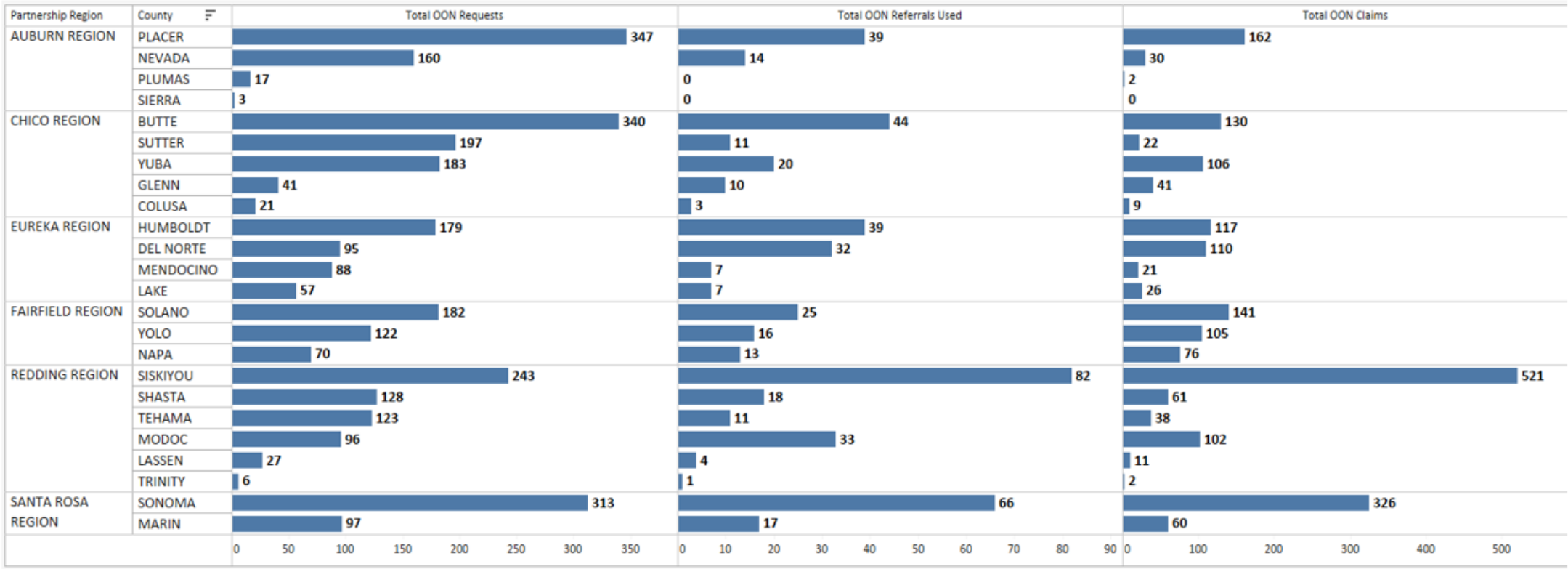
Out of Network Requests and Utilization

	AUBURN REGION	CHICO REGION	EUREKA REGION	FAIRFIELD REGION	REDDING REGION	SANTA ROSA REGION	Grand Total
Distinct Members	96,193	189,682	141,579	182,974	129,273	155,574	**895,275**
Total OON Requests	527	782	419	374	623	410	**3,135**
OON Requests per 1,000 Members	5.5	4.1	3.0	2.0	4.8	2.6	**3.5**
Approved OON Requests	175	362	188	130	361	208	**1,424**
Approved OON Requests per 1,000 M..	1.8	1.9	1.3	0.7	2.8	1.3	**1.6**
Denied OON Requests	352	420	231	244	262	202	**1,711**
Denied OON Requests per 1,000 Members	3.7	2.2	1.6	1.3	2.0	1.3	**1.9**
Total OON Referrals Used	53	88	85	54	149	83	**512**
Total OON Claims	194	308	274	322	735	386	**2,219**
OON Claims per 1,000 Members	2.0	1.6	1.9	1.8	5.7	2.5	**2**
Approved OON Claims	154	221	197	241	467	192	**1,472**
% Approved OON Claims	79.4%	71.8%	71.9%	74.8%	63.5%	49.7%	**66.3%**
Denied OON Claims	40	87	77	81	268	194	**747**
% Denied OON Claims	20.6%	28.2%	28.1%	25.2%	36.5%	50.3%	**33.7%**

The out of network requests per 1,000 members' threshold is less than or equal to 20. The Threshold for out of network utilization is less than or equal to 10 per 1,000 members. Both thresholds were met in 2025.

Data: Out of Network Requests (OON Report)

Partnership Region	County	Total OON Requests	Total OON Referrals Used	Total OON Claims
AUBURN REGION	PLACER	347	39	162
	NEVADA	160	14	30
	PLUMAS	17	0	2
	SIERRA	3	0	0
CHICO REGION	BUTTE	340	44	130
	SUTTER	197	11	22
	YUBA	183	20	106
	GLENN	41	10	41
	COLUSA	21	3	9
EUREKA REGION	HUMBOLDT	179	39	117
	DEL NORTE	95	32	110
	MENDOCINO	88	7	21
	LAKE	57	7	26
FAIRFIELD REGION	SOLANO	182	25	141
	YOLO	122	16	105
	NAPA	70	13	76
REDDING REGION	SISKIYOU	243	82	521
	SHASTA	128	18	61
	TEHAMA	123	11	38
	MODOC	96	33	102
	LASSEN	27	4	11
	TRINITY	6	1	2
SANTA ROSA REGION	SONOMA	313	66	326
	MARIN	97	17	60



The number of OON Requests decreased from 5,299 in 2024 to 3,135 in 2025.

The number of OON Claims decreased from 5,656 in 2024 to 2,219 in 2025.

Opportunity and Intervention

Opportunity: Appointment access to non-urgent primary care fell short of the goal for the second year in a row with a 6.7% decrease from 2023 to 2024 and an additional decrease of 6.4% in 2025.

- **Planned Action:** Partnership extended and refined the Provider Recruitment Program (PRP) to incentivize providers to join and remain in the Partnership network. The PRP offers sign-on bonuses to providers who are new to the Partnership network, including providers practicing outside of Partnership's 24-county service area as well as graduates completing training programs within the service area.

- **Effectiveness of Action:** During calendar year (CY) 2025, Partnership approved 185 PRP awards, an increase from 163 awards approved in CY 2024. Family Medicine remained the most frequently awarded specialty, accounting for approximately 51 percent of awards compared to 57 percent in CY 2024.