Board of Commissioners Meeting Agenda

June 22, 2022: 8:00 a.m. – 8:50 a.m.

In-person Locations:

UC Davis, Putah Creek Lodge

1 Shields Ave, Davis, CA 95616

Public Participation

Public comment is welcome during designated "Public Comments" time frames or by emailing comments to the Board Clerk at Board_FinanceClerk@partnershiphp.org by 5:00p.m on June 21, 2022. Comments received will be read during the meeting.

8:00A.M – Opening			
1.1 **Call to Order**			*Alicia Hardy, Chair*
1.2 **Roll Call**			*Clerk*
1.3	***ACTION***: Resolution to Approve the New Appointment of Laura Burch to the PHC Board	4-5	*Liz Gibboney*
1.4	***ACTION:*** Approval of Agenda and Board Meeting Minutes for April 27, 2022	6-14	*Chair*
1.5 **Public Comment & Correspondence**			*Liz Gibboney*
8:30A.M. – Consent Calendar			
2 & 3	***ACTION:*** Consent Calendar ▪ **2.1** Resolution to Ratify Finance Committee's Approval of the Q12022 Compliance Dashboard. ▪ **2.2** Resolution to Ratify Finance Committee's approval of PHC's Preliminary Health Care Budget for FY 2022-2023 ▪ **3.1** Resolution to Accept all PHC Committee Minutes, Department Operating Report, and PHC Policies, Program Descriptions, and PCP QIP Changes Approved by PAC. ▪ **3.2** Resolution to Approve Findings That, as a Result of the Continuing COVID-19 Pandemic State of Emergency, Meeting in Person Would	15-17 18-25 26-28 29-30	*Liz Gibboney*

	Present Imminent Risks to the Health or Safety of Attendees		
	▪ **3.3** Resolution to Approve Utilization Management Program Description, MPUD3001	31-99	
	▪ **3.4** Resolution to Approve Physician Advisory Committee Changes: Appointments of Bessant Parker, MD and Douglas McMullin, MD and the Resignation of Jeffrey Bosworth, MD.	100-102	
	▪ **3.5** Resolution to Approve 2022-23 Proposed Measure Changes for Perinatal Quality Improvement Program (PQIP) as Approved by PAC.	103-107	
	▪ **3.6** Resolution to Approve 2022-23 Hospital Quality Improvement Program (QIP) Measurement Set as Approved by PAC.	108-115	
	▪ **3.7** Resolution to Approve Commendations and Appreciation for Jed Rudd's Service to PHC	116-117	

Operational Reports
PAC Approved Policy Updates
Finance Committee – May 2022
Finance Committee – June 2022
Physician Advisory Committee for May 2022
Physician Advisory Committee for June 2022
Quality and Utilization Advisory Committee (Q/UAC) – May 2022
Quality and Utilization Advisory Committee (Q/UAC) – June 2022
Consumer Advisory Committee - Northern Region
Consumer Advisory Committee - Southern Region

8:35A.M. – Regular Agenda Items			
4.1	***ACTION:*** Resolution to Approve Final Budget for FY 2022-2023	118-135	*Patti McFarland / Jeff Ingram*
Regular Reports			
5.1	***INFORMATION:*** Metrics and Financial Update	137-151	*Written Report*
5.2	***INFORMATION:*** Operations Update	152-155	*Written Report*
5.3	***INFORMATION:*** Media Update	156-160	*Written Report*
8:50 A.M. – Adjournment			

Upcoming Meetings:

08/24/2022 – PHC's Fairfield Office
10/26/2022 – TBD, Redding
12/07/2022 – PHC's Santa Rosa Office

Government Code §54957.5 requires that public records related to items on the open session agenda for a regular commission meeting be made available for public inspection. Records distributed less than 72 hours prior to the meeting are available for public inspection at the same time they are distributed to all members, or a majority of the members of the Commission. The Commission has designated the Board Clerk as the contact for Partnership HealthPlan of California located at 4665 Business Center Drive, Fairfield, CA 94534, for the purpose of making those public records available for inspection. The Board Meeting Agenda and supporting documentation is available for review from 8:00 AM to 5:00 PM, Monday through Friday at all PHC regional offices (see locations above). It can also be found online at www.partnershiphp.org. PHC meeting rooms are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternative format for the agenda, meeting notice, agenda packet or other writings that may be distributed at the meeting, should contact the Board Clerk at least ten (10) days prior to the scheduled meeting at (707) 863-4516 or by email at Board_FinanceClerk@partnershiphp.org. Notification in advance of the meeting will enable the Board Clerk to make reasonable arrangements to ensure accessibility to this meeting and to materials related to it.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
1.3

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
Shasta County Board of Supervisors

Topic Description:
On April 19, 2022, Laura Burch, Acting Director at Shasta County, was appointed by the Shasta County Board of Supervisors to the Partnership HealthPlan of California (PHC) Commission (known as the Board) to replace Donnell Ewert.

Ms. Burch's appointment commences on June 22, 2022 and concludes August 31, 2025.

Reason for Resolution:
To obtain Board approval to appoint Laura Burch. to the PHC Board as the Shasta County Representative.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Shasta County Board of Supervisors, the Board is asked to approve the new appointment of Laura Burch to the PHC Board.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
1.3

Resolution Number:
22-

IN THE MATTER OF: APPROVING THE NEW SHASTA COUNTY APPOINTMENT FOR LAURA BURCH. TO THE PHC BOARD

Recital: Whereas,

A. Certain agencies have responsibility for appointing Board members.

B. Shasta County has a vacant seat.

C. The Board has authority to approve and appoint committee members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Shasta County appointment of Laura Burch to the PHC Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 22nd day of June 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

MINUTES OF THE MEETING OF
PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC) BOARD OF COMMISSIONERS
Meeting held via Webex
In person locations:
PHC's Southeast Office located at 4665 Business Center Drive, Fairfield
PHC's Northeast Office located at 2525 Airpark, Redding
On
April 27, 2022

Members Present: Jonathan Andrus, Darcie Antle, Gena Bravo, Mary Kay Brooks, Paula Cohen, Cathryn Couch, Greta Elliott, Dean Germano, Liz Hamilton, Alicia Hardy, Randall Hempling, Dave Jones, Wendy Longwell, Viola Lujan, Melissa Marshall, M.D., Benita McLarin, Erik McLaughlin, M.D., Mitesh Popat, M.D., Heather Snow, Tory Starr, Kim Tangermann, Jennifer Yasumoto, Nancy Starck (Chair).
Members Absent: None
Members Excused: Lewis Broschard, M.D, Gerald Huber, Jed Rudd, Keri Thomas
Staff: Amy Agle, Sonja Bjork, Rebecca Boyd-Anderson, Katherine Barresi, Dell Coats, Marissa Dominguez, Kim Fillette, Patty Hayes, Matt Hintereder, Peggy Hoover, Jeff Ingram, Margaret Kisliuk, Kirt Kemp, Mary Kerlin, Marshall Kubota M.D., John Lemoine, Stan Leung, Regina Littlefield, Dustin Lyda, Lisa Malvo, Melissa McCartney, Patti McFarland, Robert Moore M.D., Lisa O'Connell, Jose Puga, Erika Robinson, Nikki Rotherham, Jing Sancho, Chloe Schafer, Lynn Scuri, Tahareh Daliri Sherafat, Kevin Spencer, Amy Turnipseed, Colleen Valenti, Wendi West, Liz Gibboney, CEO and Ashlyn Scott, Board Clerk
Guests: Laura Burch, Lance LeClair

AGENDA ITEM	DISCUSSION	MOTION / ACTION
1.0 Opening	Commissioner Alicia Hardy, Board Chair, called the bi-monthly meeting to order via Webex video conference and welcomed everyone to the meeting. Board members and attendees were informed that California bill AB 361, which relates to social distancing measures being taken for COVID-19, waives the Brown Act requirement for physical presence at the meeting for members, the clerk and/ or other personnel of the body as a condition of participation for a quorum. Board members were reminded to abstain from voting on any agenda item where they might have a conflict of interest, and to state their name before asking questions or making motions. As a reminder, Commissioner Hardy read the PHC Mission Statement: "to help our members, and the communities we serve, be healthy." She also mentioned that guests would have an opportunity to speak at designated times throughout the agenda.	None
1.2 Roll Call	Ashlyn Scott, Clerk of the Commission, called the roll indicating there was a quorum.	None

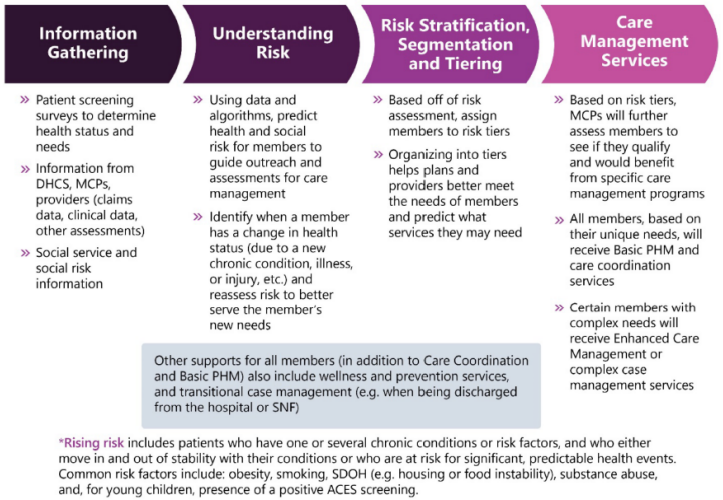
1.3 Resolution to Approve the New Board Member Appointment of Gena Bravo	Ms. Gibboney introduced Gena Bravo, who is the new Hospital Representative for Yolo County, replacing Dr. Ron Clement. Ms. Bravo is the President / CEO of Woodland Memorial Hospital. She has been with Dignity for 20 years, the last four of which have been in Woodland. She expressed excitement to serve on the PHC Board.	*Commissioner Marshall moved to approve the agenda item 1.3 as presented, seconded by Commissioner Andrus.* ***ACTION SUMMARY:*** *Yes: 21* *No: 0* *Abstention: 0* *Excused: 3 (Broschard, Huber, Rudd)* *Absent: 0* **MOTION CARRIED**
1.4 Resolution to Approve the New Board Member Appointment of Keri Thomas	Ms. Gibboney announced Keri Thomas, has been appointed by the Solano Board of Supervisors as the new Hospital Representative for Solano County, replacing Abhishek Dosi. Keri is the Vice President of External Affairs at Sutter Health, Valley Area.	*Commissioner Andrus moved to approve the agenda item 1.4 as Yasumoto, seconded by Commissioner Andrus.* ***ACTION SUMMARY:*** *Yes: 22* *No: 0* *Abstention: 0* *Excused: 3 (Broschard, Huber, Rudd)* *Absent: 0* **MOTION CARRIED**
1.5 Resolution to Approve the New Board Member Appointment of Dr. Erik McLaughlin	Ms. Gibboney introduced Dr. Erik McLaughlin, who is the new Public Health Officer in Lake County, replacing Dr. Gary Pace. He will represent Lake County on PHC's Board.. Dr. McLaughlin said he is very excited to help solve big problems on the Board.	*Commissioner Antle moved to approve the agenda item 1.5 as Yasumoto, seconded by Commissioner McLarin.* ***ACTION SUMMARY:*** *Yes: 22* *No: 0* *Abstention: 0* *Excused: 4 (Broschard, Huber, Rudd, Thomas)* *Absent: 0*

		MOTION CARRIED
1.6 Approval of Agenda and the Board Meeting Minutes for February 23, 2022.	Chairwoman Hardy asked if anyone had changes for the agenda or corrections for the February 23, 2022 minutes. Hearing no requests for modification, she asked for a motion to approve the agenda and minutes.	*Commissioner Brooks moved to approve the agenda and minutes as presented, seconded by Commissioner Powell.* ***ACTION SUMMARY:*** *Yes: 23* *No: 0* *Abstention: 0* *Excused: 4 (Broschard, Huber, Rudd, Thomas)* *Absent: 0* **MOTION CARRIED**
1.5 Public Comment and Correspondence	Chairwoman Hardy asked if there were any public comments. Hearing no requests, she moved on to correspondence. Ashlyn Scott, Clerk, stated that there had been no correspondence since the last Board Meeting.	None
1.7 CEO Report	Ms. Gibboney began her report thanking the Board for all the support in opposing Assembly Bill 2724, regarding Kaiser's proposed direct contract with the State. PHC collected and submitted letters of support from counties and providers, including four of the ten expansion counties. *Commissioner Couch mentioned she heard the Governor is still in support of the bill and asked if there is a chance for changes.* *Ms. Gibboney replied that we are not giving up, though it is an uphill battle. PHC will continue to push for amendments.* *Commissioner Germano added that he heard Assemblyman Wood is not optimistic that there will be any change, due to the Governor's strong stance on the bill.* *Commissioner Hardy asked how the bill moves forward if it is not amended.* *Ms. Gibboney said it might be included in a budget trailer bill, in which case, there is much less of a public process to influence the outcome.* *Commissioner Hempling asked if the Kaiser bills makes PHC hesitant in moving forward with geographic expansion.* *Ms. Gibboney stated not at this time, though three out of the ten expansion counties will be*	None

	impacted and it would depend on how much Kaiser's enrollment numbers are allowed to grow in those counties. Ms. Gibboney continued her report by covering the following topics: **CalAIM Waiver** – During phase one, PHC has received $18M in incentive program requests. Applications are being reviewed now and phase two begins shortly. The CalAIM D-SNP requirement for Medi-Cal managed care plans would go into effect in 2026. PHC offered Medicare coverage from 2007-2014. New services offered as of 1/1/2023 will include Respite Services and Personal Care / Homemaker Services. **California State FY 22-23 Budget** – The State budget includes $132B for Medi-Cal and we expect Medi-Cal caseload to decrease by 3%. The May Revise is due out around May 13. Medi-Cal coverage for undocumented adults will begin no sooner than January 2024 and would increase PHC's membership by approximately 31,000 in our 14 county service area. **Housing and Homelessness Incentive Program (HHIP)** – HHIP includes $1.3B in one-time funds that health plans will be responsible for distributing in the communities they serve. It is still unknown if the funds can be used to buy housing, but we are hoping for answers soon. Applications are due June 30. **Wellness and Recovery –** The Wellness and Recovery program underwent an EQRO audit with DHCS two weeks ago, which went well. Yesterday, Lake County voted to join PHC's Regional Model for Wellness and Recovery. **Health Equity –** DHCS will require a health equity officer at each health plan beginning in 2024. Dr. Moore will cover more in his report. **Upcoming Board Meetings** The Strategic Planning Retreat is scheduled for June 21 and 22 at UC Davis. DHCS Director, Michelle Baass has been invited to speak and we hope to see everyone in person. *Commissioner Hardy questioned if the State will evaluate if Medi-Cal Rx has been successful after the grace period ends.* *Ms. Gibboney responded that it is pretty vague if and how the state will provide proof of savings from the program.*	
2 & 3 Consent Calendar	Chairwoman Hardy stated that all items on the consent calendar would be approved with one	*Commissioner Longwell moved to*

	motion unless someone requests to pull an item for further discussion. Hearing no requests, she asked for a motion to approve resolutions 3.1, 3.2, 3.3, 3.4, 3.5. ▪ **3.1** Resolution to Accept all PHC Committee Minutes, Department Operating Report, and PHC Policies, Program Descriptions, and PCP QIP Changes Approved by PAC. ▪ **3.2** Resolution to Retire the 340B Advisory Committee ▪ **3.3** Resolution to Approve Care Coordination Program Description, MPCD2013 ▪ **3.4** Resolution to Approve HR Policies and Personnel Committee Minutes for April 20, 2022 ▪ **3.5** Resolution to Approve Findings That, as a Result of the Continuing COVID-19 Pandemic State of Emergency, Meeting in Person Would Present Imminent Risks to the Health or Safety of Attendees	*approve Resolutions 3.1, 3.2, 3.3, 3.4, 3.5 as presented, seconded by Commissioner Cohen.* ***ACTION SUMMARY:*** *Yes: 23* *No: 0* *Abstention: 0* *Excused: 4 (Broschard, Huber, Rudd, Thomas)* *Absent: 0* **MOTION CARRIED**
4.1 Resolution to Approve Budget Assumptions for FY2022-2023	Jeff Ingram, Senior Director of Financial Analysis, began his report by noting that the system disruption will result in some changes to the Administrative budget that were not enumerated in the assumptions. Staff will modify accordingly in the next step of the budget. With redeterminations on pause, PHC's membership has increased by 100,000 since March 2020. Mercer assumed redeterminations and therefore membership decreases would begin in January, which likely resulted in setting our PMPMs too high. Mercer also assumed we would no longer be paying the LTC 10% add-on. The Finance Team is using the limited information available to make projections and we will provide updates as we learn more.	*Commissioner Germano moved to approve Resolution 4.1 as presented, seconded by Commissioner Brooks.* ***ACTION SUMMARY:*** *Yes: 23* *No: 0* *Abstention: 0* *Excused: 4 (Broschard, Huber, Rudd, Thomas)* *Absent: 0* **MOTION CARRIED**
5.1 Metrics and Financial Update	Mr. Ingram stated that PHC reported a net surplus of $27.2 million for the month ending February 28, 2022, bringing the year-to-date surplus to $106 million. We are favorable $11.3 million year to-Date in Administrative Costs, however we do anticipate some unfavorable variances in the coming months, related to the system disruption. *Commissioner Germano stated that he expected to see a ramp up in utilization for services delayed due to COVID. He questioned if PHC is seeing that spike in utilization of those delayed services.* *Ms. McFarland responded that PHC began to see an increase until the rapid spread of the*	None

	Omicron variant. Though, PHC's data is delayed, so we will not have current data for a few months. The delay in care will likely result in more diagnosing of late-stage diseases which incurs higher costs. Ms. McFarland and Mr. Ingram's full report is included in the Board packet.	
5.2 Operations Update	Sonja Bjork, Chief Operating Officer, began her report by welcoming PHC's three new Board Members. She expressed her appreciation for PHC leaderships' creativity and support during the system disruption. Many departments came up with creative solutions, including Member Services hand writing messages and delivering them to the appropriate department. Focus has now shifted to addressing the backlogs. The Claims Team is working overtime, early mornings and late nights, to process claims. MTM kept their call center open during the disruption and had the ability to schedule rides for members without pre-authorization. They also had the ability to check eligibility via the State's eligibility system. The Population Health team used the disruption as an opportunity to get out into the community to encourage immunizations. Provider Relations contacted providers to ensure they had what they needed while systems were down. Ms. Bjork will include more information in her June report detailing the resumption of business in each department. *Commissioner Hardy questioned if PHC will recognize staff once the backlog is addressed.* *Ms. Bjork responded that PHC is holding a staff appreciation event in May and we are thinking of other ways to recognize the staff's hard work during this crisis. PHC is also in the midst of conducting a salary survey that will be positive for most employees.* *Commissioner McLarin stated that she wished there was more communication from PHC during the disruption.* *Ms. Bjork thanked Commissioner McLarin for her feedback and said she will note and evaluate if we need to increase communication with our county partners during emergencies.* Ms. Bjork's full report is included in the Board packet.	None
5.3 Media Update	Dustin Lyda, Associate Director of Communications & Public Affairs, gave a legislative update, highlighting PHC's efforts in opposing Kaiser's proposed direct contract with the state (AB2724). It is very busy in the Legislature this time of year, with committee and house meetings and the May Revise being released in a few short weeks. The Health Committee is hearing controversial bills, which is dragging out the hearings and slowing the bill review process. PHC is tracking several bills, including SB987, which will require managed care plans to contract with a national cancer institute and ensure someone diagnosed with a special type of cancer be referred to an institute within 15 days. Mr. Lyda's full report is included in the Board Packet.	None

5.4 CMO Report on Quality	Dr. Moore, Chief Medical Officer began his presentation by covering the impact of the system disruption on quality. The outage occurred in the middle of the annual HEDIS data collection process. PHC notified NCQA of the disruption and NCQA agreed to a 3-week delay in the final audit. We do not expect the disruption to have any effect on reaccreditation. During the disruption, the performance improvement team did not have access to quality data, resulting in cancelled meetings where such data is required. Dr. Moore continued to cover the CalAIM Population Health Initiative. The Population Health Management activities, from the DHCS comprehensive quality strategy, are summarized in the illustration below: **Figure 23: Population Health Management Program Framework**  There has been discussion about the potential role of DHCS and Kaiser in standardizing the use of Community Health Information Exchange, but no additional details were presented to the DHCS Medical Directors. *Commissioner McLarin said much of the population health work presented by DHCS is similar to the work counties did pre-pandemic and noted that the state did not include anything related to the pandemic in the framework.* *Dr. Moore agreed and added there is no reference to telemedicine in DHCS framework.* *Commissioner Hardy questioned if the health equity focused data is gathered in ways that will capture information on those who are not accessing care. Will these efforts reach those most vulnerable who are not accessing care?* *Dr. Moore replied that the data is old and it hinders the ability to act in a timely manner. A*	None

	key factor is lack of providers and access. Dr. Moore's full report is included in the Board Packet.	
6.1 Claims Department Update	Lisa Malvo, Director of Claims and Nikki Rotherham, Northern Region Claims Director, gave a report on the Claims department recovery post-system disruption. To tackle the backlog, staff have been cross-trained to handle the high call volume and 85% of Claims staff is working overtime, including leadership. PHC has consistently processed claims and CIFs within 30 calendar days, but current turnaround time is 45 calendar days. In the last check run, PHC processed double the amount of claims and CIFs than normal. Providers are urged to contact the Claims department via the Provider Online Services portal, call or email if they have any questions or concerns. Ms. Malvo and Ms. Rotherham's full presentation is available upon request.	None
6.2 Care Coordination Department Update	Katherine Baressi, Director of Care Coordination and Melissa McCartney, Director of Care Coordination Operations gave a presentation on the Care Coordination department. Ms. McCartney began by highlighting the transportation benefit, noting that lack of transportation is the 3rd leading cause of access to health care issues in the U.S. In 2021, PHC covered over 315,000 completed trips and in 2022, PHC has averaged 28,000 trips per month. Transportation was not impacted by the system disruption, thanks to MTM. Transportation providers must be Medi-Cal certified through the PAVE portal, which is a challenging process. MTM has a less than 1% grievance rate, although we do not want any member to experience issues. *Commissioner Starck said she sometimes hears complaints from PHC members regarding transportation. She questioned if she should encourage them to file a grievance.* *Ms. McCartney responded that any dissatisfaction with MTM should be reported.* Ms. Baressi continued the presentation by saying PHC's Care Coordination department offers case management and care coordination services to assist members with a variety of needs. There are 2,360 PHC members currently working with Care Coordination. There were Over 500+ referrals during the system disruption. The Care Coordination team also maintained 91% service levels for ACD line during the disruption. Ms. Baressi and Ms. McCartney's full presentation is available upon request.	None
7.1 Closed Session	Chairwoman Hardy adjourned the Board of Commissioner to Closed Session at 12:11PM. Ms. Gibboney announced the following item to be discussed in closed session. CONFERENCE WITH LEGAL COUNSEL—ANTICIPATED LITIGATION Significant exposure to litigation pursuant to Section 54956.9(d)(2) of Ralph M. Brown Act: Multiple Potential Cases	None

Adjournment	Chairwoman Hardy announced there was no action taken in Closed Session and the Board adjourned at 12:56P.M.	None

Respectfully submitted by:
Ashlyn Scott, Board Clerk

Board Approval Date: 06/22/22

Signed: _____ _____

Ashlyn Scott, Clerk Alicia Hardy, Chair

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Finance Committee Meeting Date:
June 15, 2022

Board Meeting Date:
June 22, 2022

Agenda Item Number:
2.1

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
Compliance Committee and PHC Staff

Topic Description:
The Compliance Dashboard outlines activities to track Partnership HealthPlan's Compliance Program and regulatory and contractual requirements.

Reason for Resolution:
To ensure Board members have the opportunity to review the Compliance dashboard biannually.

Financial Impact:
There is no measurable impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Compliance Committee, the Board is being asked to approve PHCs Q12022 Compliance Dashboard.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Finance Committee Meeting Date:
June 15, 2022
Board Meeting Date **Agenda Item Number:**
June 22, 2022 2.1

Resolution Number:
22-

IN THE MATTER OF: APPROVING PARTNERSHIP HEALTHPLAN (PHC) COMPLIANCE DASHBOARD

Recital: Whereas,

A. PHC staff is committed to conducting business in compliance with all required standards.

B. The Board has responsibility for reviewing and approving the organizational Compliance Dashboard.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve PHCs Q12022 Compliance Dashboard.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 22nd day of June 2022 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

2022 Regulatory Affairs and Compliance Dashboard

Category	Description	Q1	Comments
DELEGATION OVERSIGHT	**Annual Delegate / Subcontractor Audits**	**1 / 1**	
When PHC delegates administrative functions that it is required by contract or regulation to perform, PHC retains the ultimate responsibility for the performance of these functions and must monitor and evaluate the performance of these functions when performed by a delegate.	Quarterly percentage to demonstrate the total number of annual delegate/subcontractor audits completed within 30 days following the planned months, as defined by the audit calendar.	**100.0%**	
	Oversight of Delegate Reporting	**146 / 147**	
	Percentage of timely submissions of regulatory reports.	**99.3%**	
REGULATORY REPORTING	**DHCS Reports Submitted Timely**	**47 / 55**	
Regulatory Affairs works collaboratively with all PHC departments to implement and track the timely submission of regulatory reporting requirements to PHC's governing agencies.	Percentage of regulatory reports submitted timely by RAC to DHCS with no missed due date per RAC Master Tracker and Regulatory Reporting Calendar.	**85.5%**	8 regulatory reports were late due to the system disruption in March. PHC kept DHCS apprised of delays related to the disruption and began resumption of report submission upon DHCS connection restoration.
	Report Acceptance Rate	**47 / 47**	
	Percentage of standard regulatory reports submitted by RAC and not rejected by DHCS for being incomplete, on the wrong template, or for other findings.	**100.0%**	
HIPAA REFERRALS	**Timely DHCS Privacy Notification Filings**	**15 / 15**	
Appropriate safeguards, including administrative policies & procedures, to protect the confidentiality of PHI and ensure compliance with HIPAA regulatory requirements.	Percentage of reportable notifications that PHC filed timely within applicable DHCS required timeframe. **Initial notice within 24 hours, initial PIR within 72 hours, and final PIR within 10 business days. If any deadline is missed, it will be counted as untimely.*	**100.0%**	Q1 2022- 2 PHC Breach, 2 Delegate Breach
FWA REFERRALS	**Timely DHCS FWA Notifications**	**15 / 17**	
Regulatory Affairs oversees the Fraud, Waste and Abuse Prevention program intended to prevent, detect, investigate, report and resolve suspected and/or actual FWA in the PHC daily operations and interactions, whether internal or external.	Percentage of reportable notifications that PHC filed timely with DHCS within 10 business of discovery per contractual obligations.	**88.2%**	2 Incidents not reported timely to DHCS due to system disruption in March. PHC kept DHCS apprised of delays related to the disruption and began resumption of filings upon DHCS connection restoration.

***Threshold percentages for the above measures are as follows:**
≥ 95% = GREEN 90 - 94.9% = YELLOW < 90% = RED

CAP Tracker

*Please note that the above threshold percentages do not apply here

Updated 05/24/2022

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:**
Meeting Date: May 18, 2022 2.2
Board Meeting Date: June 22, 2022

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
The Finance Committee and PHC Staff

Topic Description:
On April 27, 2022, the Board approved Budget Assumptions for FY 2022-2023 and directed staff to prepare a full operational budget. The Preliminary Health Care Budget for FY 2022-2023 was developed. If approved, the full Board will ratify the Finance Committee's approval on June 22, 2022.

On June 15, 2022, the Finance Committee will review and approve the Final Budget. The full Board will review and approve it on June 22, 2022.

Reason for Resolution:
The purpose of this resolution is to provide the Preliminary Health Care Budget for FY 2022-2023 for review and approval.

Financial Impact:
The financial impact is material.

Requested Action of the Board:
Based on the approval of the Finance Committee and PHC staff, the Board is asked to ratify the Preliminary Health Care Budget for FY 2022-2023.

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:**
Meeting Date: May 18, 2022 2.2
Board Meeting Date: June 22, 2022

Resolution Number:
22-

IN THE MATTER OF: RATIFYING THE FINANCE COMMITTEE'S APPROVAL OF THE PRELIMINARY HEALTH CARE BUDGET FOR FY 2022-2023

Recital: Whereas,

A. The Board has responsibility for establishing budget policy and specific budget approval.

B. In prior meetings, PHC staff, the Finance Committee, and the Board have provided direction and input into the development of the budget.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To ratify the Finance Committee's approval of the Preliminary Health Care Budget for FY 2022-2023.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 22nd day of June 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

FY 2022-23

Preliminary Health Care Budget

May 2022

Introduction

As part of the PHC budget process, the next phase is to present and seek approval from the Finance Committee, the preliminary health care budget. PHC Staff has outlined the major expense categories and highlighted the risks and opportunities assumed in the first draft of the health care costs. Estimates may materially change prior to the final presentation of the full operating budget in June 2022.

Health Care Expenses

As stated in our budget assumptions last month, the COVID-19 impacts to the delivery network began to subside following the Omicron wave. Underlying utilization is returning to pre-COVID patterns, though, Staff will remain cautious for a surge in claims related to the rumored pent-up demand related to the stay-at-home orders that were implemented in the first half of the public health emergency (PHE). PHC has applied a blended per member per month (PMPM) method to construct the first pass of the health care expense budget. Utilizing the Plan's historical claims experience for all counties with dates of service ranging from January 2019 through January 2022, smoothing irregular trends using seasonal experience. State-mandated increases were assumed to remain in place until December 31, 2022, which is Staff's estimated conclusion of the PHE. In addition, the increased base membership caused by the pause in redeterminations has yielded material increases in capitation expenses and fee-for-service utilization, present in all of the cost categories. If new information becomes available prior to the final budget submission, staff will make adjustments where necessary. Information surfacing after June 2022, will be evaluated and material impacts not covered as part of the flex budget process will need to be incorporated in a full budget refresh.

The first draft of the health care budget assumes an overall expense of $2.69 billion, which is ($210.2) million, or (7.2%), less than the forecasted 2021-22 spend. Considerations and estimates by cost category are presented in more detail, below.

Global Sub-Capitation & Capitated Medical Groups

2022-23: $235.0 million | 2021-22 △: ($39.3) million or (14.3%)

The first pass of the health care budget assumes minimal year-to-year changes for provider capitation rates. The pharmacy carve-out will be incorporated in the CY 2022 rates and beyond for PHC's global sub-capitation provider, driving much of the year-over-year decrease in expense. The resumption of the redetermination process, assumed in January 2023, will decrease the global sub-capitation expense further by $6.0 million compared to the 2021-22 Forecast. Capitated medical groups will continue to have variability tied to overall plan enrollment. Variances tied to membership will be accounted for as part of the flex budget process. Similar to prior years, contract negotiations pose a risk of increased cost pressures if PHC is unable to keep rates at their current levels.

Inpatient Hospital

2022-23: $957.8 million | 2021-22 △: $84.8 million or 9.7%

The Inpatient Hospital line item includes inpatient fee-for-service, hospital capitation, and stop loss expenses. DHCS continues to apply downward pressure to PHC's inpatient reimbursement due to the cost per unit's outlier status relative to other managed care plans. Given the current macro-economic conditions, Staff expects to receive strong provider pressure to increase rates to offset ongoing inflation and employment concerns. The cost pressures combined with the release of IBNR in the 2021-22 FY will yield an increase in Inpatient Hospital expenses year-to-year. Staff will continue to evaluate hospital contracts relative to revenue and if DHCS continues to reimburse at levels lower than cost, PHC will need to continue to maintain current reimbursement levels.

Physician Services

2022-23: $470.2 million | 2021-22 △: ($14.6) million or (3.0%)

Physician Services line item includes proposition 56 (prop 56), specialty capitation, primary capitation, and physician fee-for-service expenses. Adjustments to various Prop 56 programs, which includes rate reductions and the elimination of the VBP program, are driving the bulk of the decreases from the prior year. Fee-for-services expenses are expected to increase slightly as part of an allocation adjustment. Staff will monitor paid claims for the month of May 2022 and will make material adjustments where necessary prior to finalizing the budget.

Long Term Care

2022-23: $381.3 million | 2021-22 △: ($12.0) million or (3.1%)

As explained in prior year budget cycles, the Long Term Care (LTC) expense category is difficult to budget due to the timing and complexity of periodic DHCS rate releases. The rates are often released months after their effective date, requiring PHC Staff to complete in-depth analysis to calculate and correct prior payments. COVID-19 brought a new layer with a 10% mandatory increase to help support the added burden for many facilities. These increases were implemented in March of 2020 and will continue through end of the PHE, now estimated to be December 2022. The overall decrease of $3.1 million in LTC spend is primarily due to the upcoming fiscal year only including 6 months of the 10% add-on. In addition, PHC has recognized a negative utilization trend over the course of the pandemic, likely due to the disproportionate impact COVID-19 has had on these vulnerable populations. There could be additional pandemic impacts related to behavioral changes as members will likely be hesitant to enter congregate living settings.

Pharmacy

2022-23: $0 million | 2021-22 △: ($183.6) million or (100.0%)

The large reduction of $183.6 million is directly tied to the State's pharmacy carve-out from managed care plans, which was effective January 1, 2022. Pharmacy expenses related to inpatient and physician services will be budgeted and reported within their respective categories. Aside from the potential prior period corrections or the unlikely event of claims runout, this category should not include material expenses for the upcoming fiscal year.

Ancillary Services

2022-23: $468.4 million | 2021-22 △: ($16.8) million or (3.5%)

Ancillary Services is comprised of fee-for-service and capitated ancillary services. The budget assumes a decrease of $16.8 million mainly tied to fee-for-service allocation adjustments along with IBNR releases tied to FY 2021-22. PHC faces additional pressure from hospitals for emergency department and outpatient services. Additionally, utilization for outpatient mental health services and BHT has increased substantially since the start of the pandemic. Staff will continue to monitor the paid claims for the month of May 2022 and will make material adjustments where necessary.

Other Medical

2022-23: $100.0 million | 2021-22 △: ($27.4) million or (21.5%)

The Other Medical category includes transportation, quality assurance, health care investment fund (HCIF), nurse advice line, and Health Insurance Premium Payments (HIPP). The year-to-year decreases are primarily due to the development of new grants in the prior year along with a fee-for-service allocation adjustment impacting the transportation line. Staff are initially budgeting the quality assurance and medical administrative expenses to remain flat to the 2021-22 budgeted levels. Enhanced Case Management (ECM) and Community Supports, formerly referred to as In Lieu of Services (ILOS), will be budgeted within various expense categories in which they are assigned. Staff do not anticipate the CalAIM programs to have a significant impact to the budget or financial performance. In addition, PHC will continue to flag the housing SURs as a non-budget variances due to the timing of grant accounting.

Quality Improvement Programs (Incentives)

2022-23: $80.2 million | 2021-22 △: ($1.3) million or (1.5%)

PHC plans to budget incentives flat year-to-year due to the assumed resumption of redeterminations. FY 2021-22 saw an increase in budget to account for overall membership growth tied to pandemic impacts. Incentive funding is subject to final revenue projections when revised rates from DHCS are received. There is some budgetary risk involved in estimating the exact overall payment levels, which is dependent on the actual performance of participating providers. COVID-19 introduced its own level of complexity with major disruptions to normal day-to-day activities for measurement years 2020 and 2021. Staff will continue to use historical performance along with more recent leading indicators to predict the estimated payout of all programs. Budget funding may shift between programs as each QIP has its own set of participants, guidelines, and performance.

Health Care Budget Comparison

HealthCare Categories	Budget FY 2022-23	Forecasted FY 2021-22	Y-o-Y △ $	Y-o-Y △ %
Global Subcapitation & Capitated Medical Group	$235,049,678	$274,337,591	($39,287,913)	(14.3%)
Inpatient Hospital	$957,800,170	$873,009,774	$84,790,396	9.7%
Physician Services	$470,217,033	$484,846,482	($14,629,449)	(3.0%)
Long Term Care	$381,308,096	$393,345,302	($12,037,206)	(3.1%)
Pharmacy	$0	$183,588,912	($183,588,912)	(100.0%)
Ancillary Services	$468,434,596	$485,239,403	($16,804,807)	(3.5%)
Other Medical	$99,980,759	$127,386,416	($27,405,658)	(21.5%)
Quality Improvement Programs	$80,186,040	$81,446,030	($1,259,990)	(1.5%)
Total HealthCare Costs	**$2,692,976,371**	**$2,903,199,910**	**($210,223,539)**	**(7.2%)**

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
3.1

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
PHC Advisory Groups and Committees

Topic Description:
Partnership HealthPlan of California (PHC) has a number of advisory groups and committees established by the Commission (known as the Board) with direct reporting responsibilities. These are the 340B, Compliance, Consumer Advisory, Finance, Personnel, Policies and Benefits, Physicians Advisory, Substance Use Services, Provider Advisory and Strategic Planning.

The Physician's Advisory Committee (PAC) has responsibility for oversight and monitoring for the quality and cost-effectiveness of medical care provided to PHC's members. A number of other PHC advisory groups and committees have direct reporting responsibilities to PAC. These are the Credentialing, Cultural & Linguistics & Health Education, Internal Quality Improvement, Member Grievance Review, Over/Under Utilization Workgroup, Peer Review, Pharmacy & Therapeutics, Provider Grievance Review, Quality/Utilization Advisory, Substance Use Services Internal Quality Improvement and Substance Use Services.

The Board is responsible for reviewing and accepting all minutes and packets approved by the various PHC advisory groups and committees, and approving the policies, program descriptions, and QIP policy changes that were approved by the PAC, from April 2022 through June 2022. In addition, the Board reviews and accepts PHC's Claims, Health Services, Human Resources, Member Services and Provider Relations department operating reports.

Reason for Resolution:
To provide commissioners with all PHC committee minutes, committee packets and departmental operational reports. In addition, to provide commissioners with all PHC policies and program descriptions approved by PAC and recommended for approval.

Financial Impact:
Any financial impact to the HealthPlan is included in the budget assumptions.

Requested Action of the Board:
Based on the recommendation of PHC's advisory groups & committees, the Board is asked to accept receipt of all PHC committee minutes, committee packets and the departmental operational reports. In addition, to approve all PHC policies and program descriptions approved by PAC linked to the packet.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
3.1

Resolution Number:
22-

IN THE MATTER OF: ACCEPTING ALL PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC) COMMITTEE MINUTES, COMMITTEE PACKETS, AND DEPARTMENTAL OPERATING REPORTS. IN ADDITION, TO APPROVE ALL PHC POLICIES AND PROGRAM DESCRIPTIONS APPROVED BY THE PHYSICIANS ADVISORY COMMITTEE (PAC)

Recital: Whereas,

A. The Board has fiduciary responsibility for the operation of the organization.

B. The Board has responsibility to review and accept all PHC committee minutes, packets and departmental operational reports. In addition to review and approve all PHC policies and program descriptions approved by PAC.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To accept receipt of all PHC committee minutes, committee packets and departmental operational reports.
2. To obtain approval for all PHC policies and program descriptions approved by PAC and recommended for Board approval.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 22nd day of June 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____

Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
3.2

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
PHC Staff

Topic Description:
AB361 authorizes public meetings with Brown Act requirements to be held via teleconference or telephone during a state of emergency. Virtual public meetings still require standard meeting agendas and notices and the ability for the public to provide public comment. To continue virtual meetings, the Commission must make findings every 30 days that 1) it has reconsidered the circumstances of the ongoing COVID-19 pandemic state of emergency and 2) either the state of emergency continues to directly impact the ability of the public to meet safely in person, or state or local officials continue to impose or recommend measures to promote social distancing.

Due to the ongoing risk of community transmission of COVID-19, it is recommended that the Partnership HealthPlan of California Commission continues to offer virtual attendance as an option and encourages in-person attendance following current PHC guidelines with regard to vaccinations, masking, social distancing and other protective measures.

Reason for Resolution:
To allow the Board the opportunity to review and approve ongoing virtual Board Meetings, due to the ongoing risk of community transmission of COVID-19.

Financial Impact:
There is no additional financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of PHC staff and public health officials, the Board is asked to approve the recommended to continue to offer virtual attendance, due to the ongoing risk of community transmission of COVID-19.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
3.2

Resolution Number:
22-

IN THE MATTER OF: APPROVING THE RECOMMENDED CONTINUATION OF MEETING VIRTUALLY

Recital: Whereas,

A. AB361, signed by Governor Newsom on September 16, 2021, requires the Commission must make findings every 30 days to continue to offer virtual attendance.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the recommended continuation of offering virtual attendance for meetings, due to the ongoing risk of COVID-19 transmission, for the next 30 days, per AB 361.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 22nd day of June 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
3.3

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
Quality / Utilization Advisory Committee & Physician Advisory Committee

---

Topic Description:
The Utilization Management Program Description serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and to pursue identified opportunities for improvement. The program description is updated annually by the Health Services team.

Reason for Resolution:
To allow the full Board the opportunity to review and approve the Utilization Management Program Description on an annual basis.

Financial Impact:
There is no measurable financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of the Quality/Utilization Advisory Committee & Physician Advisory Committee, the full board is asked to approve changes to the Utilization Management Program Description, MPUD3001.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
3.3

Resolution Number:
22-

IN THE MATTER OF: APPROVING THE UTILIZATION MANAGEMENT PROGRAM DESCRIPTION, MPUD3001

Recital: Whereas,

A. The Board has the authority and responsibility for ensuring PHC has a comprehensive and integrated UM Program.

B. The Board has ultimate responsibility for approving the Utilization Management Program.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To obtain Board approval for changes to the Utilization Management Program Description, MPUD3001.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 22nd day of June 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

Partnership HealthPlan of California

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

MPUD3001

May 2022

Table of Contents

PROGRAM PURPOSE

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

The mission of Partnership HealthPlan of California is "To help our Members, and the Communities we serve, be healthy." Our vision is to be "the most highly regarded health plan in California."

PHC has program descriptions and policies to describe the structures needed to provide high quality health care while being stewards of taxpayer resources. In the Utilization Management Program Description, PHC outlines the structure of our measurement and management of utilization of health care services within our system.

The PHC Utilization Management (UM) program serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and toactively pursue identified opportunities for improvement.

The utilization program is housed within the Health Services Department, which consists of five teams including:

- Utilization Management
- Care Coordination
- Population Health
- Pharmacy
- Quality Improvement

The PHC UM program serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time
- Ensure that the setting in which the service is delivered is consistent with the medical care needs of the individual

The UM program provides a reliable mechanism to review, monitor, evaluate, recommend and implement actions on identification and correction of potential and actual utilization and resource allocation issues.

PHC recognizes the potential for under-utilization and takes appropriate steps and actions to monitor for this. The processes for UM decision making are based solely on the appropriateness of care and services and existence of coverage. PHC does not reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization and PHC does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

PROGRAM OBJECTIVES

UM Program Objectives

The PHC UM program serves to ensure that appropriate, high quality cost-effective utilization of health care resources is available to all members. This is accomplished through the systematic and consistent application of utilization management processes based on current, relevant medical review criteria and expert clinical opinion when needed. The utilization management process provides a system that ensures equitable access to high quality health care across the network of providers for all eligible members as follows:

- Ensures authorized services are covered under contract with the State of California Department of Health Services (DHCS) California Code of Regulations (CCR) Title 22 - For Medi-Cal Members (Title 22).

- Coordinates thorough and timely investigations and responses to member and provider reconsideration and appeals associated with utilization issues
- Initiates needed operational revisions to prevent problematic issues from reoccurring
- Ensures that services which are delivered are medically necessary and consistent with diagnosis and level of care required for each individual, taking into account any co-morbid condition that exists and the ability of the local delivery system to meet the need
- Educates members, practitioners, providers and internal staff about PHC's goals for providing quality, cost-effective, managed health care
- Defines the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review
- Promotes and ensures the integration of utilization management with quality monitoring and improvement, risk management, and case management activities
- Ensures a process for critical review and assessment of the UM program and plan on, at minimum, an annual basis, with updates occurring more frequently if needed. The process incorporates provider, practitioner and member input along with any regulatory changes, changes to current standards of care, and technological advances
- Evaluates the ability of delegates to perform UM activities and to monitor performance

Program Structure

This section outlines the individual program staff and the assigned activities, including approval authority and the involvement of the designated physician.

Assigned Responsibilities

Program Staff

Chief Medical Officer (CMO) – MD/DO

The Chief Medical Officer is responsible for the implementation, supervision, oversight and evaluation of the UM Program.

This position provides guidance and overall direction of UM activities and has the authority to make decisions based on medical necessity which result in the approval or denial of coverage. The assigned activities for this position include but are not limited to:

- Assuring that the UM program fulfills its purpose, works towards measurable goals, and remains in regulatory compliance
- In collaboration with the Senior Director of Health Services and the Associate Directors of Utilization Management; oversees UM program operations and assists in the development and coordination of UM policies and procedures.
- Reviews for the consistent application of UM decision criteria at least annually and implements corrective actions when needed
- Serves as the Committee Chair for the Quality/Utilization Advisory Committee (Q/UAC) and regularly attends the Physician Advisory Committee (PAC). CMO (or designee) also serves as the Pharmacy and Therapeutics (P&T) Committee Chair.
- Ensures timely medical necessity review and decisions are made by daily staffing physicians for medical review consultation

- Guides and assists in the development and revision of PHC medical policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for Q/UAC review, adaptation and PAC approval
- As the chairman of the Q/UAC, presents UM activities on a regular basis to the Q/UAC and provides periodic updates on utilization management activities to the PAC and the Board of Commissioners
- Evaluates the overall effectiveness of the UM program
- Evaluates and uses provider and member experience data when evaluating the UM program in collaboration with the Senior Director of Health Services and appropriate committees

Regional Medical Director - MD/DO

The Regional Medical Director is a physician with the authority to make decisions based on medical necessity which result in the approval or denial of coverage.

The assigned activities for this position include but are not limited to:

- Evaluates the appropriateness and quality of medical care delivered through PHC in the designated regional area
- Participates in enterprise-wide projects that require Physician involvement
- Other duties as assigned by the Chief Medical Officer.

Associate Medical Director - MD/DO

This Physician has the authority to make decisions based on medical necessity that result in the approval or denial of coverage. The assigned activities for this position include:

- Coverage in the UM Department for medical necessity reviews applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for PHC members
- Provides review of quality of care issues and serves on Q/UAC
- Other duties as assigned by the Chief Medical Officer

Behavioral Health Clinical Director - MD/DO/PhD/ PsyD

The PHC Behavioral Health Clinical Director is an MD, DO, clinical PhD, or PsyD who is actively involved in the behavioral health aspects of the UM program. This Director provides clinical oversight of PHC's behavioral health activities including substance use services and the activities of PHC's delegated managed behavioral health organization(s). The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for behavioral health or substance use services. The assigned activities for this position include:

- Establishes UM policies and procedures in collaboration with PHCs delegated managed behavioral health organization(s)
- Oversees and monitors quality improvement activities
- Facilitates network adequacy
- Participates in the peer review process
- Evaluates behavioral health care and substance use disorder (SUD) treatment services requests in collaboration with PHC's delegated managed behavioral health organization(s)
- Oversees and monitors functions of PHC's delegated managed behavioral health organizations
- Serves on Quality/Utilization Advisory Committee; Pharmacy and Therapeutics Committee; Credentials Committee and Internal Quality Improvement Committee including the Substance Use Internal Quality Improvement Subcommittee.

Pharmacy Services Director – Pharm.D.

This position is responsible for overseeing all HealthPlan activities related to medication benefit and pharmacy services and supervising the PHC Pharmacy management team, PHC Clinical Pharmacists, and support staff. The assigned activities for this position include but are not limited to:

- Medication coverage management
- Development of applicable policies and guidelines
- Serves on the Pharmacy and Therapeutics (P&T) Committee (serving as Chair when designated by the CMO), the Drug Utilization Review (DUR) Board and the Pediatric Quality Committee (PQC)
- Drug utilization review
- Drug prior authorization for medications covered under the medical benefit
- Implementation of cost effective utilization management measures for medications covered under the medical benefit
- Participation in provider education initiatives such as academic detailing with plan physicians
- Medical education meetings
- Assisting with development of Clinical Practice Guidelines
- Other duties as assigned by the Chief Medical Officer

Senior Director of Health Services - RN

Responsible for the day-to-day implementation of the PHC Utilization Management Program. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Provides oversight and guidance for the UM program across all regions
- Reports to the Q/UAC on UM activity
- Coordinates departmental UM and Quality Improvement efforts
- Collaborates with providers and facilities
- Monitors and analyses UM data to inform decision making
- Develops recommendations based on data analysis and strategic planning.
- Collaborates with the Chief Medical Officer and the Q/UAC on UM activities
- Evaluates and uses provider and member experience data when evaluating the UM program in collaboration with the Chief Medical Officer
- Serves as Chairperson of the Benefit Review Evaluation Workgroup (BREW)
- Prepares and presents the annual evaluation, program description to Q/UAC and PAC

Associate Director of Utilization Management Programs- RN

Under the direction of the Senior Director of Health Services, manages and provides direction to the Utilization Management department managers, supervisors and staff for all product lines ensuring consistent development, implementation, and maintenance of health services programs. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Implements the UM program within assigned region
- Provides day to day direction to UM Managers and Supervisors within assigned region to meet department goals and objectives and is available to staff on-site or by telephone
- Conducts annual performance evaluations for assigned UM staff
- Conducts monitoring activities
- Participates in staff trainings and on-site continuing education
- Audits medical records as appropriate and monitors for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Collaborates with providers and facilities
- Develops recommendations for program improvements
- Coordinates activities with Quality Improvement, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care outcomes and trends
- Participates in establishing and maintaining reports which relay the efficacy of UM activities and summarizes, at least annually, the UM activity, quality improvement activities and utilization outcomes, with supporting statistical data at IQI and Q/UAC

Associate Director of Utilization Management Strategies- RN

Under the direction of the Senior Director of Health Services, plans, monitors and evaluates utilization management activities to identify strategic initiatives to enhance the efficacy of the UM program, while improving health outcomes, in a cost effective manner. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Collaborates with the provider relations contracting team to identify strategic opportunities and develops recommendations
- Participates in contract review and negotiations
- Attends regular meetings with hospitals, long-term care facilities and community agencies to facilitate cost effective and appropriate alternative placements
- In collaboration with the Senior Director of Health Services and Senior Director of Provider Relations, reviews and processes provider grievances in accordance with appropriate regulatory requirements and participates in provider grievance meetings
- Works with county agencies and community based organizations to facilitate the DHCS CalAIM initiative related to Community Support Services with focus on improving medical health outcomes and healthcare costs
- Works collaboratively with claims and configuration department leaders and team members to identify systematic issues or opportunities for staff and/or provider education
- Attends claims configuration meetings and Benefit Review Evaluation Workgroup (BREW) as well as IQI, Q/UAC and PAC
- Works with providers and/or vendors to facilitate issue resolution and ensure a consistent UM process
- Develops, reviews, and/or revises PHC UM policies and procedures in collaboration with the Senior Director of Health Services as appropriate.

Associate Director of Utilization Management Regulations

Under the direction of the Senior Director of Health Services, provides oversight of the UM Program to ensure compliance with regulatory requirements including, but not limited to, requirements of DHCS and the National Committee for Quality Assurance (NCQA). Assigned activities include:

- Coordinates activities with External and Regulatory Affairs Compliance, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care issues and trends related to UM Department processes
- Prepares reports on departmental activities according to established schedules and format. Identifies patterns and trends, conducts retrospective review as needed and works with UM Leadership to develop corrective action plans.
- Participates in the grievance process
- Acts as primary contact and support to each UM Delegate, providing training and support as necessary
- Conducts delegation oversight through regular auditing of each UM Delegate, prepares audit reports for review by the Senior Director of Health Services and the Chief Medical Officer or physician designee, and prepares information for the Delegation Oversight Review Sub-Committee (DORS)
- Collaborates with the Associate Director of UM Programs to ensure that all policies and procedures related to regulatory requirements are updated at least annually, or as needed, and presented to appropriate committees for review. Assists PHC staff and providers with the interpretation of PHC policies, procedures, and regulatory requirements.
- Works with UM Leadership and UM Trainer to develop standardized training content and materials for new staff and ongoing education for existing staff
- Participates in the planning and development of new/ enhanced Health Services plan benefits or product lines as needed. Attends Benefits Review and Evaluation Workgroup meetings
- Participates in audits by various regulatory agencies as necessary

Utilization Management Team Manager - RN

Responsible for the implementation, management and evaluation of an effective and systematic UM Program. Provides day-to-day guidance to UM staff and manages all aspects of utilization review activities and is available to staff on-site or by telephone. Working with the Chief Medical Officer, Senior Director of Health Services, Associate Directors of UM, utilization committees, and Health Plan Directors, promotes efficient resource utilization throughout the organization, providing leadership, teambuilding and direction needed to ensure attainment of UM goals. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Coordinates completion of activities
- Presents work plan status reports and updates to the Q/UAC
- Monitors for consistent application of UM criteria by UM staff for each level and type of UM decision
- Participates in staff trainings and on-site continuing education
- Provides recommendations for interventions designed to improve utilization management issues
- Coordinates implementation of interventions
- Develops UM policy and procedures for Q/UAC approval
- Develops, or coordinates development of, documentation of UM activities
- Conducts annual performance evaluations for assigned UM staff

Inpatient/Outpatient Nurse Supervisor UM - RN

This position is responsible for the daily mentorship and oversight of the staff assigned to inpatient or outpatient services. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Works collaboratively with all levels of leadership within the department to efficiently coordinate workflow and individual staff assignments
- Provides day to day supervision to the assigned team, overseeing daily operations of the inpatient or outpatient review process
- Participates in staff trainings and on-site continuing education. With UM Leadership, conducts annual performance evaluations for assigned UM staff
- Audits medical records as appropriate and monitors for consistent application of UM Criteria by UM staff, for each level and type of UM decision.
- This position, in addition to his/her own case load, may be assigned cases in the area of oversight as deemed necessary to provide coverage

Nurse Coordinator/ UM II - RN/ LVN

Work collaboratively with all levels of UM leadership and other PHC staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Assist in training and orientation of new staff to the department upon request
- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines
- Review and authorization of Long Term Care TARs based on established guidelines
- Review and authorization of inpatient Hospital TARs based on established guidelines
- Review and authorization of Enhanced Care Management (ECM) and Community Supports TARs based on established guidelines

cont'd

- Reviews residential placement authorization requests for substance use disorder (SUD) treatment services according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements for Medi-Cal eligible beneficiaries. Licensed staff who operate in the capacity of behavioral health authorizations are required to complete specialized ASAM[1] training annually.
- Retrospective review of services to determine medical necessity
- Refer cases to the Chief Medical Officer for requests that may not appear to meet evidence- based medical necessity criteria
- Determines if requested services are part of the member's benefit package
- Work collaboratively with the Care Coordination, Population Health, Pharmacy and Quality Improvement staff on UM issues

Nurse Coordinator/ UM I - RN/ LVN

Work collaboratively with all levels of UM leadership and other PHC staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care. This position has the authority to make decisions on coverage not relating to medical necessity. Activities assigned include:

- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines.
- Review and authorization of Long Term Care TARs based on established guidelines.
- Review and authorization of inpatient Hospital TARs based on established guidelines.
- Review and authorization of Enhanced Care Management (ECM) and Community Supports TARs based on established guidelines
- Reviews residential placement authorization requests for SUD treatment services according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements for Medi-Cal eligible beneficiaries. Licensed staff who operate in the capacity of behavioral health authorizations are required to complete specialized ASAM[1] training annually.
- Retrospective review of services to determine medical necessity
- Refer cases to the Chief Medical Officer for requests that may not meet medical necessity criteria
- Determine if requested services are part of the member's benefit plan
- Work collaboratively with the Care Coordination, Population Health, Pharmacy, and Quality Improvement staff on UM issues

Clinical Pharmacist – PharmD, RPh

Work collaboratively with all levels of Pharmacy leadership to review medication Treatment Authorization Requests (TARs) to promote safe, appropriate, and cost effective drug therapy.

- Communicate and educate prescribers on TAR processes, TAR determination, and PHC medication coverage policies
- Participate in P&T meetings and conduct drug utilization reviews to identify treatment gaps and optimize medication therapy outcomes based on national treatment guidelines and evidence-based medicine
- Participates and works with other departments on cross-departmental initiatives that require Clinical Pharmacy input/participation
- Support HEDIS and other clinical quality improvement work through provider academic detailing and member engagement activities
- Ensure compliance with regulatory and quality standards/requirements including, but not limited to, the standards of the National Committee for Quality Assurance (NCQA) and the requirements for the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS).

[1] American Society of Addiction Medicine (ASAM) Criteria - As defined in the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Intergovernmental Agreement, pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient.

Pharmacy Technician – CPhT, RPhT

Work collaboratively with all levels of Pharmacy leadership to review medication Treatment Authorization Requests to promote safe, appropriate, and cost effective drug therapy.

- Reviews and approves TARs based on established internal pharmacy technician review guidelines &/or PHC drug TAR requirements (prior authorization criteria for use). If a TAR cannot be approved based on guidelines/criteria, the pharmacy technician will refer the TAR to the Clinical Pharmacist for an escalated review.
- Educates prescribers on TAR processes, TAR determination, and PHC medication coverage policies.
- Supports HEDIS and other clinical quality improvement work through provider academic detailing and member engagement activities.

Data Coordinator/ Supervisor UM – Administrative

Works closely with UM Leadership to establish consistent evaluation of Data Coordinators' work performance. Responsible for oversight of Data Coordinators.

- Monitors day to day functions including coordination of assignments, monitoring of call volume and adherence to PHC workplace policy and is available to staff on-site or by telephone
- Assists in the refinement/improvement of the HS programs
- Provides performance feedback to the Data Coordinator staff and conducts staff trainings as needed.
- Monitors UM Data Coordinator activity for consistent application of desktop processes and procedures by UM Data Coordinator staff
- Provides leadership, direction, training, and support to the assigned staff
- Participates in staff trainings and on-site continuing education
- Conducts annual performance evaluations for assigned UM staff

Data Coordinator/ UM Lead - Administrative

Under the direction of the Data Coordinator Supervisor and UM Leadership:

- Monitors Data Coordinator documentation for accuracy
- Ensures Data Coordinator staff have the resources required for completing TAR entry and using good judgment and is available to staff on-site or by telephone
- Enters both manual and electronic submitted data into PHC systems for RAF and TAR authorizations
- Monitors UM Data Coordinator staff for consistent application of desktop processes and procedures
- Responsible for assisting with ongoing staff education in proper use of systems and PHC UM Departmental policies and procedures
- Participates in staff trainings and on-site continuing education

Executive Assistant to CMO - Administrative

Provides administrative support to the Chief Medical Officer. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

Continuing Education Program Coordinator - Administrative

Provides administrative support to the Chief Medical Officer. Responsible for coordinating the Continuing Education program, including planning meetings and trainings. Audits each CME/CE activity to ensure all elements required by organizations overseeing PHC's educational programs are documented. Maintains organized electronic versions of all continuing education records.

Health Services Administrative Assistant II - Administrative

Provides administrative support to the Senior Director and/or other UM Leadership. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

Health Services Administrative Assistant I – UM - Administrative
Provides administrative support to UM Leadership. Responsible for maintaining and updating policy and procedure manuals, managing appointment calendars, and working closely with the Information Technology Department to ensure appropriate electronic functioning for the Health Services Department.

Health Services Administrative Assistant II – CMO - Administrative
Responsible for administrative support to the Associate and Regional Medical Directors. Responsible for managing appointment calendars, scheduling daily UM and pharmacy workload coverage for the MDs, developing weekly and monthly schedules for distribution to other departments, and coordinating Peer-to-Peer requests from providers. Coordinates setup and executes minutes for designated meetings.

Authorization Specialist/ UM Trainer – Administrative
Responsible for providing training on all appropriate software platforms for new hires. Creates and maintains current training materials for the UM department. In conjunction with UM leadership team, prepares and delivers retraining of identified topics as deemed necessary.

- Facilitates independent DME consultant evaluation visits to members for specialty equipment needs as needed or directed by UM Leadership.
- Acts as a resource regarding UM department software programs and special projects upon request and is available to staff on-site or by telephone
- Coordinates with Member Services Call Center system to place members into appropriate Direct Member status related to their care.

Coordinator II - Administrative
Under the direction of the UM Team Manager and/or the Data Coordinator Supervisor:

- Serves as a resource to other departments who have inquiries into the UM process
- Responsible for the input of data and information concerning UM Referrals and Authorizations
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated

Coordinator I - Administrative
Under the direction of the UM Team Manager and/or the Data Coordinator Supervisor - responsible for the input of data and information concerning UM Referrals and Authorizations.

- Maintains departmental documents
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated

Coordinator II - Appeals - Administrative
Under the direction of the Associate Director of UM Programs:

- Responsible for clerical processing of appeals in accordance with policy, procedures, timeframes and requirements of various regulatory bodies for all lines of business
- Acts as liaison to Claims Department in coordinating timely response to all claims inquiries
- Participates in special projects, tasks and assignments as directed

Delegation Program Coordinator I – Administrative
Under the direction of the Associate Director of UM Regulations

- Responsible for collecting and tracking required document submissions from delegated entities
- Coordinates and participates in both desktop and onsite audits of delegated entities
- Ensures efficient and appropriate collaboration between the Utilization Management staff and UM delegated entities

Project Coordinator - Administrative

Under the direction of the Senior Director of Health Services or other designated leadership.

- Tracks project deliverables and resources using appropriate internal tools to ensure deadlines are met
- Works collaboratively with the HS Analytics team (Finance) and IT department to design and implement reports to accurately reflect the work completed and outcomes achieved within the Department and its programs
- Coordinates with Regulatory Affairs and Compliance (RAC) to conduct research on regulations, statutes, laws, administrative policies and procedures
- Works closely with the CalAIM team including but not limited to Community Supports duties related to outreach of providers and ensuring timely follow up where necessary.

Committees

Board of Commissioners

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

Physician Advisory Committee (PAC)

The PAC monitors and evaluates all Health Services activities and is directly accountable to the Board of Commissioners for the oversight of the UM program. The PAC meets at least ten (10) times a year and may not convene in the months of July and December, with the option to add additional meetings if need. Voting membership includes external Primary Care Providers (PCPs), board certified high-volume specialists, and behavioral health practitioners. A voting provider member of the committee chairs the PAC. The PHC Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer, Associate Medical Director of Quality, Regional Medical Director(s), Clinical Director of Behavioral Health, Senior Director of Health Services and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, and Pharmacy departments attend the PAC meetings regularly. Other PHC staff attend on an ad hoc basis to provide expertise on specific agenda items. The PAC oversees the activities of the Q/UAC and other quality-related committees and reports activities to the Board of Commissioners.

Quality/Utilization Advisory Committee (Q/UAC)

The Q/UAC is responsible to assure that quality, comprehensive health care, and services are provided to PHC members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external providers who are contracted primary care providers (PCPs) and board certified specialists in the areas of internal medicine, family medicine, pediatrics, OB/GYN, neonatology, behavioral health, and representatives from other high volume specialties. The PHC Chief Medical Officer (CMO) (chair of the committee), Clinical Director of Behavioral Health, Associate Medical Director of Quality, Associate and Regional Medical Directors and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, Care Coordination, Population Health, Pharmacy, and Grievance Departments attend the Q/UAC meetings regularly. Other PHC staff attend on an ad hoc basis to provide expertise on specific agenda items. The committee meets on a monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to the PAC and to the Commission at least quarterly. The Q/UAC provides guidance and direction to the UM program by coordinating activities and by functioning as the expert panel when needed. Coordination includes but is not limited to:

- Reviewing, making recommendations to, and approving the *UM Program Description* annually
- Assuring individual member needs are taken into consideration when determinations for care are rendered and in the development of medical policy and procedures.
- Analyzing summary data and making recommendations for action
- Reviewing action plans for quality improvements of UM activities and providing ongoing monitoring and evaluation
- Reviewing medical policy, protocol, criteria and clinical practice guidelines
- Providing oversight of delegated activities

Pharmacy and Therapeutics Committee (P&T)
The P&T Committee is chaired by PHC's Chief Medical Officer (CMO), or designee such as the Director of Pharmacy, and is comprised of PHC's Pharmacy Director, Associate and Regional Medical Directors, PHC staff and network practitioners including pharmacists, primary care physicians, behavioral health and other specialists. P&T makes decisions and recommendations on development and review of the physician administered drugs (PADs) provided under the medical drug benefit, medication policy and procedures, and drug approval criteria. P&T Committee also serves as PHC's Drug Utilization Review (DUR) Board to review PHC's DUR program and activities and make recommendations where necessary to improve PHC's drug utilization. The P&T meets quarterly, providing regular activity reports and recommendations to the PAC, the approval authority for P&T related activities.

Provider Advisory Group (PAG)
The PAG is one of the Commission's advisory committees and acts as a liaison between practitioner offices and PHC. The committee meets quarterly and has representatives from physician groups and individual offices, community clinics, ancillary providers, long-term care facilities, employees of county health departments, and community advisory groups. The PAG reports directly to the Board of Commissioners, providing feedback and making recommendations related to health care service issues, community health activities, and issues for special needs populations.

Substance Use Services Internal Quality Improvement Subcommittee (SUIQI)
A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services oversight. The SUIQI meets at least quarterly. Activities and progress are reported to the IQI. This also includes

- Review of Utilization Management retroactive and appeals review
- Review of inter-rater reliability for peer review and utilization management
- Review of quality of service, quality of facility, and access complaints and grievances
- Investigation of potential over-use, under-use, and misuse of services.
- Review of policies related to provision of SU services

Members of the committee include the Behavioral Health Clinical Director, the CMO, and representatives from the Provider Relations, Member Services, Claims, Compliance, Behavioral Health and Quality Improvement Departments.

Consumer Advisory Committee (CAC)
The CAC is composed of PHC health care consumers who represent the diversity and geographic areas of PHC's membership. There are two CAC committees – one in PHC's Northern seven counties and a second in PHC's Southern seven counties. Both groups meet quarterly. The CAC is a liaison group between members and PHC, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. The CAC reviews and makes recommendations regarding Member Services' Quality Improvement Activities, provides feedback on Quality Initiatives and serves in the capacity of a focus group. A consumer from each region serves on the Board to provide consumer input and report back to their respective CAC.

UTILIZATION MANAGEMENT PROGRAM SCOPE

UM activities are developed, implemented and conducted by the PHC Health Services Department under the direction of the Chief Medical Officer and the Senior Director of Health Services. The UM staff performs specific activities.

Specific functions include:

- Prospective, concurrent and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care and continued inpatient confinement on a frequency consistent with evidence-based criteria and PHC guidelines, PHC criteria/ medical policy and the member's condition. This review is performed cooperatively with the facility care team which may consist of the attending physician(s) and any associated health care personnel who can provide information that will substantiate medical necessity and level of care.
- Discharge planning in collaboration with the facility care team
- Review inpatient and outpatient UM data to determine appropriateness of member and provider utilization patterns
- Use of most current edition of InterQual® Criteria for medical authorization, and other PHC UM guidelines and medical policy as developed and approved by the Quality / Utilization Advisory Committee (Q/UAC)
- Use of California Department of Health and Welfare Code of Regulations Title 22, Center for Medicare & Medicaid Services (CMS) Code of Federal Regulations (CFR) Title 42 and National and Local Coverage Determinations
- Review certification requests for skilled nursing care, home health care, durable medical equipment, ambulatory surgery, ambulatory diagnostic and treatment procedures such as physical, occupational and speech therapies.

The UM program incorporates the monitoring and evaluation for the subsequent services and reviews and updates policies and procedures as appropriate but at least annually.

- Acute hospital services
- Subacute care
- Ambulatory care
- Emergency and urgent care services
- Durable Medical Equipment and supplies
- Ancillary care services, including but not limited to home health care, skilled nursing care, subacute care, pharmacy, laboratory and radiology services
- Long-term care including Skilled Nursing Facility (SNF) Care and Rehabilitation Facility Care
- Physician administered drugs (medical drug benefit)

PHARMACY PROGRAM SCOPE

The Pharmacy Department within Health Services is responsible for the utilization management of the medical drug benefit – those medications administered to a member directly during a medical stay/visit at a clinic, office, or hospital, and billed to PHC as part of a medical service claim; this includes drugs administered at time of service by physicians, dentists, podiatrists, nurse practitioners and physician assistants. Drugs and other prescription services provided to a member by a pharmacy are not within the scope of PHC's Pharmacy Program because the pharmacy benefit is carved-out to State Medi-Cal through the Medi-Cal Rx Program.

Out of Scope for PHC Pharmacy Program:

- Pharmacy benefits and services pursuant to Executive Order N-01-19 and the Medi-Cal Rx program. The Medi-Cal pharmacy benefits and services administered by DHCS in the FFS delivery system is identified collectively as Medi-Cal Rx. This includes:

- Covered Outpatient Drugs, as defined by SSA 1927(k)(2): prescription drugs which are not provided as part of *medical* service and thus are under the scope of the Pharmacy Benefit.
- Self-administered medications provided to a member to take/inject/inhale/apply/insert (or otherwise administer) at home.
- Medication and supply services provided to members at long-term care and skilled nursing facilities.
- Medications administered by an infusion pharmacy or home health agency in a pharmacy infusion suite or in the member's home

- Medications and services statutorily defined as a non-Medi-Cal benefit
- Medications provided in a medical setting which are carved out of the MCP capitation agreement: antivirals for HIV/AIDs, drugs and blood factor products for Hemophilia, drug and alcohol substance use disorder treatment (prescribed outside a narcotic treatment program), antipsychotics, and certain antidepressants (MAOI).

In Scope for PHC Pharmacy Program:

- Utilization management of drugs administered in a medical setting and billed by the medical provider under the medical benefit, which includes:
  - Drugs other than Covered Outpatient Drugs. The SSA 1927(k)(2) definition of a Covered Outpatient Drug does not include any drug, biological product, or insulin provided as part of, or as incident to, the provision of and billing for medical or institutional services [SSA 1927(k)(3)]
  - Development of coverage criteria for injectable drugs requiring prior authorization based on current nationally accepted treatment guidelines, current medical literature, and input from specialists. These criteria may be drug-specific or class-specific.
  - Application of billing limits, restrictions, or requirements based on FDA approved indications and dosing &/or State Medi-Cal billing requirements. Such utilization management examples include maximum daily dose, allowed dosing frequency, age limits, place of service (e.g. dialysis centers) and current ICD (diagnosis) requirements.
  - The medical provider submits prior authorization requests directly to the pharmacy department. See policy MCRP4068 *Medical Benefit Medication TAR Policy* for further details.
  - Pre-service, Concurrent, and Post-Service (Retrospective) pharmaceutical utilization reviews of medical necessity using established prior authorization criteria requirements set forth by PHC Pharmacy & Therapeutics (P&T) Committee, or as required by State Policy (All Plan Letters), or in accordance with PHC case-by-case review guideline (below) when PHC criteria are not yet established. Timeliness standards mirror those for UM Program Timeliness (see page 20).
  - Case-by-case review shall consider:
    - The member's individual medical needs (allergies, disease history, treatment history, concurrent medications, concurrent disease states, contraindications)
    - Prescriber's scope of practice/areas of specialization
    - The FDA approved package labeling for indication(s), maximum safe & effective dosing, appropriate age group, recommended screenings and monitoring,
    - Prescribed drug's recommended place in therapy according to indication &/or nationally recognized treatment guidelines
    - Availability & effectiveness of preferred treatments for the same indication
    - Industry-standard clinical resources including (but not limited to): Lexi-Drug, Elsevier/Gold Standard Clinical Pharmacology, National Comprehensive Cancer Network (NCCN), UpToDate, IPD Analytics, and Facts & Comparisons

- Trials of preferred alternatives: There is no set number of preferred medications that must be tried before a non-preferred medication can be approved. Trials of preferred alternatives is unique to each drug and may depend on factors including but not limited to available treatment alternatives, pharmacologic and therapeutic similarities between different treatments, indication, and member's reason for failure with previous treatments. The number of trials required will be based on the clinical judgement of the physician or clinical pharmacist reviewer.

- Retrospective Drug Utilization Review (DUR) (post-claim analysis, educational programs)
  - Improve medication therapy outcome and reduce and prevent inappropriate use, fraud, or abuse.
- Disease/Medication Management Programs
  - Improve medication adherence, address therapeutic gaps, and optimize medication therapy outcome.
- Support of Care Coordination and Case Management
  - Support members with complex medication regimen, multiple health conditions, behavioral and substance use disorder.
- Support of Quality Improvement (e.g. HEDIS, outcomes measures)
  - Performance improvement in medication related quality measures.

Mental Health

Members may self-refer for mental health services to mental health providers using the delegated Behavioral Health Organization's toll-free referral numbers or by contacting the preferred behavioral health provider directly. Members do not need a referral or prior authorization to receive mental health services.

In an effort to coordinate the member's overall health care, mental health providers are instructed to ask members to sign a release of information so that the mental health provider can contact the member's PCP or other providers. However, the release of information is not a condition for the approval or provision of services.

Mental health services for Members with Medi-Cal as their primary insurance are provided as follows:

- Members determined to have mental health needs that require mild to moderate mental health treatment are served by PHC's delegated contractor, Beacon Health Options at (855) 765-9703.
- Members assigned to Kaiser are assessed by Kaiser and served or appropriately referred.
- Members determined to have moderate to severe mental health conditions are referred to the County Mental Health Plan in the Member's county of eligibility (Except for Solano County Kaiser members who will have their moderate to severe mental health conditions managed by Kaiser). The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each respective County Mental Health Plan, consistent with California statutes and regulations.
- An initial assessment may be performed by any of these entities described above to determine the most appropriate level of service for the Member, including appropriate referral.

Effective July 1, 2020, PHC provides substance use disorder treatment services as outlined in the Regional Drug Medi-Cal Model. PHC performs utilization management for residential treatment of substance use disorders. For more information, please see the Substance Use Disorder Treatment Services/Wellness & Recovery Program section below.

County Mental Health Plans provide crisis assessments and authorizations for care. Immediate access to the crisis service remains an option throughout all phases of treatment by any provider. Each County operates crisis services which to address clients in crisis; crisis services also act as a backup after hours and on

weekends as well as at other times of provider unavailability. Members may call the County crisis line directly, without a referral. Members eligible for mental health services from PHC delegated contractors will be re-directed to appropriate County crisis services as needed.

A certain level of mental health services is appropriately dealt with in a primary care practice, including screening and referrals to services. Primary Care Providers may contact each county's Mental Health Plan or PHC's delegated contractor, Beacon Health Options, for telephone consultation. For detailed referral and consultation procedures, PCPs can refer to PHC Policy MPCP2017 Scope of Primary Care—Behavioral Health and Indications for Referral Guidelines.

PHC is responsible for the delivery of non-specialty mental health services for children under age 21 and outpatient mental health services for adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Outpatient mental health services are delivered as specified in policy MCUP3028 Mental Health Services whether they are provided by PCPs within their scope of practice or through PHC's provider network. PHC continues to be responsible for the arrangement and payment of all medically necessary, Medi-Cal-covered physical health care services, not otherwise excluded by contract, for PHC beneficiaries who require specialty mental health services.

In compliance with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR Section 438.930, PHC ensures direct access to an initial mental health assessment by a licensed mental health provider within the PHC provider network. No referral from a PCP or prior authorization is required for an initial mental health assessment to be performed by a network mental health provider.

PHC meets the general parity requirement (Title 42, CFR, §438.910(b)) which stipulates that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Neither a referral from the PCP nor prior authorization is required for a beneficiary to seek any mental health service, including the initial mental health assessment from a network mental health provider.

If a dispute occurs between the local County Mental Health plan and Partnership HealthPlan of California (PHC) or its delegated contractors, Kaiser or Beacon Health Options, both parties will participate in a dispute resolution process as defined in PHC Policy ADM52 Dispute Resolution Between PHC and MHPs in Delivery of Behavioral Health Services. This is consistent with the dispute resolution process outlined by State regulations and the individual County/PHC Memoranda of Understanding.

Triage and Referral for Mental Health

PHC monitors the triage and referral protocols for the delegated behavioral health services provider(s) to assure they are appropriately implemented, monitored and professionally managed. Protocols employed by delegates must be clinical evidence-based and an accepted industry practice. Protocols shall outline the level of urgency and appropriateness of the care setting.

Triage and referral decisions are performed by the Care Coordination and UM teams of the delegated Behavioral Health Services Provider which are co-located in the PHC offices with oversight by PHC's Behavioral Health Clinical Director. Both work collaboratively with the designated County Mental Health Plans to ensure members receive care at the appropriate level in a timely manner.

Substance Use Disorder Treatment Services/ Wellness & Recovery Program

PHC works to ensure that members receive effective and appropriate behavioral health care services for both mental health and substance use disorders. Substance Use Disorder (SUD) treatment services are administered either by PHC or through individual counties.

The range of services in the Wellness & Recovery Program include:

- Outpatient treatment (licensed professional or certified counselor, up to nine hours per week for adults)
- Intensive outpatient treatment for individuals with greater treatment needs (licensed professional or certified counselor, structured programming, 9-19 hours per week for adults)
- Detoxification services (withdrawal management)
- Residential treatment (Prior authorization is required as per policy MCUP3144 *Residential Substance Use Disorder Treatment Authorization*)
- Medication assisted treatment (MAT) (methadone, buprenorphine, disulfiram, naloxone). *PHC authorizes these medications when prescribed within a narcotic treatment program. When MAT is prescribed outside of a narcotic treatment program (e.g. dispensed through a pharmacy) the medications will be authorized through the state Medi-Cal Rx program.*
- Case management
- Recovery services (aftercare)

Behavioral Health Treatment (BHT) for Members Under 21 Years of Age

PHC has provided benefits for Behavioral Health Therapy for children diagnosed with Autism Spectrum Disorder (ASD) since September 2014.

Effective July 1, 2018, PHC expanded its benefit coverage to include Behavioral Health Treatment (BHT) for eligible Medi-Cal members under the age of 21 as required by the Early and Periodic Screening and Diagnostic Treatment (EPSDT) mandate.

Treatment services may include Applied Behavioral Analysis (ABA) and other services known as Behavioral Health Treatment (BHT).

BHT is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior.

BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services include a variety of behavioral interventions that have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence that are designed to be delivered primarily in the home and in other community settings.

PHC will provide BHT services for all members who meet the eligibility criteria for services as stated in 1905® of the Social Security Administration (SSA) and outlined in DHCS All Plan Letter (APL) 19-014.

- Additional detailed information regarding the BHT benefit can be found in the following PHC Policies and Procedures:
  - MPUP3126 *Behavioral Health Treatment (BHT) for Members Under the Age of 21*
  - MCCP2014 *Continuity of Care*

Quality Improvement Collaboration

The UM team works collaboratively with the Quality Improvement (QI) Department to enhance the care provided to our members through venues such as the Internal Quality Improvement Committee (IQI) , the Quality/ Utilization Advisory Committee (Q/UAC) and daily UM activities.

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

- Reviewing, making recommendations to, and approving the *UM Program Description* annually
- Assuring individual member needs are taken into consideration when determinations for care are rendered
- Analyzing summary data and making recommendations for action
- Reviewing the recommendations of Process Implementation Teams to develop UM improvement action plans, ongoing monitoring, and evaluation
- Recommending medical policy, protocol, and clinical practice guidelines based on provider and member experience information.

During daily activities, the UM team supports QI efforts in the identification of potential quality of care issues, reporting adverse occurrences identified while conducting UM case review, improvement of Healthcare Effectiveness Data and Information Set (HEDIS®) scoring by referrals to care coordination, and care coordination efforts to ensure members are seen by the appropriate provider for their condition.

UTILIZATION MANAGEMENT PROCESS

PHC applies written, objective, evidence-based criteria (InterQual® and pharmaceutical criteria) and considers the individual member's circumstance and community resources when making medical appropriateness determinations for behavioral health and physical health care services.

On an annual basis, PHC distributes a statement to all its practitioners, providers, members and employees alerting them to the need for special concern about the risks of under-utilization. It requires employees who make utilization-related decisions and those who supervise them to sign a statement which affirms that UM decision making is based only on appropriateness of care and service.

Furthermore, PHC does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization and PHC does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

Working with practitioners and providers of care, the following factors are taken into consideration when applying guidelines to a particular case in review:

- Input from the treating practitioner
- Age of member
- Comorbidities in existence
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Consideration of the delivery system and availability of services to include but not be limited to:
  - Availability of inpatient, outpatient, transitional and residential treatment (SUD) facilities
  - Availability of outpatient services
  - Availability of highly specialized services, such as transplant facilities or cancer centers

    - Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge
    - Local hospitals' ability to provide all recommended services
- Benefit coverage

Referrals and requests for prior authorization of services are to be submitted by the provider of service to the PHC UM department by fax or through PHC's Online Services portal, which is a Secure Electronic Internet system. The following information must be provided on all requests.

- Member demographic information
- Provider demographic information
- Requested service/procedure to include specific CPT/HCPCS code(s)
- Member diagnosis (Using current ICD Code sets)
- Clinical indications necessitating service or referral
- Pertinent medical history, treatment or clinical data
- Location of service to be provided
- Requested length of stay for all inpatient requests
- Proposed date of procedure for all outpatient surgical requests

Pertinent data and information is required to enable a thorough assessment of medical necessity.
If information is missing or incomplete, the requestor will be notified and given an opportunity to submit additional information.

Elective Admission Precertification
The UM department evaluates every proposed treatment plan, and determines benefit eligibility, suitability of location and level of care prior to the approval of service delivery for select diagnoses and procedures.

Utilizing written criteria such as InterQual®, Medi-Cal Criteria and PHC medical policy approved by the Q/UAC, licensed and professional UM staff review and approve completed Treatment Authorization Requests (TARs).

Only the Chief Medical Officer or physician designee may make a medical necessity determination and have the authority to deny a service request based on lack of medical necessity. PHC offers the practitioner the opportunity to discuss any medical necessity denial determination with the physician reviewer rendering the decision.

Referral Management
Referrals are generated by the primary care provider and submitted to PHC either by mail, fax or secure Provider Portal. PHC monitors and analyzes requests to identify trends and assist in follow-up care. Requests for out-of-network referrals are reviewed to determine if the service is available and can be provided within the service area. Out-of-Network requests are also used to evaluate provider access and to determine if the local network requires enhancements to meet member needs.

Continued Stay/Concurrent Review
Acute care hospitalization reviews are performed by licensed professionals to ensure medical necessity of continued stay, the appropriateness of level of care, and care duration. This review is conducted either on site, by accessing the facility electronic medical record through a secure portal, or telephonically using written PHC medical policy, InterQual®, and/or Medi-Cal guidelines.

Requests for authorization are reviewed within 24 hours of notification of admission and concurrently throughout the stay. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to PHC case management and social services as appropriate.

Consideration of available services in the local service area or delivery system and the ability to meet the member's specific health care needs are evaluated as part of application of criteria and the development of an ongoing plan of care and discharge plan.

Only the Chief Medical Officer or physician designee has the authority to deny a request for service based on lack of medical necessity. PHC offers the practitioner with clinical expertise in the area being reviewed the opportunity to discuss the application of criteria in determining medical necessity or any determination based on lack of clinical justification with the physician reviewer.

In addition to individual conversations with practitioners on specific case reviews, PHC conducts several committees for the purpose of hearing and incorporating practitioner input in the development of medical policy. PHC, through the Physician Advisory Committee (PAC), the Pharmacy and Therapeutics Committee (P&T) and the Physician Advisory Group (PAG), provides practitioners with clinical expertise in several areas the opportunity to advise or comment on the development and/or adaptation of UM criteria and provide feedback or instruction on the application of that criteria. Within the previously stated committees, PHC evaluates UM criteria and procedures against current clinical and medical evidence and updates them accordingly.

Skilled Nursing/Sub acute/ Long-Term Acute/Rehabilitation Facility Review

Review of all Skilled Nursing and Rehabilitation Facility confinements are performed by licensed professionals to ensure medical necessity of continued stay and the appropriateness of level and duration of care. This review is conducted telephonically using written PHC medical policy, Title 22 criteria, and/or InterQual® criteria. Requests for authorization are reviewed within 24 hours of notification of admission. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to PHC case management and social services as appropriate.

Consideration of available services in the local service area or delivery system, and the ability to meet the member's specific health care needs are evaluated as part of applying criteria and the development of an ongoing plan of care and discharge plan.

Discharge Planning

Discharge planning is a critical component of the utilization management process and begins upon admission with an assessment of the patient's potential discharge needs. It includes preparation of the family and the patient for continuing care needs and initiation of arrangements for services or placement needed after acute care discharge.

PHC Nurse Coordinators work with hospital discharge planners, case managers, admitting/attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs.

Post-Service Retrospective Review

Post-service retrospective reviews may occur when a member is retroactively granted Medi-Cal benefits by the State of California, when a provider does not realize an authorization is required prior to rendering a service, when the rendered service code billed does not match the code authorized, or the service may have been rendered after the expiration of the authorization. TARs must be received by PHC within 15 business days of the date of service or within 60 calendar days of either a denial from the primary insurance carrier or retrospective eligibility. (TARs submitted beyond these timeframes are considered late but will still be reviewed for medical necessity.)

All retrospective reviews are completed within 30 calendar days of receipt of request. Electronic or written notification of the decision and how to initiate a routine or expedited appeal if applicable, is communicated to the provider within 24 hours of decision, but no longer than 30 calendar days from the date of the receipt of the request. Written notification is mailed to the member within two (2) business days of the decision.

Services requiring an authorization can be retrospectively reviewed for medical necessity, appropriateness of setting, and length of stay up to one year after services are rendered and may result in an adverse determination.

Emergency Room Visits
Emergency room visits where a prudent layperson, acting reasonably, would believe an emergency condition exists, DO NOT require prior authorization.

Timeliness of UM Decisions

PHC makes UM decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of care. PHC measures the timeliness of decisions from the date when the organization receives the request from the member or PCP, even if the PHC does not have all the information necessary to make a decision. PHC documents the date when the request is received and the date a decision is rendered in the UM documentation system.

PHC has communicated to both providers and members the practice of processing non-urgent requests during the next business day if the request is received after business hours.

PHC Utilization Management abides by the following timeliness guidelines when processing health services requests.

Urgent Requests
A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations could jeopardize the live, health or safety of the member or others due to the member's psychological state or, in the opinion of the practitioner with knowledge of the members medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested.

Concurrent Review Request:
A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Pre-Service Request
A request for medical care or services that PHC must approve in advance, in whole or in part.

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

Post-Service Request / Retrospective Review
A request for medical care or services that have been received.

Non-Behavioral Healthcare Decisions, Pharmacy Decisions, and Behavioral Healthcare Decisions

Type of Request	Decision Time Frame	Notification[1] Time Frame	Extended Time Frame
Urgent concurrent review	72 hours of receipt of request	72 hours of receipt of request	May be extended one time up to 14 calendar days from receipt of request
Urgent pre-service	72 hours of receipt of request	72 hours of receipt of request	May be extended one time up to 14 calendar days from receipt of request
Non-urgent pre-service	5 business days of receipt of request	24 hours of determination date[1]	May be extended *two (2)* times for up to 14 calendar days each period (28 days total from receipt of request)[2]
Post-service	30 calendar days of receipt of request	30 calendar days of receipt of request	N/A

[1] Notification: Give electronic or written notification of decision to practitioner (and member when required).
Per DHCS requirement, written notification must be mailed to a member within two (2) business days of the decision.
[2] Per DHCS regulations

Review Criteria
Current InterQual® criteria sets are used as the main review guidelines. Additional criteria are selected or developed using other resources as necessary to help in determining review decisions which include, but are not limited to, Medi-Cal (State of California) guidelines and State policy letters (see policy MCUP3139 *Criteria and Guidelines for Utilization Management*). InterQual® criteria are produced using a rigorous development process based on evidence-based medicine and reviewed at least annually, but as frequently as quarterly, by a panel of board-certified specialists. All UM policies are based on InterQual® criteria and are reviewed annually by the Quality/Utilization Committee (Q/UAC) and the Physician Advisory Committee (PAC) which also include board-certified specialists who are practicing network physicians. All Pharmacy policies are reviewed annually by the Pharmacy and Therapeutics (P&T) Committee and PAC. Refer to pharmacy policies MCRP4068 *Medical Benefit Medication TAR Policy* and MPRP4001 *P&T Committee* for further details regarding pharmaceutical criteria.

In the absence of applicable criteria, the PHC UM medical staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of the individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system. Board-certified consultants are available through our providers on our Quality/Utilization Advisory Committee (Q/UAC). PHC also contracts with a third-party independent medical review organization which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence. (See policy MCUP3138 *External Independent Medical Review*.)

Criteria are selected, reviewed, updated or modified using feedback from the Q/UAC and PAC as well as member feedback identified in member survey results and the Consumer Advisory Committee (CAC), State policy letters, State Memorandums of Understanding and/or medical literature, among other sources. In collaboration with actively practicing practitioners, criteria are evaluated on at least an annual basis. Relevant clinical information is obtained when making a determination based on medical appropriateness and the treating practitioner is consulted as appropriate. All information obtained to support decision-making is documented in the utilization management documentation system.

Decisions are based on information derived from the following sources:

- Clinical records
- Medical care personnel
- Facility utilization management staff
- Attending physician (attending physician can be the primary care physician, hospitalist or the specialist physician (or all three as necessary)
- Board-certified specialists are consulted when medically necessary

When applying criteria to a treatment request, reviewers consider the needs of the individual patient (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable) as well as the availability of services in the local delivery system and their ability to meet the member's specific health care needs.

Inter-Rater Reliability (IRR)
PHC assesses the consistency with which physician and non-physician reviewers apply UM criteria in decision making and evaluates Inter-Rater Reliability. The Inter-Rater Reliability mechanism uses live cases to ensure medical management criteria are appropriately and consistently applied in making UM determinations. The methodology employed is designed to annually assess 50 cases or 5% of reviewer case load, whichever is less, over the course of a year period.

The following types of reviews/reviewers are audited:

- Nurse Coordinator Review of Inpatient Services
- Nurse Coordinator Review of Outpatient Services
- Nurse Coordinator Review of Long Term Care Services
- Nurse Coordinator Review of Residential Substance Use Disorder Treatment Authorizations
- Physician Review of Medical Necessity Authorizations
- Pharmacist and Pharmacy Technician Review of Pharmacy TARs

A performance target of 90% accuracy is set for inter-rater reliability. An audit summary is reported at least annually or more often as needed to the Internal Quality Improvement (IQI) Committee. If a reviewer falls below the targeted threshold, a corrective action plan is initiated and monitored and results are presented to the Quality/Utilization Advisory Committee (Q/UAC) for review and discussion. Please refer to policy MPUP3026 *Inter-Rater Reliability Policy* for a full description of the IRR process.

Availability of Criteria

All criteria used to review authorization request are available upon request. In the case of an adverse determination, the criteria used are made part of the determination file. Access to and copies of specific criteria utilized in the determination are also available to any requesting practitioner by mail, fax, email, or on our website: http://www.partnershiphp.org. To obtain a copy of the UM criteria, practitioners may call the PHC UM Department at (800) 863-4155.

Members may request criteria used in making an authorization determination by calling the member services department to request a copy of the criteria. The UM team will work with member services to provide the criteria used in the review decision.

PHC's Provider Relations Department notifies providers in writing through the New Provider Credentialing Packet and the provider's contract that UM criteria is available online at http://www.partnershiphp.org in the Provider Manual section. Providers are also notified quarterly in writing via the Quarterly Provider Newsletter about the on-line availability of UM criteria and policies at http://www.partnershiphp.org in the Medi-Cal Provider Manual section.

COMMUNICATION SERVICES

PHC provides access to staff for members and practitioners seeking information about the UM process and the authorization of care in the following ways:

- Calls from members are triaged through Member Services staff who are accessible to practitioners and members to discuss UM issues during normal working hours when the health plan is in operation (Monday - Friday 8 a.m. - 5 p.m.).
- Members and Providers may contact the PHC voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
- After normal business hours, members may contact the advice nurse line for assistance
- Practitioners may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
- PHC has a toll free number (800) 863-4155 that is available to either member or practitioners.
- UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- Members can view information about PHC's language assistance services and disability services in the Member Handbook which is mailed to members upon enrollment and is always available online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf

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

Linguistic services are provided by PHC to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries as well as eligible members with sensory impairment for population groups as determined by contract. These services include the following:

No Cost Linguistic Services:

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

PHC regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. (see policy MCNP9003 *Cultural and Linguistic Services*).

Denial Determinations

Denial determinations may occur at any time in the course of the review process. Only the Chief Medical Officer, or a physician designee acting through the designated authority of the Chief Medical Officer, has the authority to render a denial determination based on medical necessity (see Program Structure section for details).

A denial determination may occur during continued stay/concurrent review in which case notification and/or discussion with the treating practitioner and the Health Plan physician adviser/Chief Medical Officer or physician designee is offered.

Denial determinations may occur at different times and for various reasons including but not limited to:

- At the time of prior authorization; when the requested service is not medically indicated or not a covered benefit.
- When timely notification was not received from a facility for an inpatient stay to foster transfer of a medically stable patient
- When an inpatient facility fails to notify the Health Plan of admission within one business day of the admission or appropriate clinical information is not received
- Or after services are rendered at claims review when the services were not authorized, or are medically unnecessary

A denial may also occur for inappropriate levels of care or inappropriate care. Notwithstanding previous authorization, payment for services may be denied if it is found that information previously given in support of the authorization was inaccurate.

PHC offers the practitioner the opportunity to discuss any denial or potential denial determination based on lack of medical necessity with the Health Plan Chief Medical Officer, or a physician designee.

The denial notification states the reason for the denial in terms specific to the member's condition or service request and in language that is easy to understand and references the criterion used in making the determination so the member and provider have a clear understanding of the Health Plan's rationale and enough information to file an appeal.

Partnership HealthPlan of California is aware of the need to be concerned about under-utilization of care and services for our members. PHC monitors over and under-utilization through the Over/Under Utilization Workgroup which reviews annual utilization patterns. Decisions made by PHC's Utilization Reviewers are solely based on the appropriateness of the care or service.

The Health Plan does not compensate any individual involved in the utilization process to deny care or services for our members nor do we encourage or offer incentives for denials.

Process for a Provider to Appeal an Adverse Benefit Determination on Behalf of a Member

Members and providers are provided fair and solution-oriented means to address perceived problems in exercising rights as a Medi-Cal beneficiary or provider, in accordance with requirements of PHC's contract with the Department of Health Care Services (DHCS). This process is entirely separate from that of State Fair Hearings, to which members retain their access. Please refer to PHC policy MCUP3037 *Appeals of Utilization Management/ Pharmacy Decisions* for a full description of the process.

Appeals of Adverse Benefit Determinations (ABDs)

A member, a member's authorized representative, or a provider acting on behalf of a member, has 60 calendar days from the date of determination to submit an appeal request in response to a Notice of Action (NOA) letter. A member or a member's authorized representative may initiate an appeal by contacting PHC's Member Services department. An appeal initiated in this way is considered a Member Appeal and will be referred to the PHC Grievance and Appeals department for processing. A provider may also request an appeal on behalf of a member, with written consent from that member, by faxing or writing PHC's UM or Pharmacy Department.

After receipt of the request for appeal, PHC will provide written acknowledgement to the member and provider that is dated and postmarked within five (5) business days of receipt of the appeal. PHC has 30 calendar days from the receipt of the appeal request to render a determination.

The Chief Medical Officer or physician designee reviews the request for appeal if the determination was based on medical necessity. The Chief Medical Officer or physician designee may request further information from the provider such as:

- Diagnostic information
- Previous treatment
- Clinical justification
- Opinions from specialists or other providers
- Evidence from the scientific literature prior to processing the request.

The provider is expected to respond to a request for further information within the 30 calendar day determination time frame. If the provider does not respond to the request for further information within that time frame, the appeal can be extended no more than 14 calendar days.

When a decision has been made, the provider and/or member, if applicable, are notified in writing within five (5) business days with a Notice of Appeal Resolution (NAR) letter. PHC is not required to notify the member of a decision when the member is not at financial risk for the services being requested (e.g. concurrent reviews).

Providers who disagree with the appeal decision may then file a grievance with PHC by the process described in the MPPRGR210 *Provider Grievance* policy.

If PHC's determination specifies the requested service is not a covered benefit, PHC shall include in its written response the provision in the Contract, Evidence of Coverage, or Member Handbook that excludes the service.

The response shall either identify the document and page where the provision is found, direct the provider and member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applies to the specific health care service or benefit request.

Expedited Appeals of Adverse Benefit Determinations

Expedited appeals may be initiated by the member or the provider. A member may initiate an expedited appeal by calling the Member Services Department. A provider may initiate an expedited appeal on behalf of a member with written consent by faxing or writing the PHC UM or Pharmacy Department. If the request for expedited appeal is not accompanied by written consent from the member, the Plan will proceed with the request.

Expedited appeals are performed by PHC only when, in the judgment of the Chief Medical Director or Physician Designee, a delay in decision-making may seriously jeopardize the life or health of the member.

PHC refers the expedited appeal request to the Chief Medical Officer or Physician Designee for decision on the appeal. The Chief Medical Officer or Physician Designee is expected to make a decision as expeditiously as the medical condition requires, but no later than 72 hours after the receipt of the request for an expedited appeal.

Expedited reviews are also granted to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

PHC provides verbal confirmation of its decisions concurrent with mailing of written notification no later than 72 hours after receipt of an expedited appeal. If the expedited appeal involves a concurrent review determination, the member continues to receive services until a decision is made and written notification is sent to the provider. PHC is not required to notify the member of a concurrent decision as the member is not at financial risk for the services being requested.

Appeal Rights

A member may ask assistance from a patient advocate, provider, ombudsperson or any other person to represent them in their request.

A member may also request a State Hearing if a member has filed an appeal and received a "Notice of Appeal Resolution" letter upholding the initial denial of service or in instances of deemed exhaustion. Information on how to obtain an expedited State Hearing is included as a part of the "Notice of Appeal Resolution" letter to the member.

Member grievance and appeal information is included in the member handbook, distributed annually in the member newsletter, and is posted on the PHC website.

It is the responsibility of the Member Services Director and the Member Services Department to ensure:

- Member Rights and Responsibilities are included in the member handbook which is mailed to all new members and posted on the PHC website
- Members are advised of their right to receive a copy of the Member Rights and Responsibility statement annually in the PHC's member newsletter.
- Members are notified of all revisions to the Member Rights and Responsibilities statement in the member newsletter following revisions.

It is the responsibility of the Provider Relations Director and the Provider Relations Department to ensure

- The Member's Rights and Responsibilities statement is included in the PHC provider manual issued to all contracted providers. The manual is issued to providers after their contract has been fully executed.
- Any revisions to the Member's Rights and Responsibilities statement are issued to all contracted providers within 90 days from the date these revisions are finalized.

Data Sources

Utilization Management supports the effective, efficient, and appropriate utilization of member benefits through ongoing review, evaluation and monitoring of the member's personal health information in making medical necessity determinations.

Data sources may include, but are not limited to:

- Medical records, from outpatient provider offices and hospital records (including accessing hospital Electronic Medical Records (EMR); for current and historical data
- Member handbook or Evidence of Coverage
- Consultations with treating physicians
- network adequacy information
- Local delivery system capacity information
- Specialist referrals
- Recent Physical exam results
- Diagnostic testing results
- Treatment plans and progress notes
- Operative and pathological reports
- Rehabilitation evaluations
- Patient characteristics and information
- Patient psychosocial history
- Information from family / social support network
- Prospective/concurrent/retrospective utilization management activities
- Claim/encounter (administrative) data

Data Collection, Analysis, and Reporting

Data collection activities for analysis and reporting are coordinated by the UM department. At the data gathering/performance measurement phase, participants in the process include programmers and analysts in the Finance and Health Services departments, staff nurses, and any other personnel required for the collection and validation of data. All data collection activities are documented and reported to the Q/UAC twice a year and more often if requested. Data collection activities may include, but are not limited to:

- Member satisfaction surveys
- Provider satisfaction surveys
- Readmission statistics
- Potential quality incident data
- Member appeal data
- Provider appeal data
- Internally developed databases
- Pharmacy utilization data

- Other administrative or clinical data

EVALUATION OF NEW MEDICAL TECHNOLOGY

PHC evaluates the inclusion of new medical technologies and the new application of existing technologies in its benefit packages. While the basic benefits are set by the State of California Department of Health Care Services (DHCS) and outlined in Title 22 of the Health and Welfare Code, PHC has the option of adding to this basic package of benefits for its members.

PHC's Policy MCUP3042 *Technology Assessment* outlines the steps taken during the determination process. The PHC Physician Advisory Committee will review all cases and make a final recommendation to the Board of Commissioners as to new benefits. The Commission is the only entity that can add benefits.
Once a new benefit is added, the information is disseminated to all Primary Care Providers and appropriate specialists in the form of a mail notification of benefit addition, and to all members in the next member newsletter.

New technologies are handled on a case-by-case basis which includes obtaining information regarding the safety, efficacy and indications that support the use of the intervention. There must be evidence that the proposed intervention will add to improved outcomes as compared to what is currently available. The service provider must have a record of safety and success with the intervention and cannot be part of a funded research protocol. The Chief Medical Officer works closely with the requesting physician and specialists as needed in researching these cases.

DELEGATION

UM activities that are delegated to contract providers are reviewed and approved on an annual basis by the Q/UAC. A delegation agreement, including a detailed list of activities delegated and reporting requirements is signed by both the delegate and PHC.

- Providers to whom UM activities have been delegated are responsible for reporting results and analyses to PHC on a quarterly or annual basis. Reports are summarized for review and evaluation by PHC's Delegation Oversight Review Sub-Committee (DORS) and Q/UAC.
- Audits are conducted no less than annually and evaluation includes a review of both the processes applied in carrying out delegated UM activities, and the outcome achieved in accordance with the respective policy(s) and agreement governing the delegated responsibility.
- The Q/UAC reviews evaluations and make recommendations regarding opportunities for improvement and continuation of delegated functions.

A pre-delegation evaluation is conducted when delegation of functions to providers is being considered.

Protected Health Information (PHI)

The Privacy Rule, described in 45 CFR Parts 160 and 165, applies to covered entities. The Privacy Rule allows covered providers, entities, and health plans to disclose PHI in order to carry out their health care functions.

Partnership HealthPlan of California is fully compliant with the general rules, regulations and implementation specified in The Privacy Rule. PHC also provides reasonable administrative, technical, and physical safeguards to ensure PHI confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI.

The PHC Director of Regulatory Affairs and Program Development also serves as the PHC Privacy Officer. PHC has implemented a comprehensive program that includes "Notice of Privacy Practices" (NPP) sent to all members, as well as implementation of a confidential toll-free complaint line available to members, providers and PHC staff. For non-covered entities, PHC requires Business Associate Agreements (BAA). Additionally,

there is training on an annual basis for the PHC workforce and PHC providers/networks, and PHC maintains policies and procedures around documentation of complaints of violations or suspected privacy incidents.

STATEMENT OF CONFIDENTIALITY

Confidentiality of provider and member information is ensured at all times in the performance of UM activities through enforcement of the following:

- Members of the Q/UAC and PAC are required to sign a confidentiality statement that will be maintained in the QI files.
- UM documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, and Credentials Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to Q/UAC and Credentials Committee meeting minutes and agendas, QI and Peer Review reports and findings, UM reports, or any correspondence or memos relating to confidential issues where the name of a provider or member are included.
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only, or they are electronically archived and stored on protected drives.
- Confidential paper documents are destroyed by shredding.

NON-DISCRIMINATION STATEMENT

PHC complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

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

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

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

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

- Qualified sign language interpreters
- Information written in other languages
- Use of California Relay Services for hearing impaired

STATEMENT OF CONFLICT OF INTEREST

Any individual who has been personally involved in the care and/or service provided to a patient, an event or finding undergoing quality evaluation may not vote or render a decision regarding the appropriateness of such care. All members of the Q/UAC are required to review and sign a conflict of interest statement, agreeing to abide by its terms.

Provider and Member Satisfaction

PHC conducts satisfaction surveys on both members and providers. Included in the evaluation are questions that deal with both member and provider satisfaction with the UM program. The responses to the survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by the HealthPlan. The results, as well as plans for corrective action, are developed in conjunction with the Q/UAC. Corrective actions that were in place are evaluated at the time the follow-up annual survey is done unless the committee feels an expedited time frame needs to be implemented.

Annual Program Evaluation

The Utilization Management program undergoes a written evaluation of its overall effectiveness annually by the Q/UAC, which is reviewed and approved by the PAC.

At a minimum the evaluation considers UM department activities and outcomes, the review of Key Performance Indicator metrics such as Productivity, Timeliness, Bed-days, readmission rates and denial rates along with resource effectiveness and barriers to performance.

Preparation for the Annual Program Evaluation involves participation by all Utilization Management and Pharmacy leadership including but not limited to:

- Senior Health Services Director
- Director, Pharmacy Services
- Associate Directors of UM
- UM Team Manager

Elements of the program evaluation include an objective assessment of meeting targeted goals to ensure appropriate, efficient utilization of resources/services for PHC members across the continuum of care in compliance with requirements of state/federal and regulatory entities.

- Annual UM Program Description update
- Annual review and evaluation of UM processes (meeting goals and identifying opportunities for process improvements)
- Timely review and update of UM policies and procedures
- Obtain approval of UM policies and procedures at Q/UAC

Inter-Rater Reliability scoring and TAR timeliness are compared with regulatory compliance standards and internal benchmarks.

To determine if the UM program remains current and appropriate, the organization annually evaluates:

- The program structure
- The program scope, processes, information sources used in the determination of benefit coverage and medical necessity
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program
- Consideration of member and practitioner experience data when evaluating the UM program

The organization updates the UM program and its description annually based on the evaluation.

To ensure the provision of healthcare services at the appropriate level of care the evaluation considers:

- Inpatient bed day rate
- Inpatient average length of stay
- SNF admit rate
- SNF average length of stay

- Readmission rate
- Denial rate
- Timely completion of notifications of denial of care
- Timely completion of notifications of authorization of care
- Rate of referrals to Care Coordination
- Effectively integrating feedback - the program reflects on Member/Provider satisfaction results concerning the UM program looking at:
    - Daily Work Flow Monitoring
    - Call Abandonment rates
    - Call Volume
    - Average caller wait time

An assessment of Department resources is determined by looking at the impact of staffing changes, learning curves and system limitations which impede work effectiveness. There is a review of Inter-Rater Reliability scoring in relation to staff training/re-education, acclimation to new technology such as documentation software/ hardware based on evaluating user acceptance, and the assessment of appropriate staffing ratio to ensure adherence to regulatory and internal performance standards.

A summary of the program evaluation, including a description of the program, is provided to members or practitioners upon request.

REFERENCES:

- Department of Health Care Services (DHCS) standards
- National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2022) UM Standards 1-5, 7
- Covered Outpatient Drugs, SSA 1927(k)(2), SSA 1927(k)(3)
- California State Department of Health Care Services (DHCS) Medi-Cal Rx Resources and Reference Materials:
- https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx
- State Medi-Cal MCP: County Organized Health System (COHS): https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part1/mcpcohs.pdf

Original Date: QI/UM Program 04/22/1994 effective 05/01/1994
Revision Date(s): 08/16/95
Revision Date(s): UM Program Description - 04/17/97; Board Approval January 28, 1998; 06/10/98; 01/20/99; 05/2000; 05/01/01; (UD100301) 03/20/02; 08/20/03; 10/20/04; 10/13/05; 06/21/06; (MPUD3001) 04/16/08; 08/03/10; 11/19/14; 02/17/16; 04/19/17; *06/13/18; 04/10/19, 06/12/19 *(Amended)*, 10/09/19 *(Amended);* 04/08/20; 06/10/20 (*Amended*); 04/14/21; 01/12/22; 05/11/22

*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.

UM Program Description Approval

	04/20/2022

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

	05/11/2022

Robert Moore, MD, MPH, MBA — *Date Approved*
Physician Advisory Committee Acting Chairperson

	06/22/2022

Alicia Hardy — *Date Approved*
Board of Commissioners Chairperson

Partnership HealthPlan of California

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

MPUD3001

~~April 2021~~May 2022

~~Amendment 1. 01/12/2022~~

Table of Contents

PROGRAM PURPOSE

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

The mission of Partnership HealthPlan of California is "To help our Members, and the Communities we serve, be healthy." Our vision is to be "the most highly regarded health plan in California."

PHC has program descriptions and policies to describe the structures needed to provide high quality health care while being stewards of taxpayer resources. In the Utilization Management Program Description, PHC outlines the structure of our measurement and management of utilization of health care services within our system.

The PHC Utilization Management (UM) program serves to implement a comprehensive integrated process that actively evaluates and manages utilization of health care resources delivered to all members, and to actively pursue identified opportunities for improvement.

The utilization program is housed within the Health Services Department, which consists of five teams including:

- Utilization Management
- Care Coordination
- Population Health
- Pharmacy
- Quality Improvement

The PHC UM program serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time
- Ensure that the setting in which the service is delivered is consistent with the medical care needs of the individual

The UM program provides a reliable mechanism to review, monitor, evaluate, recommend and implement actions on identification and correction of potential and actual utilization and resource allocation issues.

PHC recognizes the potential for under-utilization and takes appropriate steps and actions to monitor for this. The processes for UM decision making are based solely on the appropriateness of care and services and existence of coverage. PHC does not reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization and PHC does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

PROGRAM OBJECTIVES

UM Program Objectives

The PHC UM program serves to ensure that appropriate, high quality cost-effective utilization of health care resources is available to all members. This is accomplished through the systematic and consistent application of utilization management processes based on current, relevant medical review criteria and expert clinical opinion when needed. The utilization management process provides a system that ensures equitable access to high quality health care across the network of providers for all eligible members as follows:

- Ensures authorized services are covered under contract with the State of California Department of Health Services (DHCS) California Code of Regulations (CCR) Title 22 - For Medi-Cal Members (Title 22).

- Coordinates thorough and timely investigations and responses to member and provider reconsideration and appeals associated with utilization issues
- Initiates needed operational revisions to prevent problematic issues from reoccurring
- Ensures that services which are delivered are medically ~~needed~~ necessary and consistent with diagnosis and level of care required for each individual, taking into account any co-morbid condition that exists and the ability of the local delivery system to meet the need
- Educates members, practitioners, providers and internal staff about PHC's goals for providing quality, cost-effective, managed health care
- Defines the methods by which utilization criteria and clinical practice guidelines are selected, developed, reviewed, and modified based upon appropriate and current standards of practice and professional review
- Promotes and ensures the integration of utilization management with quality monitoring and improvement, risk management, and case management activities
- Ensures a process for critical review and assessment of the UM program and plan on, at minimum, an annual basis, with updates occurring more frequently if needed. The process incorporates provider, practitioner and member input along with any regulatory changes, changes to current standards of care, and technological advances
- Evaluates the ability of delegates to perform UM activities and to monitor performance

Program Structure

This section outlines the individual program staff and the assigned activities, including approval authority and the involvement of the designated physician.

Assigned Responsibilities

Program Staff

Chief Medical Officer (CMO) – MD/DO

The Chief Medical Officer is responsible for the implementation, supervision, oversight and evaluation of the UM Program.

This position provides guidance and overall direction of UM activities and has the authority to make decisions based on medical necessity which result in the approval or denial of coverage. The assigned activities for this position include but are not limited to:

- Assuring that the UM program fulfills its purpose, works towards measurable goals, and remains in regulatory compliance
- In collaboration with the Senior Director of Health Services and the Associate Directors of Utilization Management; oversees UM program operations and assists in the development and coordination of UM policies and procedures.
- Reviews for the consistent application of UM decision criteria at least annually and implements corrective actions when needed
- Serves as the Committee Chair for the Quality/Utilization Advisory Committee (Q/UAC) ~~the Pharmacy and Therapeutics (P&T) Committee~~ and regularly attends the Physician Advisory Committee (PAC). CMO (or designee) also serves as the Pharmacy and Therapeutics (P&T) Committee Chair.
- Ensures timely medical necessity review and decisions are made by daily staffing physicians for medical review consultation

- Guides and assists in the development and revision of PHC medical policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for Q/UAC review, adaptation and PAC approval
- As the chairman of the Q/UAC, presents UM activities on a regular basis to the Q/UAC and provides periodic updates on utilization management activities to the PAC and the Board of Commissioners
- Evaluates the overall effectiveness of the UM program
- Evaluates and uses provider and member experience data when evaluating the UM program in collaboration with the Senior Director of Health Services and appropriate committees

Regional Medical Director - MD/DO

The Regional Medical Director is a physician with the authority to make decisions based on medical necessity which result in the approval or denial of coverage.

The assigned activities for this position include but are not limited to:

- Evaluates the appropriateness and quality of medical care delivered through PHC in the designated regional area
- Participates in enterprise-wide projects that require Physician involvement
- Other duties as assigned by the Chief Medical Officer.

Associate Medical Director - MD/DO

This Physician has the authority to make decisions based on medical necessity that result in the approval or denial of coverage. The assigned activities for this position include:

- Coverage in the UM Department for medical necessity reviews applying evidence-based UM decision criteria to the review process in determining medical appropriateness and necessity of services for PHC members
- Provides review of quality of care issues and serves on Q/UAC
- Other duties as assigned by the Chief Medical Officer

Behavioral Health Clinical Director - MD/DO/PhD/ PsyD

The PHC Behavioral Health Clinical Director is an MD, DO, clinical PhD, or PsyD who is actively involved in the behavioral health aspects of the UM program. This Director provides clinical oversight of PHC's behavioral health activities including substance use services and the activities of PHC's delegated managed behavioral health organization(s). The Behavioral Health Clinical Director has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for behavioral health or substance use services. The assigned activities for this position include:

- Establishes UM policies and procedures in collaboration with PHCs delegated managed behavioral health organization(s)
- Oversees and monitors quality improvement activities
- Facilitates network adequacy
- Participates in the peer review process
- Evaluates behavioral health care and substance use disorder (SUD) treatment services requests in collaboration with PHC's delegated managed behavioral health organization(s)
- Oversees and monitors functions of PHC's delegated managed behavioral health organizations
- Serves on Quality/Utilization Advisory Committee; Pharmacy and Therapeutics Committee; Credentials Committee and Internal Quality Improvement Committee including the Substance Use Internal Quality Improvement Subcommittee.

Pharmacy Services Director – Pharm.D.

This position is responsible for overseeing all HealthPlan activities related to medication benefit and pharmacy services and supervising the PHC Pharmacy management team, PHC Clinical Pharmacists, and support staff. The assigned activities for this position include but are not limited to:

- ~~Formulary~~ Medication coverage management
- Development of applicable policies and guidelines
- Serves on the Pharmacy and Therapeutics (P&T) Committee (serving as Chair when designated by the CMO), the Drug Utilization Review (DUR) Board and the Pediatric Quality Committee (PQC)
- Drug utilization review
- Drug prior authorization for medications covered under the medical benefit
- Implementation of cost effective ~~pharmacy~~ utilization management measures for medications covered under the medical benefit
- ~~Serving as primary contact with the contracted Pharmacy Benefit Manager (PBM), pharmacy providers, and pharmacists~~
- Participation in provider education initiatives such as academic detailing with plan physicians
- Medical education meetings
- Assisting with development of Clinical Practice Guidelines
- Other duties as assigned by the Chief Medical Officer

Senior Director of Health Services - RN

Responsible for the day-to-day implementation of the PHC Utilization Management Program. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Provides oversight and guidance for the UM program across all regions
- Reports to the Q/UAC on UM activity
- Coordinates departmental UM and Quality Improvement efforts
- Collaborates with providers and facilities
- Monitors and analyses UM data to inform decision making
- Develops recommendations based on data analysis and strategic planning.
- Collaborates with the Chief Medical Officer and the Q/UAC on UM activities
- Evaluates and uses provider and member experience data when evaluating the UM program in collaboration with the Chief Medical Officer
- Serves as Chairperson of the Benefit Review Evaluation Workgroup (BREW)
- Prepares and presents the annual evaluation, program description to Q/UAC and PAC

Associate Director of Utilization Management Programs- RN

Under the direction of the Senior Director of Health Services, manages and provides direction to the Utilization Management department managers, supervisors and staff for all product lines ensuring consistent development, implementation, and maintenance of health services programs. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Implements the UM program within assigned region
- Provides day to day direction to UM Managers and Supervisors within assigned region to meet department goals and objectives and is available to staff on-site or by telephone
- Conducts annual performance evaluations for assigned UM staff
- Conducts monitoring activities
- Participates in staff trainings and on-site continuing education
- Audits medical records as appropriate and monitors for consistent application of UM criteria by UM staff, for each level and type of UM decision
- Collaborates with providers and facilities
- Develops recommendations for program improvements
- Coordinates activities with Quality Improvement, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care outcomes and trends
- Participates in establishing and maintaining reports which relay the efficacy of UM activities and summarizes, at least annually, the UM activity, quality improvement activities and utilization outcomes, with supporting statistical data at IQI and Q/UAC

Associate Director of Utilization Management Strategies- RN

Under the direction of the Senior Director of Health Services, plans, monitors and evaluates utilization management activities to identify strategic initiatives to enhance the efficacy of the UM program, while improving health outcomes, in a cost effective manner. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Collaborates with the provider relations contracting team to identify strategic opportunities and develops recommendations
- Participates in contract review and negotiations
- Attends regular meetings with hospitals, long-term care facilities and community agencies to facilitate cost effective and appropriate alternative placements
- In collaboration with the Senior Director of Health Services and Senior Director of Provider Relations, reviews and processes provider grievances in accordance with appropriate regulatory requirements and participates in provider grievance meetings
- Works with county agencies and community based organizations to facilitate the DHCS CalAIM initiative related to Community Support Services with focus on improving medical health outcomes and healthcare costs
- Works collaboratively with claims and configuration department leaders and team members to identify systematic issues or opportunities for staff and/or provider education
- Attends claims configuration meetings and Benefit Review Evaluation Workgroup (BREW) as well as IQI, Q/UAC and PAC
- Works with providers and/or vendors to facilitate issue resolution and ensure a consistent UM process
- Develops, reviews, and/or revises PHC UM policies and procedures in collaboration with the Senior Director of Hhealth Sservices as appropriate.

Associate Director of Utilization Management Regulations

Under the direction of the Senior Director of Health Services, provides oversight of the UM Program to ensure compliance with regulatory requirements including, but not limited to, requirements of DHCS and the National Committee for Quality Assurance (NCQA). Assigned activities include:

- Coordinates activities with External and Regulatory Affairs Compliance, Member Services, Claims, and Provider Relations departments to identify, track, and monitor quality of care issues and trends related to UM Department processes
- Prepares reports on departmental activities according to established schedules and format. Identifies patterns and trends, conducts retrospective review as needed and works with UM Leadership to develop corrective action plans.
- Participates in the grievance process
- Acts as primary contact and support to each UM Delegate, providing training and support as necessary
- Conducts delegation oversight through regular auditing of each UM Delegate, prepares audit reports for review by the Senior Director of Health Services and the Chief Medical Officer or physician designee, and prepares information for the Delegation Oversight Review Sub-Committee (DORS)
- Collaborates with the Associate Director of UM Programs to ensure that all policies and procedures related to regulatory requirements are updated at least annually, or as needed, and presented to appropriate committees for review. Assists PHC staff and providers with the interpretation of PHC policies, procedures, and regulatory requirements.
- Works with UM Leadership and UM Trainer to develop standardized training content and materials for new staff and ongoing education for existing staff
- Participates in the planning and development of new/ enhanced Health Services plan benefits or product lines as needed. Attends Benefits Review and Evaluation Workgroup meetings
- Participates in audits by various regulatory agencies as necessary

Utilization Management Team Manager - RN

Responsible for the implementation, management and evaluation of an effective and systematic UM Program. Provides day-to-day guidance to UM staff and manages all aspects of utilization review activities and is available to staff on-site or by telephone. Working with the Chief Medical Officer, Senior Director of Health Services, Associate Directors of UM, utilization committees, and Health Plan Directors, promotes efficient resource utilization throughout the organization, providing leadership, teambuilding and direction needed to ensure attainment of UM goals. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Coordinates completion of activities
- Presents work plan status reports and updates to the Q/UAC
- Monitors for consistent application of UM criteria by UM staff for each level and type of UM decision
- Participates in staff trainings and on-site continuing education
- Provides recommendations for interventions designed to improve utilization management issues
- Coordinates implementation of interventions
- Develops UM policy and procedures for Q/UAC approval
- Develops, or coordinates development of, documentation of UM activities
- Conducts annual performance evaluations for assigned UM staff

Inpatient/Outpatient Nurse Supervisor UM - RN

This position is responsible for the daily mentorship and oversight of the staff assigned to inpatient or outpatient services. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Works collaboratively with all levels of leadership within the department to efficiently coordinate workflow and individual staff assignments
- Provides day to day supervision to the assigned team, overseeing daily operations of the inpatient or outpatient review process
- Participates in staff trainings and on-site continuing education. With UM Leadership, conducts annual performance evaluations for assigned UM staff
- Audits medical records as appropriate and monitors for consistent application of UM Criteria by UM staff, for each level and type of UM decision.
- This position, in addition to his/her own case load, may be assigned cases in the area of oversight as deemed necessary to provide coverage

Nurse Coordinator/ UM II - RN/ LVN

Work collaboratively with all levels of UM leadership and other PHC staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care. This position has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Assist in training and orientation of new staff to the department upon request
- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines
- Review and authorization of Long Term Care TARs based on established guidelines
- Review and authorization of inpatient Hospital TARs based on established guidelines
- Review and authorization of Enhanced Care Management (ECM) and Community Supports TARs based on established guidelines

cont'd

- Reviews residential placement authorization requests for ~~residential~~substance use disorder (SUD) treatment services according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements for Medi-Cal eligible beneficiaries. Licensed staff who operate in the capacity of behavioral health authorizations are required to complete specialized ASAM[1] training annually.
- Retrospective review of services to determine medical necessity
- Refer cases to the Chief Medical Officer for requests that may not appear to meet evidence- based medical necessity criteria
- Determines if requested services are part of the member's benefit package
- Work collaboratively with the Care Coordination, Population Health, Pharmacy and Quality Improvement staff on UM issues

Nurse Coordinator/ UM I - RN/ LVN

Work collaboratively with all levels of UM leadership and other PHC staff to develop, implement, and evaluate health outcomes, provider performance and other performance indicators pertinent to quality of care. This position has the authority to make decisions on coverage not relating to medical necessity. Activities assigned include:

- Review and authorization of DME, Ancillary and Medical TARs based on established guidelines.
- Review and authorization of Long Term Care TARs based on established guidelines.
- Review and authorization of inpatient Hospital TARs based on established guidelines.
- Review and authorization of Enhanced Care Management (ECM) and Community Supports TARs based on established guidelines
- Reviews residential placement authorization requests for ~~residential~~SUD treatment services according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements for Medi-Cal eligible beneficiaries.~~s~~ Licensed staff who operate in the capacity of behavioral health authorizations are required to complete specialized ASAM[1] training annually.
- Retrospective review of services to determine medical necessity
- Refer cases to the Chief Medical Officer for requests that may not meet medical necessity criteria
- Determine if requested services are part of the member's benefit plan
- Work collaboratively with the Care Coordination, Population Health, Pharmacy, and Quality Improvement staff on UM issues

Clinical Pharmacist – PharmD, RPh

Work collaboratively with all levels of Pharmacy leadership to review medication Treatment Authorization Requests (TARs) to promote safe, appropriate, and cost effective drug therapy.

- Communicate and educate prescribers on TAR processes, TAR determination, and PHC medication coverage policies
- Participate in P&T meetings and conduct drug utilization reviews to identify treatment gaps and optimize medication therapy outcomes based on national treatment guidelines and evidence-based medicine
- Participates and works with other departments on cross-departmental initiatives that require Clinical Pharmacy input/participation
- Support HEDIS and other clinical quality improvement work through provider academic detailing and member engagement activities
- Ensure compliance with regulatory and quality standards/requirements including, but not limited to, the standards of the National Committee for Quality Assurance (NCQA) and the requirements for the California Department of Health Care Services (DHCS) and the Centers for Medicare and Medicaid Services (CMS).

[1] American Society of Addiction Medicine (ASAM) Criteria - As defined in the Department of Health Care Services (DHCS) Drug Medi-Cal Organized Delivery System Intergovernmental Agreement, pertains to necessary care for biopsychosocial severity and is defined by the extent and severity of problems in all six multidimensional assessment areas of the patient.

Pharmacy Technician – CPhT, RPhT

Work collaboratively with all levels of Pharmacy leadership to review medication Treatment Authorization Requests to promote safe, appropriate, and cost effective drug therapy.

- Reviews and approves TARs based on established internal pharmacy technician review guidelines &/or PHC drug TAR requirements (prior authorization criteria for use). If a TAR cannot be approved based on guidelines/criteria, the pharmacy technician will refer the TAR to the Clinical Pharmacist for an escalated review.
- Educates prescribers on TAR processes, TAR determination, and PHC medication coverage policies.
- Supports HEDIS and other clinical quality improvement work through provider academic detailing and member engagement activities.

~~*Behavioral Health Clinical Specialist – LCSW, LMFT or RN or other licensed behavioral health specialties*~~

~~Licensed Practitioner of the Healing Arts (LPHA)[2] who develops, implements, and coordinates medically necessary treatment services within PHC's Health Services for adults and children with behavioral health and/or substance use service needs. Reviews residential placement authorization requests for residential treatment services according to the specific terms of the contract with the provider and in accordance with the medical necessity requirements for Medi-Cal eligible beneficiaries.~~

Data Coordinator/ Supervisor UM – Administrative

Works closely with UM Leadership to establish consistent evaluation of Data Coordinators' work performance. Responsible for oversight of Data Coordinators.

- Monitors day to day functions including coordination of assignments, monitoring of call volume and adherence to PHC workplace policy and is available to staff on-site or by telephone
- Assists in the refinement/improvement of the HS programs
- Provides performance feedback to the Data Coordinator staff and conducts staff trainings as needed.
- Monitors UM Data Coordinator activity for consistent application of desktop processes and procedures by UM Data Coordinator staff
- Provides leadership, direction, training, and support to the assigned staff
- Participates in staff trainings and on-site continuing education
- Conducts annual performance evaluations for assigned UM staff

Data Coordinator/ UM Lead - Administrative

Under the direction of the Data Coordinator Supervisor and UM Leadership:

- Monitors Data Coordinator documentation for accuracy
- Ensures Data Coordinator staff have the resources required for completing TAR entry and using good judgment and is available to staff on-site or by telephone
- Enters both manual and electronic submitted data into PHC systems for RAF and TAR authorizations
- Monitors UM Data Coordinator staff for consistent application of desktop processes and procedures
- Responsible for assisting with ongoing staff education in proper use of systems and PHC UM Departmental policies and procedures
- Participates in staff trainings and on-site continuing education

Executive Assistant to CMO - Administrative

Provides administrative support to the Chief Medical Officer. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

Continuing Education Program Coordinator - Administrative

~~[2] Licensed Practitioner of the Healing Arts (LPHA): Physicians, Nurse Practitioners, Physician Assistants, Registered Nurses, Registered Pharmacists, Licensed Clinical Psychologist, Licensed Clinical Social Worker (LCSW), Licensed Professional Clinical Counselor, Licensed Marriage and Family Therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians.~~

Provides administrative support to the Chief Medical Officer. Responsible for coordinating the Continuing Education program, including planning meetings and trainings. Audits each CME/CE activity to ensure all elements required by organizations overseeing PHC's educational programs are documented. Maintains organized electronic versions of all continuing education records.

Health Services Administrative Assistant II - Administrative
Provides administrative support to the Senior Director and/or other UM Leadership. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

Health Services Administrative Assistant I – UM - Administrative
Provides administrative support to UM Leadership. Responsible for maintaining and updating policy and procedure manuals, managing appointment calendars, and working closely with the Information Technology Department to ensure appropriate electronic functioning for the Health Services Department.

Health Services Administrative Assistant II – CMO - Administrative
Responsible for administrative support to the Associate and Regional Medical Directors. Responsible for managing appointment calendars, scheduling daily UM and pharmacy workload coverage for the MDs, developing weekly and monthly schedules for distribution to other departments, and coordinating Peer-to-Peer requests from providers. Coordinates setup and executes minutes for designated meetings.

Authorization Specialist/ UM Trainer – Administrative
Responsible for providing training on all appropriate software platforms for new hires. Creates and maintains current training materials for the UM department. In conjunction with UM leadership team, prepares and delivers retraining of identified topics as deemed necessary.

- Facilitates independent DME consultant evaluation visits to members for specialty equipment needs as needed or directed by UM Leadership.
- Acts as a resource regarding UM department software programs and special projects upon request and is available to staff on-site or by telephone
- Coordinates with Member Services Call Center system to place members into appropriate Direct Member status related to their care.

Coordinator II - Administrative
Under the direction of the UM Team Manager and/or the Data Coordinator Supervisor:

- Serves as a resource to other departments who have inquiries into the UM process
- Responsible for the input of data and information concerning UM Referrals and Authorizations
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated

Coordinator I - Administrative
Under the direction of the UM Team Manager and/or the Data Coordinator Supervisor - responsible for the input of data and information concerning UM Referrals and Authorizations.

- Maintains departmental documents
- Receives and responds to telephonic inquiries from providers regarding status of authorization requests and other questions or concerns
- Performs triage and transfers calls to appropriate professional staff when indicated

Coordinator II - Appeals - Administrative
Under the direction of the Associate Director of UM Programs:

- Responsible for clerical processing of appeals in accordance with policy, procedures, timeframes and requirements of various regulatory bodies for all lines of business
- Acts as liaison to Claims Department in coordinating timely response to all claims inquiries

- Participates in special projects, tasks and assignments as directed

Delegation Program Coordinator I – Administrative
Under the direction of the Associate Director of UM Regulations

- Responsible for collecting and tracking required document submissions from delegated entities
- Coordinates and participates in both desktop and onsite audits of delegated entities
- Ensures efficient and appropriate collaboration between the Utilization Management staff and UM delegated entities

Project Coordinator - Administrative
Under the direction of the Senior Director of Health Services or other designated leadership.

- Tracks project deliverables and resources using appropriate internal tools to ensure deadlines are met
- Works collaboratively with the ~~HS analyst~~HS Analytics team (Finance)~~,~~ and IT department ~~and Finance~~ to design and implement reports to accurately reflect the work completed and outcomes achieved within the Department and its programs
- Coordinates with ~~the~~ Regulatory Affairs and Compliance (RAC) ~~Department~~ to conduct research on regulations, statutes, laws, administrative policies and procedures
- Works closely with the CalAIM team including but not limited to Community Supports duties related to outreach of providers and ensuring timely follow up where necessary.

Committees

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

Physician Advisory Committee (PAC)
The PAC monitors and evaluates all Health Services activities and is directly accountable to the Board of Commissioners for the oversight of the UM program. The PAC meets at least ten (10) times a year and may not convene in the months of July and December, with the option to add additional meetings if need. Voting membership includes external Primary Care Providers (PCPs), board certified high-volume specialists, and behavioral health practitioners. A voting provider member of the committee chairs the PAC. The PHC Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer, Associate Medical Director of Quality, Regional Medical Director(s), Clinical Director of Behavioral Health, Senior Director of Health Services and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, and Pharmacy departments attend the PAC meetings regularly. Other PHC staff attend on an ad hoc basis to provide expertise on specific agenda items. The PAC oversees the activities of the Q/UAC and other quality-related committees and reports activities to the Board of Commissioners.

Quality/Utilization Advisory Committee (Q/UAC)
The Q/UAC is responsible to assure that quality, comprehensive health care, and services are provided to PHC members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external providers who are contracted primary care providers (PCPs) and board certified specialists in the areas of internal

medicine, family medicine, pediatrics, OB/GYN, ~~nephrology,~~ neonatology, behavioral health, and representatives from other high volume specialties. The PHC Chief Medical Officer (CMO) (chair of the committee), Clinical Director of Behavioral Health, Associate Medical Director of Quality, Associate and Regional Medical Directors and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, Care Coordination, Population Health, Pharmacy, and Grievance Departments attend the Q/UAC meetings regularly. Other PHC staff attend on an ad hoc basis to provide expertise on specific agenda items. The committee meets on a monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to the PAC and to the Commission at least quarterly. The Q/UAC provides guidance and direction to the UM program by coordinating activities and by functioning as the expert panel when needed. Coordination includes but is not limited to:

- Reviewing, making recommendations to, and approving the *UM Program Description* annually
- Assuring individual member needs are taken into consideration when determinations for care are rendered and in the development of medical policy and procedures.
- Analyzing summary data and making recommendations for action
- Reviewing action plans for quality improvements of UM activities and providing ongoing monitoring and evaluation
- Reviewing medical policy, protocol, criteria and clinical practice guidelines
- Providing oversight of delegated activities

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee is chaired by PHC's Chief Medical Officer (CMO), or designee such as the Director of Pharmacy, and is comprised of PHC's Pharmacy Director, Associate and Regional Medical Directors, PHC staff and network practitioners including pharmacists, primary care physicians, behavioral health and other specialists. P&T makes decisions and recommendations on development and review of the physician administered drugs (PADs) provided under the medical drug benefit, ~~prescription drug formulary*, pharmacy~~ medication policy and procedures, and drug approval criteria. P&T Committee also serves as PHC's Drug Utilization Review (DUR) Board to review PHC's DUR program and activities and make recommendations where necessary to improve PHC's drug utilization. The P&T meets quarterly, providing regular activity reports and recommendations to the PAC, the approval authority for P&T related activities.
~~(*Note: PHC's formulary and medication coverage benefits shall continue as described in this policy until such time as the pharmacy benefit carve-out to Medi-Cal Fee-for-Service described in APL 20-020 and the Governor's Executive Order N-01-19 may take effect.)~~

Provider Advisory Group (PAG)

The PAG is one of the Commission's advisory committees and acts as a liaison between practitioner offices and PHC. The committee meets quarterly and has representatives from physician groups and individual offices, community clinics, ancillary providers, long-term care facilities, employees of county health departments, and community advisory groups. The PAG reports directly to the Board of Commissioners, providing feedback and making recommendations related to health care service issues, community health activities, and issues for special needs populations.

Substance Use Services Internal Quality Improvement Subcommittee (SUIQI)

A committee comprised of appropriate PHC and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the PHC's Substance Use Services oversight. The SUIQI meets at least quarterly. Activities and progress are reported to the IQI. This also includes

- Review of Utilization Management retroactive and appeals review
- Review of inter-rater reliability for peer review and utilization management
- Review of quality of service, quality of facility, and access complaints and grievances
- Investigation of potential over-use, under-use, and misuse of services.
- Review of policies related to provision of SU services

Members of the committee include the Behavioral Health Clinical Director, the CMO, and representatives from the Provider Relations, Member Services, Claims, Compliance, Behavioral Health and Quality Improvement Departments.

Consumer Advisory Committee (CAC)
The CAC is composed of PHC health care consumers who represent the diversity and geographic areas of PHC's membership. There are two CAC committees – one in PHC's Northern seven counties and a second in PHC's Southern seven counties. Both groups meet quarterly. The CAC is a liaison group between members and PHC, advocating for members by ensuring that the health plan is responsive to the health care and information needs of all members. The CAC reviews and makes recommendations regarding Member Services' Quality Improvement Activities, provides feedback on Quality Initiatives and serves in the capacity of a focus group. A consumer from each region serves on the Board to provide consumer input and report back to their respective CAC.

UTILIZATION MANAGEMENT PROGRAM SCOPE

UM activities are developed, implemented and conducted by the PHC Health Services Department under the direction of the Chief Medical Officer and the Senior Director of Health Services. The UM staff performs specific activities.

Specific functions include:

- Prospective, concurrent and retrospective utilization review for medical necessity, appropriateness of hospital admission, level of care and continued inpatient confinement on a frequency consistent with evidence-based criteria and PHC guidelines, PHC criteria/ medical policy and the member's condition. This review is performed cooperatively with the facility care team which may consist of the attending physician(s) and any associated health care personnel who can provide information that will substantiate medical necessity and level of care.
- Discharge planning in collaboration with the facility care team
- Review inpatient and outpatient UM data to determine appropriateness of member and provider utilization patterns
- Use of most current edition of InterQual® Criteria ~~-~~for medical authorization, and other PHC UM guidelines and medical policy as developed and approved by the Quality / Utilization Advisory Committee (Q/UAC)
- Use of California Department of Health and Welfare Code of Regulations Title 22, Center for Medicare & Medicaid Services (CMS) Code of Federal Regulations (CFR) Title 42 and National and Local Coverage Determinations
- Review certification requests for skilled nursing care, home health care, durable medical equipment, ambulatory surgery, ambulatory diagnostic and treatment procedures such as physical, occupational and speech therapies.

The UM program incorporates the monitoring and evaluation for the subsequent services and reviews and updates policies and procedures as appropriate but at least annually.

- Acute hospital services
- Subacute care
- Ambulatory care
- Emergency and urgent care services
- Durable Medical Equipment and supplies
- Ancillary care services, including but not limited to home health care, skilled nursing care, subacute care, pharmacy, laboratory and radiology services
- Long-term care including Skilled Nursing Facility (SNF) Care and Rehabilitation Facility Care
- Physician administered drugs (medical drug benefit)~~Pharmacy drug formulary~~

~~(*Note: PHC's formulary and medication coverage benefits shall continue as described in this policy until such time as the pharmacy benefit carve-out to Medi-Cal Fee-for-Service described in APL 20-020 and the Governor's Executive Order N-01-19 may take effect.*)~~

PHARMACY PROGRAM SCOPE

The Pharmacy Department within Health Services is responsible for the utilization management of the medical drug benefit – those medications administered to a member directly during a medical stay/visit at a clinic, office, or hospital, and billed to PHC as part of a medical service claim; this includes drugs administered at time of service by physicians, dentists, podiatrists, nurse practitioners and physician assistants. Drugs and other prescription services provided to a member by a pharmacy are not within the scope of PHC's Pharmacy Program because the pharmacy benefit is carved-out to State Medi-Cal through the Medi-Cal Rx Program.

Out of Scope for PHC Pharmacy Program:

- Pharmacy benefits and services pursuant to Executive Order N-01-19 and the Medi-Cal Rx program. The Medi-Cal pharmacy benefits and services administered by DHCS in the FFS delivery system is identified collectively as Medi-Cal Rx. This includes:
  - Covered Outpatient Drugs, as defined by SSA 1927(k)(2): prescription drugs which are not provided as part of *medical* service and thus are under the scope of the Pharmacy Benefit.
  - Self-administered medications provided to a member to take/inject/inhale/apply/insert (or otherwise administer) at home.
  - Medication and supply services provided to members at long-term care and skilled nursing facilities.
  - Medications administered by an infusion pharmacy or home health agency in a pharmacy infusion suite or in the member's home
- Medications and services statutorily defined as a non-Medi-Cal benefit
- Medications provided in a medical setting which are carved out of the MCP capitation agreement: antivirals for HIV/AIDs, drugs and blood factor products for Hemophilia, drug and alcohol substance use disorder treatment (prescribed outside a narcotic treatment program), antipsychotics, and certain antidepressants (MAOI).

In Scope for PHC Pharmacy Program:

- Utilization management of drugs administered in a medical setting and billed by the medical provider under the medical benefit, which includes:
  - Drugs other than Covered Outpatient Drugs. The SSA 1927(k)(2) definition of a Covered Outpatient Drug does not include any drug, biological product, or insulin provided as part of, or as incident to, the provision of and billing for medical or institutional services [SSA 1927(k)(3)]
  - Development of coverage criteria for injectable drugs requiring prior authorization based on current nationally accepted treatment guidelines, current medical literature, and input from specialists. These criteria may be drug-specific or class-specific.
  - Application of billing limits, restrictions, or requirements based on FDA approved indications and dosing &/or State Medi-Cal billing requirements. Such utilization management examples include maximum daily dose, allowed dosing frequency, age limits, place of service (e.g. dialysis centers) and current ICD~~-10~~ (diagnosis) requirements.
  - The medical provider submits prior authorization requests directly to the pharmacy department. See policy MCRP4068~~,~~ *Medical Benefit Medication TAR Policy*~~,~~ for further details.

- Pre-service, Concurrent, and Post-Service (Retrospective) pharmaceutical utilization reviews of medical necessity using established prior authorization criteria requirements set forth by PHC Pharmacy & Therapeutics (P&T) Committee, or as required by State Policy (All Plan Letters), or in accordance with PHC case-by-case review guideline (below) when PHC criteria are not yet established. Timeliness standards mirror those for UM Program Timeliness (see page 20).
- Case-by-case review shall consider:
  - The member's individual medical needs (allergies, disease history, treatment history, concurrent medications, concurrent disease states, contraindications)
  - Prescriber's scope of practice/areas of specialization
  - The FDA approved package labeling for indication(s), maximum safe & effective dosing, appropriate age group, recommended screenings and monitoring,
  - Prescribed drug's recommended place in therapy according to indication &/or nationally recognized treatment guidelines
  - Availability & effectiveness of preferred treatments for the same indication
  - Industry-standard clinical resources including (but not limited to): Lexi-Drug, Elsevier/Gold Standard Clinical Pharmacology, ~~NCCN (~~National Comprehensive Cancer Network ~~)~~(NCCN), UpToDate, IPD Analytics, and Facts & Comparisons
  - ~~-~~ Trials of preferred alternatives: There is no set number of preferred medications that must be tried before a non-preferred medication can be approved. Trials of preferred alternatives is unique to each drug and may depend on factors including but not limited to available treatment alternatives, pharmacologic and therapeutic similarities between different treatments, indication, and member's reason for failure with previous treatments. The number of trials required will be based on the clinical judgement of the physician or clinical pharmacist reviewer.
  -

- Retrospective Drug Utilization Review (DUR) (post-claim analysis, educational programs)
  - ~~o~~ Improve medication therapy outcome and reduce and prevent inappropriate use, fraud, or abuse.
  -
- Disease/Medication Management Programs
  - Improve medication adherence, address therapeutic gaps, and optimize medication therapy outcome.
- Support of Care Coordination and Case Management
  - ~~o~~ Support members with complex medication regimen, multiple health conditions, behavioral and substance use disorder.
  -
- Support of Quality Improvement (e.g. HEDIS, outcomes measures)
  - Performance improvement in medication related quality measures.

Mental Health

Members may self-refer for mental health services to mental health providers using the delegated Behavioral Health Organization's toll-free referral numbers or by contacting the preferred behavioral health provider directly. Members do not need a referral or prior authorization to receive mental health services.

In an effort to coordinate the member's overall health care, mental health providers are instructed to ask members to sign a release of information so that the mental health provider can contact the member's PCP or other providers. However, the release of information is not a condition for the approval or provision of services.

Mental health services for Members with Medi-Cal as their primary insurance are provided as follows:

- Members determined to have mental health needs that require mild to moderate mental health treatment are served by PHC's delegated contractor, Beacon Health Options at (855) 765-9703.
- Members assigned to Kaiser are assessed by Kaiser and served or appropriately referred.
- Members determined to have moderate to severe mental health conditions are referred to the County Mental Health Plan in the Member's county of eligibility (Except for Solano County Kaiser members who will have their moderate to severe mental health conditions managed by Kaiser). The administration of such referrals is addressed in the respective Memorandum of Understanding (MOU) with each respective County Mental Health Plan, consistent with California statutes and regulations.
- An initial assessment may be performed by any of these entities described above to determine the most appropriate level of service for the Member, including appropriate referral.

Effective July 1, 2020, PHC provides substance use disorder treatment services as outlined in the Regional Drug Medi-Cal Model. PHC performs utilization management for residential treatment of substance use disorders. For more information, please see the Substance Use Disorder Treatment Services/-Wellness & Recovery Program section below.

County Mental Health Plans provide crisis assessments and authorizations for care. Immediate access to the crisis service remains an option throughout all phases of treatment by any provider. Each County operates crisis services which to address clients in crisis; crisis services also act as a backup after hours and on weekends as well as at other times of provider unavailability. Members may call the County crisis line directly, without a referral. Members eligible for mental health services from PHC delegated contractors will be re-directed to appropriate County crisis services as needed.

A certain level of mental health services is appropriately dealt with in a primary care practice, including screening and referrals to services. Primary Care Providers may contact each county's Mental Health Plan or PHC's delegated contractor, Beacon Health Options, for telephone consultation. For detailed referral and consultation procedures, PCPs can refer to PHC Policy MPCP2017 Scope of Primary Care—Behavioral Health and Indications for Referral Guidelines.

PHC is responsible for the delivery of non-specialty mental health services for children under age 21 and outpatient mental health services for adult beneficiaries with mild to moderate impairment of mental, emotional, or behavioral functioning resulting from a mental health disorder, as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM). Outpatient mental health services are delivered as specified in policy MCUP3028 Mental Health Services whether they are provided by PCPs within their scope of practice or through PHC's provider network. PHC continues to be responsible for the arrangement and payment of all medically necessary, Medi-Cal-covered physical health care services, not otherwise excluded by contract, for PHC beneficiaries who require specialty mental health services.

In compliance with Mental Health Parity requirements on October 1, 2017, as required by Title 42, CFR Section 438.930, PHC ensures direct access to an initial mental health assessment by a licensed mental health provider within the PHC provider network. No referral from a PCP or prior authorization is required for an initial mental health assessment to be performed by a network mental health provider.

PHC meets the general parity requirement (Title 42, CFR, §438.910(b)) which stipulates that treatment limitations for mental health benefits may not be more restrictive than the predominant treatment limitations applied to medical or surgical benefits. Neither a referral from the PCP nor prior authorization is required for a beneficiary to seek any mental health service, including the initial mental health assessment from a network mental health provider.

If a dispute occurs between the local County Mental Health plan and Partnership HealthPlan of California (PHC) or its delegated contractors, Kaiser or Beacon Health Options, both parties will participate in a dispute

resolution process as defined in PHC Policy ~~MCUP3127~~ ADM52 Dispute Resolution Between PHC and MHPs in Delivery of Behavioral Health Services. This is consistent with the dispute resolution process outlined by State regulations and the individual County/PHC Memoranda of Understanding.

Triage and Referral for Mental Health

PHC monitors the triage and referral protocols for the delegated behavioral health services provider(s) to assure they are appropriately implemented, monitored and professionally managed. Protocols employed by delegates must be clinical evidence-based and an accepted industry practice. Protocols shall outline the level of urgency and appropriateness of the care setting.

Triage and referral decisions are performed by the Care Coordination and UM teams of the delegated Behavioral Health Services Provider which are co-located in the PHC offices with oversight by PHC's Behavioral Health Clinical Director. Both work collaboratively with the designated County Mental Health Plans to ensure members receive care at the appropriate level in a timely manner.

Substance Use Disorder Treatment Services/ Wellness & Recovery Program

PHC works to ensure that members receive effective and appropriate behavioral health care services for both mental health and substance use disorders. Substance Use Disorder (SUD) treatment services are administered either by PHC or through individual counties.

The range of services in the Wellness & Recovery Program include:

- Outpatient treatment (licensed professional or certified counselor, up to nine hours per week for adults)
- Intensive outpatient treatment for individuals with greater treatment needs (licensed professional or certified counselor, structured programming, 9-19 hours per week for adults)
- Detoxification services (withdrawal management)
- Residential treatment (Prior authorization is required as per policy ~~MCCP2028~~ MCUP3144 *Residential Substance Use Disorder Treatment Authorization*)
- Medication assisted treatment (MAT) (methadone, buprenorphine, disulfiram, naloxone). *PHC authorizes these medications when prescribed within a narcotic treatment program. When MAT is prescribed outside of a narcotic treatment program (e.g. dispensed through a pharmacy) the medications will be authorized through the state Medi-Cal Rx program.*
- Case management
- Recovery services (aftercare)

Behavioral Health Treatment (BHT) for Members Under 21 Years of Age

PHC has provided benefits for Behavioral Health Therapy for children diagnosed with Autism Spectrum Disorder (ASD) since September 2014.

Effective July 1, 2018, PHC expanded its benefit coverage to include Behavioral Health Treatment (BHT) for eligible Medi-Cal members under the age of 21 as required by the Early and Periodic Screening and Diagnostic Treatment (EPSDT) mandate.

Treatment services may include Applied Behavioral Analysis (ABA) and other services known as Behavioral Health Treatment (BHT).

BHT is the design, implementation and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the direct observation, measurement and functional analysis of the relations between environment and behavior.

BHT services teach skills through the use of behavioral observation and reinforcement, or through prompting to teach each step of targeted behavior. BHT services include a variety of behavioral interventions that have been identified as evidence-based by nationally recognized research reviews and/or other nationally recognized scientific and clinical evidence that are designed to be delivered primarily in the home and in other community settings.

PHC will provide BHT services for all members who meet the eligibility criteria for services as stated in 1905® of the Social Security Administration (SSA) and outlined in DHCS All Plan Letter (APL) 19-014.

- Additional detailed information regarding the BHT benefit can be found in the following PHC Policies and Procedures:
  - MPUP3126 *Behavioral Health Treatment (BHT) for Members Under the Age of 21*
  - MCCP2014 *Continuity of Care*

Quality Improvement Collaboration

The UM team works collaboratively with the Quality Improvement (QI) Department to enhance the care provided to our members through venues such as the Internal Quality Improvement Committee (IQI) , the Quality/ Utilization Advisory Committee (Q/UAC) and daily UM activities.

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

- Reviewing, making recommendations to, and approving the *UM Program Description* annually
- Assuring individual member needs are taken into consideration when determinations for care are rendered
- Analyzing summary data and making recommendations for action
- Reviewing the recommendations of Process Implementation Teams to develop UM improvement action plans, ongoing monitoring, and evaluation
- Recommending medical policy, protocol, and clinical practice guidelines based on provider and member experience information.

During daily activities, the UM team supports QI efforts in the identification of potential quality of care issues, reporting adverse occurrences identified while conducting UM case review, improvement of Healthcare Effectiveness Data and Information Set (HEDIS®) scoring by referrals to care coordination, and care coordination efforts to ensure members are seen by the appropriate provider for their condition.

UTILIZATION MANAGEMENT PROCESS

PHC applies written, objective, evidence-based criteria (InterQual® and pharmaceutical criteria) and considers the individual member's circumstance and community resources when making medical appropriateness determinations for behavioral health and physical health care services.

On an annual basis, PHC distributes a statement to all its practitioners, providers, members and employees alerting them to the need for special concern about the risks of under-utilization. It requires employees who make utilization-related decisions and those who supervise them to sign a statement which affirms that UM decision making is based only on appropriateness of care and service.

Furthermore, PHC does not reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization and PHC does not use incentives to encourage barriers to care and service. This does not preclude the use of appropriate incentives for fostering efficient, appropriate care.

Working with practitioners and providers of care, the following factors are taken into consideration when applying guidelines to a particular case in review:

- Input from the treating practitioner
- Age of member
- Comorbidities in existence
- Complications
- Progress of treatment
- Psychosocial situation
- Home environment
- Consideration of the delivery system and availability of services to include but not be limited to:
  - Availability of inpatient, outpatient, transitional and residential treatment (SUD) facilities
  - Availability of outpatient services
  - Availability of highly specialized services, such as transplant facilities or cancer centers

- Availability of skilled nursing facilities, subacute care facilities or home care in the organization's service area to support the patient after hospital discharge
- Local hospitals' ability to provide all recommended services

- Benefit coverage

Referrals and requests for prior authorization of services are to be submitted by the provider of service to the PHC UM department by ~~mail,~~ fax or through PHC's ~~Provider~~ Online Services p~~P~~ortal, which is a Secure Electronic Internet system. The following information must be provided on all requests.

- Member demographic information
- Provider demographic information
- Requested service/procedure to include specific CPT/HCPCS code(s)
- Member diagnosis (Using current ICD Code sets)
- Clinical indications necessitating service or referral
- Pertinent medical history, treatment or clinical data
- Location of service to be provided
- Requested length of stay for all inpatient requests
- Proposed date of procedure for all outpatient surgical requests

Pertinent data and information is required to enable a thorough assessment of medical necessity.
If information is missing or incomplete, the requestor will be notified and given an opportunity to submit additional information.

Elective Admission Precertification
The UM department evaluates every proposed treatment plan, and determines benefit eligibility, suitability of location and level of care prior to the approval of service delivery for select diagnoses and procedures.

Utilizing written criteria such as InterQual®, Medi-Cal Criteria and PHC medical policy approved by the Q/UAC, licensed and professional UM staff review and approve completed Treatment Authorization Requests (TARs).

Only the Chief Medical Officer or physician designee may make a medical necessity determination and have the authority to deny a service request based on lack of medical necessity. PHC offers the practitioner the opportunity to discuss any medical necessity denial determination with the physician reviewer rendering the decision.

Referral Management
Referrals are generated by the primary care provider and submitted to PHC either by mail, fax or secure Provider Portal. PHC monitors and analyzes requests to identify trends and assist in follow-up care. Requests for out-of-network referrals are reviewed to determine if the service is available and can be provided within the service area. Out-of-Network requests are also used to evaluate provider access and to determine if the local network requires enhancements to meet member needs.

Continued Stay/Concurrent Review
Acute care hospitalization reviews are performed by licensed professionals to ensure medical necessity of continued stay, the appropriateness of level of care, and care duration. This review is conducted either on site, by accessing the facility electronic medical record through a secure portal, or telephonically using written PHC medical policy, InterQual®, and/or Medi-Cal guidelines.

Requests for authorization are reviewed within 24 hours of notification of admission and concurrently throughout the stay. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to PHC case management and social services as appropriate.

Consideration of available services in the local service area or delivery system and the ability to meet the member's specific health care needs are evaluated as part of application of criteria and the development of an ongoing plan of care and discharge plan.

Only the Chief Medical Officer or physician designee has the authority to deny a request for service based on lack of medical necessity. PHC offers the practitioner with clinical expertise in the area being reviewed the opportunity to discuss the application of criteria in determining medical necessity or any determination based on lack of clinical justification with the physician reviewer.

In addition to individual conversations with practitioners on specific case reviews, PHC conducts several committees for the purpose of hearing and incorporating practitioner input in the development of medical policy. PHC, through the Physician Advisory Committee (PAC), the Pharmacy and Therapeutics Committee (P&T) and the Physician Advisory Group (PAG), provides practitioners with clinical expertise in several areas the opportunity to advise or comment on the development and/or adaptation of UM criteria and provide feedback or instruction on the application of that criteria. Within the previously stated committees, PHC evaluates UM criteria and procedures against current clinical and medical evidence and updates them accordingly.

Skilled Nursing/Sub acute/ Long-Term Acute/Rehabilitation Facility Review
Review of all Skilled Nursing and Rehabilitation Facility confinements are performed by licensed professionals to ensure medical necessity of continued stay and the appropriateness of level and duration of care. This review is conducted telephonically using written PHC medical policy, Title 22 criteria, and/or InterQual® criteria. Requests for authorization are reviewed within 24 hours of notification of admission. The UM team facilitates discharge planning in collaboration with the facility care team and makes referrals to PHC case management and social services as appropriate.

Consideration of available services in the local service area or delivery system, and the ability to meet the member's specific health care needs are evaluated as part of applying criteria and the development of an ongoing plan of care and discharge plan.

Discharge Planning
Discharge planning is a critical component of the utilization management process and begins upon admission with an assessment of the patient's potential discharge needs. It includes preparation of the family and the patient for continuing care needs and initiation of arrangements for services or placement needed after acute care discharge.

PHC Nurse Coordinators work with hospital discharge planners, case managers, admitting/attending physicians and ancillary service providers to assist in making necessary arrangements for post-discharge needs.

Post-Service Retrospective Review
Post-service retrospective reviews may occur when a member is retroactively granted Medi-Cal benefits by the State of California, when a provider does not realize an authorization is required prior to rendering a service, when the rendered service code billed does not match the code authorized, or the service may have been rendered after the expiration of the authorization. TARs must be received by PHC within ~~fifteen (15)~~15 business days of the date of service or within 60 calendar days of either a denial from the primary insurance carrier or retrospective eligibility. (TARs submitted beyond these timeframes are considered late but will still be reviewed for medical necessity.)

All retrospective reviews are completed within 30 calendar days of receipt of request. Electronic or written notification of the decision and how to initiate a routine or expedited appeal if applicable, ~~will be~~is ~~provided~~ communicated to the provider within 24 hours of decision, but no longer than 30 calendar days from the date of the receipt of the request. Written notification is mailed to the member within two (2) business days of the decision. ~~PHC is not required to notify members of post-service review decisions as the member is not at financial risk for the services being requested.~~

Services requiring an authorization can be retrospectively reviewed for medical necessity, appropriateness of setting, and length of stay up to one year after services are rendered and may result in an adverse determination.

Emergency Room Visits
Emergency room visits where a prudent layperson, acting reasonably, would believe an emergency condition exists, DO NOT require prior authorization.

Timeliness of UM Decisions

PHC makes UM decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of care. PHC measures the timeliness of decisions from the date when the organization receives the request from the member or PCP, even if the PHC does not have all the information necessary to make a decision. PHC documents the date when the request is received and the date a decision is rendered in the UM documentation system.

PHC has communicated to both providers and members the practice of processing non-urgent requests during the next business day if the request is received after business hours.

PHC Utilization Management abides by the following timeliness guidelines when processing health services requests.

Urgent Requests
A request for medical care or services where application of the time frame for making routine or non-life threatening care determinations could jeopardize the live, health or safety of the member or others due to the member's psychological state or, in the opinion of the practitioner with knowledge of the members medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested.

Concurrent Review Request:
A request for coverage of medical care or services made while a member is in the process of receiving the requested medical care or services, even if the organization did not previously approve the earlier care.

Pre-Service Request
A request for medical care or services that PHC must approve in advance, in whole or in part.

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

Post-Service Request / Retrospective Review
A request for medical care or services that have been received.

Non-Behavioral Healthcare Decisions, Pharmacy Decisions, and Behavioral Healthcare Decisions

Type of Request	Decision Time Frame	Notification[1] Time Frame	Extended Time Frame
Urgent concurrent review	72 hours ~~(3 calendar days)~~ of receipt of request	72 hours ~~(3 calendar days)~~ of receipt of request	May be extended one time up to 14 calendar days from receipt of request
Urgent pre-service	72 hours~~- (3 calendar days)~~ of receipt of request	72 hours~~- (3 calendar days)~~ of receipt of request	May be extended one time up to 14 calendar days from receipt of request
Non-urgent pre-service	5 business days of receipt of request	24 hours of determination date[1]	May be extended *two (2)* times for up to 14 calendar days each period[2] (28 days total from~~of~~ receipt of~~r~~ request) [2]

Post-service	30 calendar days of receipt of request	30 calendar days of receipt of request	N/A

[1] Notification: Give electronic or written notification of decision to practitioner (and member when required). *Per DHCS requirement, written notification must be mailed to a member within two (2) business days of the decision.*
[2] Per DHCS regulations

Review Criteria
Current InterQual® criteria sets are used as the main review guidelines. Additional criteria are selected or developed using other resources as necessary to help in determining review decisions which include, but are not limited to, Medi-Cal (State of California) guidelines and State policy letters (see policy MCUP3139 *Criteria and Guidelines for Utilization Management*). InterQual® criteria are produced using a rigorous development process based on evidence-based medicine and reviewed at least annually, but as frequently as quarterly, by a panel of board-certified specialists. All UM policies are based on InterQual® criteria and are reviewed annually by the Quality/Utilization Committee (Q/UAC) and the Physician Advisory Committee (PAC) which also include board-certified specialists who are practicing network physicians. All Pharmacy policies are reviewed annually by the Pharmacy and Therapeutics (P&T) Committee and PAC. Refer to pharmacy policies MCRP4068 *Medical Benefit Medication TAR Policy* and MPRP4001 *P&T Committee* for further details regarding pharmaceutical criteria.

In the absence of applicable criteria, the PHC UM medical staff refers the case for review to a licensed, board-certified practitioner in the same or similar specialty as the requested service. The reviewing practitioners base their determinations on their training, experience, the current standards of practice in the community, published peer-reviewed literature, the needs of the individual patients (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable), and characteristics of the local delivery system. Board-certified consultants are available through our providers on our Quality/Utilization Advisory Committee (Q/UAC). PHC also contracts with a third-party independent medical review organization which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence. (See policy MCUP3138 *External Independent Medical Review*.)

Criteria are selected, reviewed, updated or modified using feedback from the Q/UAC and PAC as well as member feedback identified in member survey results and the Consumer Advisory Committee (CAC), State policy letters, State Memorandums of Understanding and/or medical literature, among other sources. In collaboration with actively practicing practitioners, criteria are evaluated on at least an annual basis. Relevant clinical information is obtained when making a determination based on medical appropriateness and the treating practitioner is consulted as appropriate. All information obtained to support decision-making is documented in the utilization management documentation system.

Decisions are based on information derived from the following sources:

- Clinical records
- Medical care personnel
- Facility utilization management staff
- Attending physician (attending physician can be the primary care physician, hospitalist or the specialist physician (or all three as necessary)
- Board-certified specialists are consulted when medically necessary

When applying criteria to a treatment request, reviewers consider the needs of the individual patient (age, comorbidities, complications, progress of treatment, psychosocial situation, and home environment when applicable) as well as the availability of services in the local delivery system and their ability to meet the member's specific health care needs.

Inter-Rater Reliability (IRR)
PHC assesses the consistency with which physician and non-physician reviewers apply UM criteria in decision making and evaluates Inter-Rater Reliability. The Inter-Rater Reliability mechanism uses live cases

to ensure medical management criteria are appropriately and consistently applied in making UM determinations. The methodology employed is designed to annually assess 50 cases or 5% of reviewer case load, whichever is less, over the course of a year period.

The following types of reviews/reviewers are audited:

- Nurse Coordinator Review of Inpatient Services
- Nurse Coordinator Review of Outpatient Services
- Nurse Coordinator Review of Long Term Care Services
- Nurse Coordinator Review of Residential Substance Use Disorder Treatment Authorizations
- Physician Review of Medical Necessity Authorizations
- Pharmacist and Pharmacy Technician Review of Pharmacy TARs
- ~~LCSW/LMFT Review of Residential Substance Use Disorder Treatment Authorizations~~

A performance target of 90% accuracy is set for inter-rater reliability. An audit summary is reported at least annually or more often as needed to the Internal Quality Improvement (IQI) Committee. If a reviewer falls below the targeted threshold, a corrective action plan is initiated and monitored and results are presented to the Quality/Utilization Advisory Committee (Q/UAC) for review and discussion. Please refer to policy MPUP3026 *Inter-Rater Reliability Policy* for a full description of the IRR process.

Availability of Criteria

All criteria used to review authorization request are available upon request. In the case of an adverse determination, the criteria used are made part of the determination file. Access to and copies of specific criteria utilized in the determination are also available to any requesting practitioner by mail, fax, email, or on our website: http://www.partnershiphp.org. To obtain a copy of the UM criteria, practitioners may call the PHC UM Department at (800) 863-4155.

Members may request criteria used in making an authorization determination by calling the member services department to request a copy of the criteria. The UM team will work with member services to provide the criteria used in the review decision.

PHC's Provider Relations Department notifies providers in writing through the New Provider Credentialing Packet and the provider's contract that UM criteria is available online at http://www.partnershiphp.org in the Provider Manual section. Providers are also notified quarterly in writing via the Quarterly Provider Newsletter about the on-line availability of UM criteria and policies at http://www.partnershiphp.org in the Medi-Cal Provider Manual section.

COMMUNICATION SERVICES

PHC provides access to staff for members and practitioners seeking information about the UM process and the authorization of care in the following ways:

- Calls from members are triaged through M~~m~~ember S~~s~~ervices staff who are accessible to practitioners and members to discuss UM issues during normal working hours when the health plan is in operation (Monday - Friday 8 a.m. - 5 p.m.).
- Members and Providers may contact the PHC voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
- After normal business hours, members may contact the advice nurse line for assistance
- Practitioners may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after

normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
- PHC has a toll free number (800) 863-4155 that is available to either member or practitioners.
- UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- Members can view information about PHC's language assistance services and disability services in the Member Handbook which is mailed to members upon enrollment and is always available online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf Additionally, PHC provides annual written notice to Members about our language assistance services and disability services (e.g. TTY for hearing impaired) in our Member Newsletter.

Linguistic services are provided by PHC to monolingual, non-English speaking or limited English proficiency (LEP) Medi-Cal beneficiaries as well as eligible members with sensory impairment for population groups as determined by contract. These services include the following:

No Cost Linguistic Services:
- Qualified o~~O~~ral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
- Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for PHC Members according to regulatory timeframes, and into other languages or alternative formats upon request. Materials are also available in audio, large print and electronically for members with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. The organization may continue to provide translated materials in other languages represented by the population at the discretion of PHC, such as when the materials were previously translated or when translation may address Health Equity concerns.
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735- 2929 or 711]

PHC regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. (see policy MCNP9003 *Cultural and Linguistic Services*).

Denial Determinations

Denial determinations may occur at any time in the course of the review process. Only the Chief Medical Officer, or a physician designee acting through the designated authority of the Chief Medical Officer, has the authority to render a denial determination based on medical necessity (see Program Structure section for details).

A denial determination may occur during continued stay/concurrent review in which case notification and/or discussion with the treating practitioner and the Health Plan physician adviser/Chief Medical Officer or physician designee is offered.

Denial determinations may occur at different times and for various reasons including but not limited to:
- At the time of prior authorization; when the requested service is not medically indicated or not a covered benefit.
- When timely notification was not received from a facility for an inpatient stay to foster transfer of a medically stable patient
- When an inpatient facility fails to notify the Health Plan of admission within one business day of the admission or appropriate clinical information is not received

- Or after services are rendered at claims review when the services were not authorized, or are medically unnecessary

A denial may also occur for inappropriate levels of care or inappropriate care. Notwithstanding previous authorization, payment for services may be denied if it is found that information previously given in support of the authorization was inaccurate.

PHC offers the practitioner the opportunity to discuss any denial or potential denial determination based on lack of medical necessity with the Health Plan Chief Medical Officer, or a physician designee.

The denial notification states the reason for the denial in terms specific to the member's condition or service request and in language that is easy to understand and references the criterion used in making the determination so the member and provider have a clear understanding of the Health Plan's rationale and enough information to file an appeal.

Partnership HealthPlan of California is aware of the need to be concerned about under-utilization of care and services for our members. PHC monitors over and under-utilization through the Over/Under Utilization Workgroup which reviews annual utilization patterns. Decisions made by PHC's Utilization Reviewers are solely based on the appropriateness of the care or service.

The Health Plan does not compensate any individual involved in the utilization process to deny care or services for our members nor do we encourage or offer incentives for denials.

Process for a Provider to Appeal an Adverse Benefit Determination on Behalf of a Member

Members and providers are provided fair and solution-oriented means to address perceived problems in exercising rights as a Medi-Cal beneficiary or provider, in accordance with requirements of PHC's contract with the Department of Health Care Services (DHCS). This process is entirely separate from that of State Fair Hearings, to which members retain their access. Please refer to PHC policy MCUP3037 *Appeals of Utilization Management/ Pharmacy Decisions* for a full description of the process.

Appeals of Adverse Benefit Determinations (ABDs)

A member, a member's authorized representative, or a provider acting on behalf of a member, has 60 calendar days from the date of determination to submit an appeal request in response to a Notice of Action (NOA) letter. A member or a member's authorized representative may initiate an appeal by contacting PHC's Member Services department. An appeal initiated in this way is considered a Member Appeal and will be referred to the PHC Grievance and Appeals department for processing. A provider may also request an appeal on behalf of a member, with written consent from that member, by faxing or writing PHC's UM or Pharmacy Department.

After receipt of the request for appeal, PHC will provide written acknowledgement to the member and provider that is dated and postmarked within five (5) business days of receipt of the appeal. PHC has 30 calendar days from the receipt of the appeal request to render a determination.

The Chief Medical Officer or physician designee reviews the request for appeal if the determination was based on medical necessity. The Chief Medical Officer or physician designee may request further information from the provider such as:

- Diagnostic information
- Previous treatment
- Clinical justification
- Opinions from specialists or other providers
- Evidence from the scientific literature prior to processing the request.

The provider is expected to respond to a request for further information within the 30 calendar day determination time frame. If the provider does not respond to the request for further information within that time frame, the appeal can be extended no more than 14 calendar days.

When a decision has been made, the provider and/or member, if applicable, are notified in writing within five (5) business days with a Notice of Appeal Resolution (NAR) letter. PHC is not required to notify the member of a decision when the member is not at financial risk for the services being requested (e.g. concurrent ~~or retroactive~~ reviews).

Providers who disagree with the appeal decision may then file a grievance with PHC by the process described in the MPPRGR210 *Provider Grievance* policy ~~MP PR GR 210~~.

If PHC's determination specifies the requested service is not a covered benefit, PHC shall include in its written response the provision in the Contract, Evidence of Coverage, or Member Handbook that excludes the service.

The response shall either identify the document and page where the provision is found, direct the provider and member to the applicable section of the contract containing the provision, or provide a copy of the provision and explain in clear concise language how the exclusion applies to the specific health care service or benefit request.

Expedited Appeals of Adverse Benefit Determinations

Expedited appeals may be initiated by the member or the provider. A member may initiate an expedited appeal by calling the Member Services Department. A provider may initiate an expedited appeal on behalf of a member with written consent by faxing or writing the PHC UM or Pharmacy Department. If the request for expedited appeal is not accompanied by written consent from the member, the Plan will proceed with the request.

Expedited appeals are performed by PHC only when, in the judgment of the Chief Medical Director or Physician Designee, a delay in decision-making may seriously jeopardize the life or health of the member.

PHC refers the expedited appeal request to the Chief Medical Officer or Physician Designee for decision on the appeal. The Chief Medical Officer or Physician Designee is expected to make a decision as expeditiously as the medical condition requires, but no later than ~~seventy-two (~~72~~)~~ hours ~~-~~after the receipt of the request for an expedited appeal.

Expedited reviews are also granted to all requests concerning admissions, continued stay or other health care services for a member who has received emergency services but has not been discharged from a facility.

PHC provides verbal confirmation of its decisions concurrent with mailing of written notification no later than ~~seventy-two (~~72~~)~~ hours after receipt of an expedited appeal. If the expedited appeal involves a concurrent review determination, the member continues to receive services until a decision is made and written notification is sent to the provider. PHC is not required to notify the member of a concurrent decision as the member is not at financial risk for the services being requested.

Appeal Rights

A member may ask assistance from a patient advocate, provider, ombudsperson or any other person to represent them in their request.

A member may also request a State Hearing if a member has filed an appeal and received a "Notice of Appeal Resolution" letter upholding the initial denial of service or in instances of deemed exhaustion. Information on

how to obtain an expedited State Hearing is included as a part of the "Notice of Appeal Resolution" letter to the member.

Member grievance and appeal information is included in the member handbook, distributed annually in the member newsletter, and is posted on the PHC website.

It is the responsibility of the Member Services Director and the Member Services Department to ensure:

- Member Rights and Responsibilities are included in the member handbook which is mailed to all new members and posted on the PHC website
- Members are advised of their right to receive a copy of the Member Rights and Responsibility statement annually in the PHC's member newsletter.
- Members are notified of all revisions to the Member Rights and Responsibilities statement in the member newsletter following revisions.

It is the responsibility of the Provider Relations Director and the Provider Relations Department to ensure

- The Member's Rights and Responsibilities statement is included in the PHC provider manual issued to all contracted providers. The manual is issued to providers after their contract has been fully executed.
- Any revisions to the Member's Rights and Responsibilities statement are issued to all contracted providers within 90 days from the date these revisions are finalized.

Data Sources

Utilization Management supports the effective, efficient, and appropriate utilization of member benefits through ongoing review, evaluation and monitoring of the member's personal health information in making medical necessity determinations.

Data sources may include, but are not limited to:

- Medical records, from outpatient provider offices and hospital records (including accessing hospital Electronic Medical Records (EMR); for current and historical data
- Member handbook or Evidence of Coverage
- Consultations with treating physicians
- network adequacy information
- Local delivery system capacity information
- Specialist referrals
- Recent Physical exam results
- Diagnostic testing results
- Treatment plans and progress notes
- Operative and pathological reports
- Rehabilitation evaluations
- Patient characteristics and information
- Patient psychosocial history
- Information from family / social support network
- Prospective/concurrent/retrospective utilization management activities
- Claim/encounter (administrative) data

Data Collection, Analysis, and Reporting

Data collection activities for analysis and reporting are coordinated by the UM department. At the data gathering/performance measurement phase, participants in the process include programmers and analysts in the Finance and Health Services departments, staff nurses, and any other personnel required for the collection and validation of data. All data collection activities are documented and reported to the Q/UAC twice a year and more often if requested. Data collection activities may include, but are not limited to:

- Member satisfaction surveys
- Provider satisfaction surveys
- Readmission statistics
- Potential quality incident data
- Member appeal data
- Provider appeal data
- Internally developed databases
- Pharmacy utilization data
- Other administrative or clinical data

EVALUATION OF NEW MEDICAL TECHNOLOGY

PHC evaluates the inclusion of new medical technologies and the new application of existing technologies in its benefit packages. While the basic benefits are set by the State of California Department of Health Care Services (DHCS) and outlined in Title 22 of the Health and Welfare Code, PHC has the option of adding to this basic package of benefits for its members.

PHC's Policy MCUP3042 *Technology Assessment* outlines the steps taken during the determination process. The PHC Physician Advisory Committee will review all cases and make a final recommendation to the Board of Commissioners as to new benefits. The Commission is the only entity that can add benefits.
Once a new benefit is added, the information is disseminated to all Primary Care Providers and appropriate specialists in the form of a mail notification of benefit addition, and to all members in the next member newsletter.

New technologies are handled on a case-by-case basis which includes obtaining information regarding the safety, efficacy and indications that support the use of the intervention. There must be evidence that the proposed intervention will add to improved outcomes as compared to what is currently available. The service provider must have a record of safety and success with the intervention and cannot be part of a funded research protocol. The Chief Medical Officer works closely with the requesting physician and specialists as needed in researching these cases.

DELEGATION

UM activities that are delegated to contract providers are reviewed and approved on an annual basis by the Q/UAC. A delegation agreement, including a detailed list of activities delegated and reporting requirements is signed by both the delegate and PHC.

- Providers to whom UM activities have been delegated are responsible for reporting results and analyses to PHC on a quarterly or annual basis. Reports are summarized for review and evaluation by PHC's Delegation Oversight Review Sub-Committee (DORS) and Q/UAC.
- Audits are conducted no less than annually and evaluation includes a review of both the processes applied in carrying out delegated UM activities, and the outcome achieved in accordance with the respective policy(s) and agreement governing the delegated responsibility.
- The Q/UAC reviews evaluations and make recommendations regarding opportunities for improvement and continuation of delegated functions.

A pre-delegation evaluation is conducted when delegation of functions to providers is being considered.

Protected Health Information (PHI)

The Privacy Rule, described in 45 CFR Parts 160 and 165, applies to covered entities. The Privacy Rule allows covered providers, entities, and health plans to disclose PHI in order to carry out their health care functions.

Partnership HealthPlan of California is fully compliant with the general rules, regulations and implementation specified in The Privacy Rule. PHC also provides reasonable administrative, technical, and physical safeguards to ensure PHI confidentiality, integrity and availability and to prevent unauthorized or inappropriate access, use or disclosure of PHI.

The PHC Director of Regulatory Affairs and Program Development also serves as the PHC Privacy Officer. PHC has implemented a comprehensive program that includes "Notice of Privacy Practices" (NPP) sent to all members, as well as implementation of a confidential toll-free complaint line available to members, providers and PHC staff. For non-covered entities, PHC requires Business Associate Agreements (BAA). Additionally, there is training on an annual basis for the PHC workforce and PHC providers/networks, and PHC maintains policies and procedures around documentation of complaints of violations or suspected privacy incidents.

STATEMENT OF CONFIDENTIALITY

Confidentiality of provider and member information is ensured at all times in the performance of UM activities through enforcement of the following:

- Members of the Q/UAC and PAC are required to sign a confidentiality statement that will be maintained in the QI files.
- UM documents are restricted solely to authorized Health Services Department staff, members of the PAC, Q/UAC, and ~~Credentialing~~ Credentials Committee, and reporting bodies as specifically authorized by the Q/UAC.
- Confidential documents may include, but are not limited to Q/UAC and ~~Credentialing~~ Credentials Committee meeting minutes and agendas, QI and Peer Review reports and findings, UM reports, or any correspondence or memos relating to confidential issues where the name of a provider or member are included.
- Confidential documents are stored in locked file cabinets with access limited to authorized persons only, or they are electronically archived and stored on protected drives.
- Confidential paper documents are destroyed by shredding.

NON-DISCRIMINATION STATEMENT

PHC complies with applicable Federal civil rights laws and does not discriminate, exclude people, or treat them differently on the basis of race, color, national origin, age, disability, or sex.

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

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

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

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

- Qualified sign language interpreters
- Information written in other languages
- Use of California Relay Services for hearing impaired

Statement of Conflict of Interest

Any individual who has been personally involved in the care and/or service provided to a patient, an event or finding undergoing quality evaluation may not vote or render a decision regarding the appropriateness of such care. All members of the Q/UAC are required to review and sign a conflict of interest statement, agreeing to abide by its terms.

Provider and Member Satisfaction

PHC conducts satisfaction surveys on both members and providers. Included in the evaluation are questions that deal with both member and provider satisfaction with the UM program. The responses to the survey are reviewed by staff from Health Services, Member Services, and Provider Services. Thresholds are set and responses that fall below are considered for corrective action by the HealthPlan. The results, as well as plans for corrective action, are developed in conjunction with the Q/UAC. Corrective actions that were in place are evaluated at the time the follow-up annual survey is done unless the committee feels an expedited time frame needs to be implemented.

Annual Program Evaluation

The Utilization Management program undergoes a written evaluation of its overall effectiveness annually by the Q/UAC, which is reviewed and approved by the PAC.

At a minimum the evaluation considers UM department activities and outcomes, the review of Key Performance Indicator metrics such as Productivity, Timeliness, Bed-days, readmission rates and denial rates along with resource effectiveness and barriers to performance.

Preparation for the Annual Program Evaluation involves participation by all Utilization Management and Pharmacy leadership including but not limited to:

- Senior Health Services Director
- Director, Pharmacy Services
- Associate Directors of UM
- UM Team Manager

Elements of the program evaluation include an objective assessment of meeting targeted goals to ensure appropriate, efficient utilization of resources/services for PHC members across the continuum of care in compliance with requirements of state/federal and regulatory entities.

- Annual UM Program Description update
- Annual review and evaluation of UM processes (meeting goals and identifying opportunities for process improvements)
- Timely review and update of UM policies and procedures
- Obtain approval of UM policies and procedures at Q/UAC

Inter-Rater Reliability scoring and~~,~~ TAR timeliness~~, percentage of eRAFs vs. Manual RAFs, and Call Performance is~~are compared with regulatory compliance standards and internal benchmarks.

To determine if the UM program remains current and appropriate, the organization annually evaluates:

- The program structure
- The program scope, processes, information sources used in the determination of benefit coverage and medical necessity
- The level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program

- Consideration of member and practitioner experience data when evaluating the UM program

The organization updates the UM program and its description annually based on the evaluation.

To ensure the provision of healthcare services at the appropriate level of care the evaluation considers:

- Inpatient bed day rate
- Inpatient average length of stay
- SNF admit rate
- SNF average length of stay
- Readmission rate
- Denial rate
- Timely completion of notifications of denial of care
- Timely completion of notifications of authorization of care
- Rate of referrals to Care Coordination
- Effectively integrating feedback - the program reflects on Member/Provider satisfaction results concerning the UM program looking at:
    - Daily Work Flow Monitoring
    - Call Abandonment rates
    - Call Volume
    - Average caller wait time

An assessment of Department resources is determined by looking at the impact of staffing changes, learning curves and system limitations which impede work effectiveness. There is a review of Inter-Rater Reliability scoring in relation to staff training/re-education, acclimation to new technology such as documentation software/ hardware based on evaluating user acceptance, and the assessment of appropriate staffing ratio to ensure adherence to regulatory and internal performance standards.

A summary of the program evaluation, including a description of the program, is provided to members or practitioners upon request. ~~When the evaluation is complete, an announcement indicating the availability of UM information is published in the member and provider newsletter.~~

REFERENCES:

- Department of Health Care Services (DHCS) standards
- National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2022~~1~~) UM Standards 1-5, 7
- Covered Outpatient Drugs, SSA 1927(k)(2), SSA 1927(k)(3)
- California State Department of Health Care Services (DHCS) Medi-Cal Rx Resources and Reference Materials:
- https://www.dhcs.ca.gov/provgovpart/pharmacy/Pages/Medi-CalRX.aspx
- State Medi-Cal MCP: County Organized Health System (COHS): https://files.medi-cal.ca.gov/pubsdoco/Publications/masters-MTP/Part1/mcpcohs.pdf

Original Date: QI/UM Program 04/22/1994 effective 05/01/1994
Revision Date(s): 08/16/95
Revision Date(s): UM Program Description - 04/17/97; Board Approval January 28, 1998; 06/10/98; 01/20/99; 05/2000; 05/01/01; (UD100301) 03/20/02; 08/20/03; 10/20/04; 10/13/05; 06/21/06; (MPUD3001) 04/16/08; 08/03/10; 11/19/14; 02/17/16; 04/19/17; *06/13/18; 04/10/19, 06/12/19 *(Amended)*, 10/09/19 *(Amended);* 04/08/20; 06/10/20 (*Amended*); 04/14/21; 01/12/22; 05/11/22

*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.

UM PROGRAM DESCRIPTION APPROVAL

	~~*03/17/2021*~~*04/20/2022*

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

	~~*04/14/2021*~~*05/11/2022*

Robert Moore, MD, MPH, MBA *Date Approved*
Physician Advisory Committee Acting Chairperson

	~~*04/28/2021*~~*06/22/2022*

Nancy Starck *Date Approved*
Board of Commissioners Chairperson

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Agenda Item Number: 3.4

Board Meeting Date: June 22, 2022

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Approved by:
Physician Advisory Committee

Topic Description:
Thomas Paukert, MD, Napa Valley Nephrology, has submitted his resignation to the Physician Advisory Committee.

Bessant Parker, MD, Medical Officer Mendocino County, Adventist Health, has tendered his resignation to the Physician Advisory Committee (PAC), since he is leaving Adventist Health in mid-March. Dr. Parker will be focusing on chronic kidney disease through a new company being launched in June and will continue to serve the community in that capacity. A replacement to fill his vacancy at PAC is being addressed.

Amy Brom, MSW, PsyD**,** Director of Behavioral Health, Alexander Valley Healthcare, has submitted her resignation to the Quality / Utilization Advisory Committee (Q/UAC), due to increased work responsibilities over the past year. A recommendation to fill her Q/UAC vacancy is being addressed.

Reason for Resolution:
To obtain Board approval to accept the resignations of Thomas Paukert, MD and Bessant Parker, MD from the Physician Advisory Committee and the resignation of Amy Brom, MSW, PsyD from the Quality / Utilization Advisory Committee (Q/UAC).

Financial Impact:
There is no measureable financial impact to the HealthPlan.

Requested Action of the Board:
Based on the approval of the Physician Advisory Committee, the Board is asked to ratify the resignations of Thomas Paukert, MD and Bessant Parker, MD from the Physician Advisory Committee and the resignation of Amy Brom, MSW, PsyD from the Quality / Utilization Advisory Committee (Q/UAC).

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date: June 22, 2022 **Agenda Item Number:** 3.4

Resolution Number:
22-

IN THE MATTER OF: APPROVING PHYSICIAN ADVISORY COMMITTEE AND QUALITY / UTILIZATION ADVISORY COMMITTEE MEMBER CHANGES

Recital: Whereas,

A. Thomas Paukert, MD is resigning from the Physician Advisory Committee.

B. Bessant Parker, MD, is resigning from the Physician Advisory Committee

C. Amy Brom, MSW, PsyD is resigning from the Quality / Utilization Advisory Committee (Q/UAC).

D. The Board has authority to appoint committee members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the resignations of Thomas Paukert, MD, Bessant Parker, MD from the Physician Advisory Committee and Amy Brom, MSW, PsyD from the Quality / Utilization Advisory Committee.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 22nd day of June 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
3.5

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Approved by:
Physician Advisory Committee and PHC Staff

Topic Description:
In order to provide high quality preventive health services, staff is proposing changes to the 2022-2023 Perinatal Quality Improvement Program (PQIP) measurement set (see attached summary).

Reason for Resolution:
To optimize the Perinatal QIP to improve quality of care.

Financial Impact:
The impact to the HealthPlan is included in the budget assumptions.

Requested Action of the Board:
Based on the recommendation of PHC staff, the Board is asked to approve proposed changes to the 2022-2023 Perinatal Quality Improvement Program (PQIP) measurement set.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
3.5

Resolution Number:
22-

IN THE MATTER OF: APPROVING PROPOSED CHANGES TO THE 2022-2023 PERINATAL QUALITY IMPROVEMENT PROGRAM (PQIP) MEASUREMENT SET

Recital: Whereas,

A. The Board has responsibility to review and approve HealthPlan policies, programs, and benefits.

B. The Board has fiduciary responsibility for the operation of the organization.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve proposed changes to the 2022-2023 Perinatal Quality Improvement Program (PQIP) measurement set.

PASSED, APPROVED, AND by the Partnership HealthPlan of California this 22nd day of June 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

Quality Improvement Department
Partnership HealthPlan of California
4665 Business Center Dr., Fairfield CA 94534
Fax: (707)863-4316
Email: QIP@partnershiphp.org

Proposed Measure Changes for Perinatal Quality Improvement Program (PQIP) FY 2022-2023

I. Summary of Proposed Measures

(A) Core Measurement Set Measures

Participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers who provide quality and timely prenatal and postpartum care to PHC members have the option to earn additional financial incentives. The PQIP framework offers a simple and meaningful measurement set developed with PCPs and OB/GYNs in mind and includes the following measures: 1) Timely Tdap and Influenza Vaccine 2) Timely Prenatal Care, and 3) Timely Postpartum Care.

Key:

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

FY2021-22 Measures	FY2022-23 Proposed
Clinical Domain	
Perinatal Medicine: 1. Prenatal Immunization 2. Timely Prenatal Care 3. Timely Postpartum Care	**Perinatal Medicine:** 1. Prenatal Immunization 2. Timely Prenatal Care 3. Timely Postpartum Care

(B) Unit of Service

Unit of Service	
All Sites: 1. Electronic Clinical Data Systems (ECDS)	**All Sites:** ~~**1. Electronic Clinical Data Systems (ECDS)**~~

PQIP FY 2022-2023 DESCRIPTIONS OF MEASURES AND PROPOSED CHANGES

Programmatic Changes:

A. CLINICAL MEASURES *WITHOUT* PROPOSED CHANGES

Prenatal Immunization Status
The number of women who had one dose of the tetanus, diphtheria, acellular pertussis vaccine (Tdap) within 30 weeks before delivery date and an influenza vaccine during their pregnancy.

Timely Prenatal Care
Timely prenatal care services rendered to pregnant PHC members in the first trimester, as defined as less than 14 weeks of gestation, or within 42 days of enrollment in the organization

Timely Postpartum Care
Timely postpartum care is a measure of quality care and can contribute to healthier outcomes for women after delivery. The postpartum visit is an important opportunity to educate new mothers on expectations about motherhood, address concerns, and reinforces the importance of routine preventive health care.

B. UNIT OF SERVICE

~~**Electronic Clinical Data System (ECDS) Implementation**~~

The Electronic Clinical Data System (ECDS) measure is a vital component of furthering PQIP advancement of 100% administrative capture through claims and ECDS that will capture, estimated date-of-delivery, depression tool and score captured from participating sites through their EHR systems.

Rationale:
The ECDS measure has been an offered Unit of Service measure for the past two fiscal years. The intent of this measure was to encourage participating providers to transition to the future state of this program which is to be 100% administratively captured. While we have had some success we are not seeing the desired outcome of all participating providers submitting data on ECDS.

Proposal:
Remove the incentive opportunity of ECDS implementation and make this a gateway program requirement. Providers choosing to continue in this invitation based pay-for-performance program will be required to successfully be submitting monthly ECDS data.

Providers currently submitting monthly ECDS will be required to continue monthly submissions. Providers who have not yet implemented ECDS, we will not accept any manual submissions for prenatal care, but you will have an opportunity to implement ECDS by January, 2023 and monthly thereafter to be eligible for FY22-23 incentive opportunities.

C. MEASURE INCENTIVE BREAKDOWN

Measure	Incentive Per Submission	Measure Requirement
Prenatal Immunization Status	$34.50 – (Tdap) $12.50 (Influenza)	The number of women who had one dose of the tetanus, diphtheria, acellular pertussis vaccine (Tdap) within 30 weeks before delivery date and an influenza vaccine during their pregnancy (i.e. within 40 weeks of delivery date).
Timely Prenatal Care	$75 (per visit)	Timely prenatal care services rendered to pregnant PHC members in the first trimester, as defined as less than 14 weeks of gestation, or within 42 days of enrollment in the organization.
Timely Postpartum Care	$25 (1st visit) $50 (2nd visit)	Two Timely postpartum care services rendered to PHC members with one occurring within 21 days after delivery and the other occurring between 22 and 84 days after delivery.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
3.6

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Approved by:
Physician Advisory Committee and PHC Staff

Topic Description:
In order to provide high quality preventive health services, staff is proposing changes to the 2022-2023 Hospital Quality Improvement Program (QIP) measurement set (see attached summary).

Reason for Resolution:
To optimize the Hospital QIP to improve quality of care.

Financial Impact:
The impact to the HealthPlan is included in the budget assumptions.

Requested Action of the Board:
Based on the recommendation of PHC staff, the Board is asked to approve proposed changes to the 2022-2023 Hospital Quality Improvement Program (QIP) measurement set.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
3.6

Resolution Number:
22-

IN THE MATTER OF: APPROVING PROPOSED CHANGES TO THE 2022-2023 HOSPITAL QUALITY IMPROVEMENT PROGRAM (QIP) MEASUREMENT SET

Recital: Whereas,

A. The Board has responsibility to review and approve HealthPlan policies, programs, and benefits.

B. The Board has fiduciary responsibility for the operation of the organization.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve proposed changes to the 2022-2023 Hospital Quality Improvement Program (QIP) measurement set.

PASSED, APPROVED, AND by the Partnership HealthPlan of California this 22nd day of June 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

2022-23 Hospital QIP (HQIP) Proposed Measurement Set

Large hospitals (≥ 50 general acute beds) and Small hospitals (< 50 general acute beds) report on measures as indicated below. Each hospital may earn up to 100 points.

Measures/Requirements	Proposed 2022-23 Hospital Measurement Changes/Updates/Additions	Considerations
Health Information Exchange All hospitals. By the end of the measurement year, both of the following: 1. Live with Emergency Department Interface Exchange (EDIE) including a mechanism for the EDIE data to be pushed to ED physicians for patients who are seen. 2. ADT interface with a community HIE. If not met, entire incentive amount will be withheld.	No Change.	
Delegation Requirement All **capitated** hospitals. Capitated hospitals must submit timely and accurate delegation deliverables, according to deadlines outlined in your hospital's delegation agreement. Deliverables include 1) Utilization Program Structure and 2) delegation reporting requirements. Impact: • Timely submitting > 90.0% of requirements results in 100% incentive. • Timely submitting > 75.0% and < 90.0% of requirements results in 10% cut from incentive. • Timely submitting < 75.0% of requirements results in a 20% cut from incentive.	1. From July 1, 2022 to June 30, 2023, Hospitals must utilize Collective Plan (module of Collective Medical Technology's EDIE) for their capitated members to alert their internal Utilization Management team to out of network admissions. a) Collective Plan utilization must remain regular and consistent throughout the measurement year. b) Collective Medical will report usage data to Partnership HealthPlan confirming routine (month-by-month) utilization of the Collective Plan module via responsiveness to previously established alerts. 2. Capitated hospitals must submit timely* and accurate delegation deliverables to Partnership HealthPlan according to deadlines outlined in your hospital's delegation agreement in order to receive the full Hospital QIP incentive payment. Deliverables include timely and accurate reporting of 1) Utilization Program Structure and 2) delegation reporting requirements indicated in Exhibit A of your hospital's delegation agreement. Impact of this requirement is as follows: • Timely submitting > 90.0% of delegation reporting requirements results in 100% distribution of earned Hospital QIP incentive payment. • Timely submitting > 75.0% and < 90.0% of delegation reporting requirements results in a 10% cut from the earned Hospital QIP incentive payment. • Timely submitting < 75.0% of requirements results in a 20% cut from incentive	

1. Risk Adjusted Readmissions For assigned members 18 to 64 years of age the number of acute inpatient and observation stays during the measurement year that were followed by an unplanned acute readmission for any diagnosis within 30 days and the predicted probability of an acute readmission. • Full Points: <1.0 Full Points • Partial Points: ≥1.0 - 1.2	No Change.	
2. Palliative Care Capacity **Hospitals ≤ 99 beds**: • Hospital < 50 beds: One Physician Champion, one trained* Licensed Clinical Social Worker or trained* Licensed RN, NP, or PA, and availability of consultation with Palliative Care Physician • At least two trained* Licensed Clinician (RN, NP, or PA), and availability of consultation with a Palliative Care Physician **Hospitals > 100 beds:** • Require Palliative Care Quality Collaborative (PCQC) participation: • Report summarizing # of Palliative Care Consults per month • Rate of all consults who have completed Advance Directive • Rate of all consults who have a signed POLST on the chart	No Change.	
3. Hospital Quality Improvement Platform Participation (HQI)	**New Measure** Participation in the Hospital Quality Improvement Platform. The HQI Platform is available to all California Hospital Association members at no additional charge. This measure is broken into three parts; 1. Participation in HQI Platform (proof of participation due December 30, 2022) 2. Timely, consistent submission of data into HQI Platform (PHC will assess hospital usage June 30, 2023) 3. In order to participate in this measure, hospitals must sign a data sharing agreement with Partnership Healthplan to share summary data for scoring **Target**	Participation in this platform will allow PHC the visibility to see hospital-specific measure performance for network hospitals using validated hospital quality measures. Hospitals who sign up are encouraged to continue submitting data into the platform for the remainder of the year in order to achieve full points in the measure. The data submitted will then allow PCH more insight into improvement opportunities for partnering hospitals.

	• Partial Points = 5 points: Hospitals successfully sign up and submit at least one (1) data cycle into the Hospital Quality Improvement Platform by December 30, 2022. • Full Points = 10 points: Hospitals successfully sign up and submit at least one (1) data cycle into the Hospital Quality Improvement Platform by December 30, 2022 AND continue submitting data into the platform for the remainder of the measurement year (PHC assesses timely data submission June 30, 2023).	
4. Rate of Elective Delivery (Reporting via CMQCC) All hospitals with maternity services. Excluded for non-maternity hospitals. Percent of patients with newborn deliveries at ≥ 37 to < 39 weeks gestation completed, where the delivery was elective. • Full Points: ≤1.0% • Partial Points: >1.0% - 2.0%	No Change.	
5. Exclusive Breast Milk Feeding (Reporting via CMQCC) All hospitals with maternity services. Excluded for non-maternity hospitals. • Full Points: ≥75.0% • Partial Points: 70.0% - <75.0%	No Change.	
6. Nulliparous, Term, Singleton, Vertex (NTSV) Cesarean Birth Rate (Reporting via CMQCC) All hospitals with maternity services. Excluded for non-maternity hospitals. • Full Points: <21.7% • Partial Points: 22.0% - 23.6%	No Change.	

7. Vaginal Birth After C-Section (VBAC) **Large hospitals (> 50 general acute beds)** Percent of patients who had a previous cesarean delivery who deliver vaginally. • Full Points: ≥ 5.0% VBAC Uncomplicated • No partial points	No Change.	
8. CHPSO Patient Safety Organization Participation **Small Hospitals (<50 beds):** • Participation in at least 1 Safe Table Forum • Submission of 50 patient safety events to CHPSO **Large Hospitals (>50 beds):** • Participation in at least 4 Safe Table Forums • Submission of 100 patient safety events to CHPSO	No Change.	
9. Substance Use Disorder, Medication Assisted Treatment (MAT) PHC members stared on Medication Assisted Treatment (MAT) in the ED or Inpatient setting. PHC Members: • **Small Hospitals** < 50 Beds: > 5 PHC Members • **Large Hospitals** > 50 beds: > 10 PHC Members	No Change.	
10. Hepatitis B Vaccination/CAIR Utilization All hospitals with maternity services. Excluded for non-maternity hospitals. **Target Option 1**: **Full Points**: ≥ 20% **Partial Points**: 10-20% Hospital providing maternity services	Partnership will be asking hospitals to provide their CAIR reports at end of measurement year (June 30, 2022) rather than sourcing data from within.	Each year HQIP team receives feedback from the hospitals that the CAIR reports they can access and the reports generated from within PHC differ. Health Analytics has confirmed that this issue could be due to variances in member names when entered into CAIR system vs. PHC system.

• Numerator: # of newborn Hepatitis B vaccinations documented in CAIR • Denominator: newborn hospital births occurring between July 1, 2021 – June 30, 2022 **Target Option 2**: **Full Points:** > 1.20 **Partial Points**: 0.20-1.20 Option 2: Hospital *not providing* maternity services • Numerator: # of vaccines documented in CAIR from July 1, 2021 - June 30, 2022 • Denominator # of licensed acute inpatient beds		
11. Quality Improvement Capacity **Small hospitals (< 50 beds)**: • Full points for attending the Hospital Quality Symposium in 2022 **Large Hospitals (> 50 beds)**: • Full points for attending the Hospital Quality Symposium in 2022	No Change.	
12. Cal Hospital Compare-Patient Experience **Full Points**: Hospital aggregate score is greater than average California hospital score (via CMS reporting) 0.95 = 10 points. No partial points are available for this measure.	PHC will request that hospitals submit the same data on patient experience to PHC that they submit to CMS.	Current data capture period on CMS reflects January 1, 2019 – December 31, 2019. HQIP hopes to get more current patient experience data to incentivize for hospital performance.
13. Health Equity All Hospitals • Hospitals will submit a project based on Health Equity. At the beginning of the measurement year we will request providers to submit an outline of their project that we will review and approve or reject. • Project requirements include how best practices apply to internal domains such as. Admissions, Assessment, Treatment, Discharge and Transfers. Completion and results of the project are also required.	**Health Equity – Identification of Healthcare Translation & Interpretive Services** All Hospitals • Pay-for-Reporting measure design intended to identify healthcare Translation and Interpretation services being used by hospitals • Will include template requesting the following data points from hospitals as is reflected throughout the measurement year: ○ Name of translation/interpretation service used by hospital ○ Number of in-house certified staff translators/interpreters ○ Organization individuals are certified through ○ Contracted translation/interpretation service type (video/telephonic/other)	Measure was based on a two year reporting structure (2020-21 and 2021-22) in which Health Equity project plan was submitted to HQIP team (20-21MY) and proof of execution of submitted plan is due no later than the end of 21-22MY. Overhauling Health equity Measure as a pay-for-reporting measure for 22-23MY to focus on language barriers faced by PHC members and ensure adequate translation

	○ Total hours of all translation/interpretation services ○ Number of unique patients for whom translation/interpretation services were used ○ Average duration of translation/interpretation service time per patient/usage ○ Unique languages identified for translation/interpretation services ○ Type of clinical action translation/interpretation services are primarily used for • Requirement of report submission accounting for usage data on all translation/interpretation services to include: social service, admission, dietary, clergy, radiology and pharmacy, etc.	services are offered by participating hospitals.
14. Sexual Orientation/Gender Identity (SOGI) All Hospitals In 2020-21 measurement year, providers submitted a SO/GI EHR Implementation plan. Providers were to start this plan on July 1, 2021, and complete all steps noted in their previously submitted implementation plan by June 30, 2022. Demonstration of implemented plan (screen capture of updated EHR system) is required for full points in 2021-22 measurement year. No partial points.	Propose to remove.	Measure was based on a two year reporting structure (2020-21 and 2021-22) in which Sexual Orientation/Gender Identity (SO/GI) specific questions were implemented into existing EHR systems and proof of implementation is required no later than June 30, 2022. Future SO/GI efforts will fall under the broader “Health Equity” umbrella.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
3.7

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
PHC Staff

Topic Description:
Commissioner Jed Rudd, Health Center Representative for Humboldt County has resigned.

Reason for Resolution:
To provide Commissioner Rudd with commendations and appreciation for his excellent service.

Financial Impact:
There is no financial impact to the HealthPlan.

Requested Action of the Board:
Based on the recommendation of PHC staff, the Board is asked to approve appreciation for the support Commissioner Jed Rudd has provided to PHC and the Board.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 22, 2022

Agenda Item Number:
3.7

Resolution Number:
22-

IN THE MATTER OF: COMMENDATIONS AND APPRECIATION FOR JED RUDD'S SERVICE TO PHC AND THE BOARD

Recital: Whereas,

A. Jed Rudd provided valuable advice and support for PHC and the Board.

B. Jed Rudd was a faithful and active member of the Board.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the highest level of commendations and appreciation for Commissioner Rudd's outstanding service to PHC and the Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 22nd day of June 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: June 15, 2022
Board Meeting Date: June 22, 2022

Agenda Item Number:
4.1

Resolution Sponsor:
Liz Gibboney, CEO, Partnership HealthPlan of CA

Recommendation by:
Finance Committee & PHC Staff

Topic Description:
On April 27, 2022, the Board approved Budget Assumptions for FY 2022-2023 and directed staff to prepare a full operational budget. On May 18, 2022, the Finance Committee approved the Preliminary Health Care Budget for FY 2022-2023, so a final Budget could be prepared.

Reason for Resolution:
To give the Board the opportunity to review and approve the final Budget for FY 2022-2023 that includes PHC's core business: administration, health care, capital and updated assumptions for review and approval.

Financial Impact:
The impact to the HealthPlan is implicit in the budget.

Requested Action of the Board:
Based on the recommendation of the Finance Committee and PHC Staff, the Board is asked to approve the final budget for FY 2022-2023.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: June 15, 2022
Board Meeting Date: June 22, 2022

Agenda Item Number:
4.1

Resolution Number:
22-

IN THE MATTER OF: APPROVING THE FINAL BUDGET FOR FY 2022-2023

Recital: Whereas,

A. The Board has responsibility for establishing budget policy and specific budget approval.

B. In prior meetings, PHC staff, the Finance Committee and Board provided direction and input.

C. The final Budget conforms to general assumptions established.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To obtain approval for the final Budget for FY 2022-2023.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 22nd day of June, 2022 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Alicia Hardy, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

FY 2022-23

Annual Operating & Capital Budget

June 2022

Table of Contents

Introduction

The next phase of the PHC budget process is to present the 2022-23 Operating & Capital Budget to the Finance Committee and Board of Directors for final consideration and approval. PHC Staff has consolidated the prior components of the budget into one comprehensive summary. A version history has been provided at the conclusion of this report to walk between the healthcare assumptions presented in May 2022 and the final healthcare costs presented below.

Outlook for 2022-23

Although the COVID-19 pandemic impacts have softened on the delivery system, the emergency response continues to have a significant impact on our financial planning efforts. The continuation, and unknown end, of the public health emergency (PHE) remains to be the largest variable to the Plan's finances. More specifically, the pause in redeterminations steadily increased the plans membership since the start of the pandemic impacting revenue, rate development, non-operating income and health care trends. The resumption of the redeterminations will likely have an unknown gradual impact as the Counties work through their respective eligibility back-logs. The unknowns in membership have material impacts to our revenue rates as Mercer bases overall reimbursement on underlying membership assumptions. PHC will eventually receive updated rates with an expected delivery of November 2022 for CY 2023 and Q1 2023 for CY 2022.

Due to the materiality of the impacts relating to the PHE, Staff may need to complete an off-cycle budget during the upcoming fiscal year.

Membership

PHC's membership has experienced consistent month-over-month growth since March 2020, which is almost completely a result of the PHE declaration. The freeze of member redeterminations has steadily increased the membership by means of limiting the terms managed care organizations would have experienced under normal circumstances. The chart below illustrates, by county, the growth trends along with the overall point in time increases for PHC's membership.

PHC Membership as of 4/1/2022

County	T3M	T6M	T10M	Apr '22 vs Mar '20	# of MM
Solano	0.7%	0.7%	0.6%	25.3%	26,296
Sonoma	0.5%	0.5%	0.5%	21.8%	22,050
Shasta	0.4%	0.3%	0.4%	19.9%	11,430
Yolo	0.4%	0.7%	0.6%	20.3%	9,973
Marin	0.6%	0.5%	0.6%	25.0%	9,252
Humboldt	0.4%	0.4%	0.4%	15.9%	8,218
Napa	0.4%	0.4%	0.4%	20.7%	5,684
Mendocino	0.4%	0.3%	0.3%	16.3%	5,627
Lake	0.3%	0.3%	0.3%	15.8%	4,640
Siskiyou	0.1%	0.1%	0.2%	14.2%	2,379
Lassen	0.6%	0.6%	0.6%	20.6%	1,468
Del Norte	0.3%	0.2%	0.2%	11.4%	1,268
Trinity	0.6%	0.5%	0.5%	29.0%	1,221
Modoc	0.7%	0.5%	0.5%	22.1%	719
Total	**0.5%**	**0.5%**	**0.5%**	**20.7%**	**110,225**
	Trailing # Month average month-to-month increase			**Point-in-time comparison, % Δ and # of members**	

Overall, PHC has increased membership by roughly 110,000 members. It is also evident that the growth trends have leveled off as most of the counties trailing averages are relatively flat. The trailing 10-month average (T10M) of 0.5% is down from 0.9% this time last year. The net member increases have been primarily in the Family (Child & Adult) and Medi-Cal expansion (MCE) aid categories; which is fitting as these are the members that are most likely to move in and out of Medi-Cal as life circumstances change. PHC's overall long term care (LTC) counts have decreased, which is a result of COVID related impacts.

Membership will continue to slowly grow until the PHE has officially ended and redeterminations are resumed. Each of PHC's fourteen counties will have twelve months to systematically work through all enrolled members to determine Medi-Cal eligibility. There will be a substantial amount of ineligible members, reversing the month-over-month gains at an unknown rate. Like prior years, PHC picked a more aggressive attrition rate to ensure the overall budget does not include an unrealistic revenue target. This provides inherent upside if the membership counts remain higher than estimated, relieving margin pressures.

Revenue

PHC budgeted overall revenues at $3.0 billion for a year-over-year decrease of ($156.9) million. The budget utilized modified CY 2022 draft rates received from DHCS and estimated CY 2023 rates for the latter half of the upcoming fiscal year. DHCS communicated on June 8, 2022 that final CY 2023 rates will

be delivered to plans in November 2022 while CY 2022 rates be delivered sometime in Q1 2023. Although the release dates seem to be written in error, the complications around prospective rate setting and the delayed conclusion of the public health emergency have created a unique circumstance that requires the misalignment of delivering rate packages.

Medi-Cal Base Capitation

2022-23: $3.0 billion | 2021-22 △: ($152.2) million or (4.9%)

The Medi-Cal Base Capitation includes offsetting variances driven by base revenue, membership trends, and other supplemental revenues. The CY 2022 base rates, though estimated, contain a material component change that drives most of the year-over-year decrease. The pharmacy carve-out, effective January 1, 2022, represents a decrease north of ($180.0) million in base capitation. Additionally, proposition 56 (Prop 56) revenue is decreasing ($16.5) million due to reduced reimbursement for existing programs in addition to the elimination of the VBP program. Offsetting these reductions are increases tied to supplemental payments, which have historically been difficult to estimate due to the fluctuations in utilization.

Interest & Other Income

2022-23: $14.0 million | 2021-22 △: ($4.7) million or (25.2%)

Other Revenue includes interest income, tenant revenue and grant revenue (when applicable). In the current fiscal year, the State offered a Behavioral Health Incentive (BHI) program to the Plan's providers where the Plan is responsible for managing the related program grant funds. The current year includes $6 million in BHI grant revenue that is offset in other health care costs within health care investment category.

Health Care Expenses

As stated in our budget assumptions, the COVID-19 impacts to the delivery network began to subside following the Omicron wave. Underlying utilization is returning to pre-COVID patterns, though, Staff will remain cautious for a surge in claims related to the rumored pent-up demand related to the stay-at-home orders that were implemented in the first half of the PHE. PHC has applied a blended per member per month (PMPM) method to construct the health care expense budget. Utilizing the Plan's historical claims experience for all counties with dates of service ranging from January 2019 through January 2022, smoothing irregular trends using seasonal experience. State-mandated increases were assumed to remain in place until December 31, 2022, which is Staff's estimated conclusion of the PHE. In addition, the increased base membership caused by the pause in redeterminations has yielded material increases in capitation expenses and fee-for-service utilization, present in all of the cost categories. Information surfacing after June 2022, will be evaluated and material impacts not covered as part of the flex budget process will need to be incorporated in a full budget refresh.

The health care budget assumes an overall expense of $2.77 billion, which is ($134.6) million, or (4.6%), less than the forecasted 2021-22 spend. Considerations and estimates by cost category are presented in more detail, below.

Global Sub-Capitation & Capitated Medical Groups

2022-23: $241.9 million | 2021-22 △: ($32.4) million or (11.8%)

The first pass of the health care budget assumes minimal year-to-year changes for provider capitation rates. The pharmacy carve-out will be incorporated in the CY 2022 rates and beyond for PHC's global sub-capitation provider, driving much of the year-over-year decrease in expense. The resumption of the redetermination process, assumed in January 2023, will decrease the global sub-capitation expense further by $6.0 million compared to the 2021-22 Forecast. Capitated medical groups will continue to have variability tied to overall plan enrollment. Variances tied to membership will be accounted for as part of the flex budget process. Similar to prior years, contract negotiations pose a risk of increased cost pressures if PHC is unable to keep rates at their current levels.

Physician Services

2022-23: $507.5 million | 2021-22 △: $22.7 million or 4.7%

Physician Services line item includes Prop 56, specialty capitation, primary capitation, and physician fee-for-service expenses. Adjustments to various Prop 56 programs, which includes rate reductions and the elimination of the VBP program, are driving the bulk of the decreases from the prior year. Fee-for-service expenses are expected to increase slightly as part of an allocation adjustment.

Inpatient Hospital

2022-23: $958.3 million | 2021-22 △: $85.3 million or 9.8%

The Inpatient Hospital line item includes inpatient fee-for-service, hospital capitation, and stop loss expenses. DHCS continues to apply downward pressure to PHC's inpatient reimbursement due to the cost per unit's outlier status relative to other managed care plans. Given the current macro-economic conditions, Staff expects to receive strong provider pressure to increase rates to offset ongoing inflation and employment concerns. The cost pressures combined with the release of IBNR in the 2021-22 FY will yield an increase in Inpatient Hospital expenses year-to-year. Staff will continue to evaluate hospital contracts relative to revenue and if DHCS continues to reimburse at levels lower than cost, PHC will need to continue to maintain current reimbursement levels.

Long Term Care

2022-23: $381.7 million | 2021-22 △: ($11.6) million or (3.0%)

As explained in prior year budget cycles, the Long Term Care (LTC) expense category is difficult to budget due to the timing and complexity of periodic DHCS rate releases. The rates are often released months after their effective date, requiring PHC Staff to complete in-depth analysis to calculate and correct prior payments. COVID-19 brought a new layer with a 10% mandatory increase to help support the added burden for many facilities. These increases were implemented in March of 2020 and will continue through end of the PHE, now estimated to be December 2022. The overall decrease of $11.6 million in LTC spend is primarily due to the upcoming fiscal year only including 6 months of the 10% add-on. In addition, PHC has recognized a negative utilization trend over the course of the pandemic, likely due to the disproportionate impact COVID-19 has had on these vulnerable populations. There could be additional pandemic impacts related to behavioral changes as members will likely be hesitant to enter congregate living settings.

Pharmacy

2022-23: $ - | 2021-22 △: ($183.6) million or (100.0%)

The large reduction of $183.6 million is directly tied to the State's pharmacy carve-out from managed care plans, which was effective January 1, 2022. Pharmacy expenses related to inpatient and physician services will be budgeted and reported within their respective categories. Aside from the potential prior period corrections or the unlikely event of claims runout, this category should not include material expenses for the upcoming fiscal year.

Ancillary Services

2022-23: $475.7 million | 2021-22 △: ($9.5) million or (2.0%)

Ancillary Services is comprised of fee-for-service and capitated ancillary services. The budget assumes a decrease of ($9.5) million tied to fee-for-service allocation adjustments along with IBNR releases within FY 2021-22. PHC faces additional pressure from hospitals for emergency department and outpatient services. Additionally, utilization for outpatient mental health services and BHT has increased substantially since the start of the pandemic.

Other Medical

2022-23: $123.2 million | 2021-22 △: ($4.1) million or (3.3%)

The Other Medical category includes transportation, quality assurance, health care investment fund (HCIF), nurse advice line, and Health Insurance Premium Payments (HIPP). The year-to-year net decrease is primarily due to a change in the HCIF that included the development of new grants in the prior year and the conclusion of certain strategic use of reserve initiatives. This is offset by increases in quality assurance where costs are expected to increase in support of CalAim and health equity initiatives mandated by the State. Additionally, transportation expenses are expected to increase with the steady increase in membership and overall upward trend in utilization.

Quality Improvement Programs (Incentives)

2022-23: $80.2 million | 2021-22 △: ($1.3) million or (1.5%)

PHC plans to budget incentives flat year-to-year due to the assumed resumption of redeterminations. FY 2021-22 saw an increase in budget to account for overall membership growth tied to pandemic impacts. Incentive funding is subject to final revenue projections when revised rates from DHCS are received. There is some budgetary risk involved in estimating the exact overall payment levels, which is dependent on the actual performance of participating providers. COVID-19 introduced its own level of complexity with major disruptions to normal day-to-day activities for measurement years 2020 and 2021. Staff will continue to use historical performance along with more recent leading indicators to predict the estimated payout of all programs. Budget funding may shift between programs as each QIP has its own set of participants, guidelines, and performance.

Administrative Expense

Overall administrative spend is estimated to be $166.9 million which is an increase to the prior year's forecast of $30.0 million or 21.9 percent. The increase in administrative spending is driven by a number of factors including investments in IT infrastructure, the delay of the core system implementation, depreciation tied to completed capital projects, transportation initiatives, and numerous investments that will be made in response to planned DHCS requirements and initiatives.

Historically, the Plan has been able to operate at or below an administrative expense ratio (admin ratio) of 5.0 percent. However, changes to benefit offerings and healthcare financing requires a rebasing to the historical "sub-5.0 percent" goal for all managed care plans within California.

The removal of the pharmacy benefit yielded a significant reduction in revenue, as referenced above. This reduction of revenue inherently increases the admin ratio as the denominator decreases disproportionately to the numerator. Conversely, directed payments that have historically been treated as pass-through payments will now be recognized in top line revenue. These programs, by design, historically posed no risk to the health plan and were handled as a balance sheet item only. As required by CMS, DHCS has restructured the programs to be "at-risk" and will be treated as such in the upcoming fiscal year. The inclusion of the revenue materially increases the numerator with no direct impact to the denominator.

In the spirit of transparency, PHC is presenting the admin ratio with and without the directed payment revenue. The Plan has budgeted an admin ratio of 5.6 percent excluding directed payments, but could be as low as 4.9 percent with the inclusion. The targeted investments in talent and infrastructure will ensure PHC adequately enhances infrastructure, successfully implements a new core system, and prepares itself to execute lofty DHCS initiatives all while remaining financially prudent relative to sister plans.

Workforce

As noted below, during the current fiscal year a number of budgeted positions remained unfilled due to COVID restrictions and a tight labor market. With the return to office and the opportunity to increase recruitment efforts, the expectation is that many of the positions will be filled. Additionally, as mentioned earlier, the Plan will expand its overall staffing to meet infrastructure needs and to accommodate growing DHCS initiatives.

Employee

2022-23: $105.1 million | 2021-22 △: $16.5 million or 18.6%

Many positions remained open and unfilled throughout the current fiscal year primarily as a result of an increasingly tight labor market. The increase from the prior year's forecast is primarily due to the expectation that many of the unfilled positions will be hired as well as the addition of a number of new positions needed to meet a significant increase in DHCS program requirements. During the current fiscal year, a mid-year 4% COLA was issued to all staff in an effort to help address inflationary issues currently greater than 8%. The effects of this increase will be reflected in fiscal year 2022-2023 for a full year. Also contributing to the fiscal year 2022-23 increase is a projected 4% increase for a combined COLA and merit and an assumed average 12% increase to employee medical, dental and vision benefits. No new employee benefits are projected for fiscal year 2022-23.

Occupancy

2022-23: $18.4 million | 2021-22 △: $5.1 million or 38.3%

Increases in Occupancy costs are expected from tenant improvements and additional depreciation costs from new capital purchases, including the implementation of the new claims processing system expecting to occur in the latter half of the fiscal year.

Operational

2022-23: $5.7 million | 2021-22 △: $2.8 million or 95.3%

Operating costs are comprised of general office supplies, printing, and postage. Increases in Operational costs are expected from additional printing and mailings for the redetermination outreach and other member engagement efforts.

Professional Services

2022-23: $19.7 million | 2021-22 △: ($1.0) million or (4.8%)

Professional Services primarily includes outside services such as consultants, contracted claims processing, and other third party processing vendors. An overall decrease in Professional Services is expected from the removal of processing costs from the pharmacy carve out and also from the system disruption that occurred in the prior year.

Computer & Data

2022-23: $17.3 million | 2021-22 △: $6.3 million or 56.7%

Several planned hardware, software, and data processing purchases in IT and other departments were postponed in the previous year and are expected to occur in the upcoming year. Additional Computer & Data costs are expected from licensing costs relating to the new claims processing system as well as other new software implementation.

Profit & Loss Statement

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

Annual Capital & Operating Budget

	2022-23 Annual Budget	2021-22 8+4 Forecast	$ VARIANCE	Budget PMPM	Forecast PMPM
Total Membership	**626,550**	**622,188**	**4,362**		
Total Member Months	**7,837,575**	**7,539,131**	**298,444**		
REVENUE					
State Capitation Revenue	2,971,352,017	3,123,581,299	(152,229,282)	379.12	414.32
Interest Income	1,173,374	747,192	426,182	0.15	0.10
Other Revenue	12,843,078	17,978,821	(5,135,743)	1.64	2.38
TOTAL REVENUE	**2,985,368,469**	**3,142,307,312**	**(156,938,843)**	**380.90**	**416.80**
HEALTHCARE COSTS					
Global Subcapitation	213,627,434	246,199,453	32,572,019	27.26	32.66
Capitated Medical Groups	28,281,819	28,138,138	(143,681)	3.61	3.73
Physician Services					
PCP Capitation	72,225,534	72,616,019	390,485	9.22	9.63
Specialty Capitation	2,708,597	2,428,636	(279,961)	0.35	0.32
Non-Capitated Physician Services	432,565,210	409,801,827	(22,763,383)	55.19	54.36
Total Physician Services	**507,499,341**	**484,846,482**	**(22,652,859)**	**64.75**	**64.31**
Inpatient Hospital					
Hospital Capitation	206,786,902	206,441,870	(345,032)	26.38	27.38
Inpatient Hospital - FFS	736,296,936	664,566,965	(71,729,971)	93.94	88.15
Hospital Stoploss	15,216,734	2,000,939	(13,215,795)	1.94	0.27
Total Inpatient Hospital	**958,300,572**	**873,009,774**	**(85,290,798)**	**122.27**	**115.80**
Long Term Care	381,730,849	393,345,302	11,614,453	48.71	52.17
Pharmacy	-	183,588,912	183,588,912	-	24.35
Ancillary Services					
Ancillary Services - Capitated	11,314,230	11,505,840	191,610	1.44	1.53
Ancillary Services - Non-Capitated	464,399,123	473,733,564	9,334,441	59.25	62.84
Total Ancillary Services	**475,713,353**	**485,239,404**	**9,526,051**	**60.70**	**64.36**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

Annual Capital & Operating Budget

	2022-23 Annual Budget	2021-22 8+4 Forecast	$ VARIANCE	Budget PMPM	Forecast PMPM
Other Medical					
Quality Assurance	35,329,680	28,004,053	(7,325,627)	4.51	3.71
Healthcare Investment Funds	14,213,000	32,951,247	18,738,247	1.81	4.37
Advice Nurse	1,376,000	1,116,967	(259,033)	0.18	0.15
HIPP Payments	100,000	68,878	(31,122)	0.01	0.01
Transportation	72,223,864	65,245,272	(6,978,592)	9.22	8.65
Total Other Medical	**123,242,544**	**127,386,417**	**4,143,873**	**15.72**	**16.90**
Quality Improvement Programs	80,186,040	81,446,030	1,259,990	10.23	10.80
TOTAL HEALTHCARE COSTS	**2,768,581,952**	**2,903,199,911**	**134,617,959**	**353.24**	**385.08**
ADMINISTRATIVE COSTS					
Employee	105,103,520	88,644,764	(16,458,756)	13.41	11.76
Travel And Meals	619,751	210,675	(409,076)	0.08	0.03
Occupancy	18,351,326	13,270,437	(5,080,889)	2.34	1.76
Operational	5,747,944	2,942,984	(2,804,960)	0.73	0.39
Professional Services	19,744,544	20,731,348	986,804	2.52	2.75
Computer And Data	17,284,150	11,028,897	(6,255,253)	2.21	1.46
TOTAL ADMINISTRATIVE COST	**166,851,234**	**136,829,105**	**(30,022,129)**	**21.29**	**18.15**
Medi-Cal Managed Care Tax	-	-	-	-	-
Surplus / (Deficit)	**49,935,283**	**102,278,296**	**(52,343,013)**	**6.37**	**13.57**

Fund Balance

Board Designated Reserves (BDR) are calculated according to policy: 60 days of operating expenses. An additional amount equivalent to one-third of the BDR has been set aside for County Expansion. Also of note is the Strategic use of Reserves (SUR) that was previously approved but not yet incurred. PHC, through Board approval, created the SUR initiatives and over the years has been able to utilize a substantial amount of reserves in a manner that increased member access, provider reimbursement, and improved overall operational efficiency; PHC will continue to utilize the funds as approved. The remaining SUR balance is primarily comprised of funds set aside for the Drug Medi-Cal Program, quality initiatives and capital investments. The total fund balance – including the County Expansion amount, the final SUR amount, and the projected Board Designated amount – for the year ending June 30, 2023 is estimated at $802.8 million.

Partnership Healthplan of California

Fiscal Year 2022/23 Fund Balance Analysis

Projected through June 2023

Fund Balance Analysis / TNE

Fund Balance at 4/30/2022		766,955,361
Actual Year to Date Surplus (Deficit) at 4/30/2022	116,324,498	
Projected Year to Date Surplus (Deficit) at 6/30/2022	102,278,296	
Projected Surplus (Deficit) for May - June 2022		(14,046,202)
Projected Fund Balance at 06/30/2022		**752,909,159**
Projected Surplus (Deficit) for FY 2022/23		49,935,283
Estimated Fund Balance at 06/30/2023		**802,844,442**
Estimated Fund Balance Allocated at 06/30/2023		
Reserve Fund-Board Designated		373,691,000
Reserve Fund-Board Designated-Capital Assets		130,787,000
Reserve Fund-County Expansion		168,159,000
Reserve Fund-Strategic Use Of Reserve		70,773,000
Reserve For Restricted Fund-Knox-Keene		300,000
Unrestricted		59,134,442
Estimated Fund Balance at 06/30/2023		**802,844,442**

Capital Projects

As part of developing the capital budget, each of the projects were evaluated based on the current economic conditions along with the strategic goals and priorities of the organization. Due to delays caused by COVID-19 and other unforeseen circumstances, certain projects that were approved in the 2021-22 budget were either not started or were started and not completed during the fiscal year as originally planned. These projects have been included, below and indicated with (**), for 2022-23 budget consideration.

The capital budget for Facilities includes expenditures for building improvements, maintenance of the facilities, safety, business continuity, and tenant improvements for vacant spaces expected to be leased in fiscal year 2023.

The capital budget for Information Technology includes expenditures intended to enhance system security, improve efficiency and data storage for general operations, and provide support for the core system implementation (Project Phoenix). Phoenix has been delayed due to the system disruption suffered by PHC in March of 2022, requiring additional costs of $2,502,000. Purchases related to the core system implementation will continue to be recorded as a capital project in progress until the year the system is fully implemented, in which case depreciation begins. Staff are currently evaluating the impacts of the system disruption and determining an appropriate revised official implementation date.

A summary of capital expenditures by department and region is list below:

SUMMARY OF CAPITAL BUDGET				
DEPARTMENT	REGION	CHANGE IN ESTIMATED PURCHASE	COST (Approved in Prior Fiscal Years)	TOTAL ESTIMATED PURCHASE COST
Facilities	Northern	$ 778,000	$ 658,000	$ 1,436,000
	Southern	2,125,447	6,765,970	8,891,417
Total Facilities Purchase Cost FY 2022-23		**2,903,447**	**7,423,970**	**10,327,417**
Information Technology	Northern	130,000	-0-	130,000
	Southern	9,152,000	1,230,000	10,382,000
	Phoenix	4,327,000	35,217,164	39,544,164
Total Information Technology Purchase Cost FY 2022-23		**13,609,000**	**36,447,164**	**50,056,164**
Total Purchase Cost FY 2022-23		**$ 16,512,447**	**$ 43,871,134**	**$ 60,383,581**

DETAIL FACILITIES CAPITAL BUDGET						
DEPARTMENT	REGION	Carryover	BUDGET ITEM DESCRIPTION	NEW OR CHANGE IN ESTIMATED PURCHASE COST	CARRYOVER COST (Approved in Prior Fiscal Years)	TOTAL ESTIMATED PURCHASE COST
Facilities	Northern	**	Airpark Office: Tenant Improvements	$ 290,000	$ 460,000	$ 750,000
		**	Airpark Office: Infrastructure Investments	232,000	156,000	388,000
			Avtech Office: Infrastructure Investments	$ 64,000	$ -	$ 64,000
			Eureka Office: Infrastructure Investments	90,000	-	90,000
		**	New Vehicles (3)	$ 102,000	$ 42,000	$ 144,000
Total Northern Facilities Purchase Cost FY 2022-23				**$ 778,000**	**$ 658,000**	**$ 1,436,000**

DETAIL FACILITIES CAPITAL BUDGET (CONTINUED)						
DEPARTMENT	REGION	Carryover	BUDGET ITEM DESCRIPTION	CHANGE IN ESTIMATED PURCHASE COST	CARRYOVER COST (Approved in Prior Fiscal Years)	TOTAL ESTIMATED PURCHASE COST
Facilities	Southern	**	Building 4605: Tenant Improvements	$ 420,000	$ 2,800,000	$ 3,220,000
		**	Building 4605: Infrastructure Investments	112,350	749,000	861,350
		**	Building 4665: Infrastructure Investments	499,511	790,770	1,290,281
		**	Building 4820: Tenant Improvements	708,281	1,235,000	1,943,281
		**	Building 4820: Infrastructure Investments	356,985	1,002,400	1,359,385
		**	Santa Rosa Office: Infrastructure Investments	28,320	188,800	217,120
Total Southern Facilities Purchase Cost FY 2022-23				**$ 2,125,447**	**$ 6,765,970**	**$ 8,891,417**

DETAIL INFORMATION TECHNOLGY CAPITAL BUDGET						
DEPARTMENT	REGION	Carryover	BUDGET ITEM DESCRIPTION	NEW OR CHANGE IN ESTIMATED PURCHASE COST	CARRYOVER COST (Approved in Prior Fiscal Years)	TOTAL ESTIMATED PURCHASE COST
Information Technology	Northern		Infrastructure Enhancements	$ 130,000	$ -0-	$ 130,000
	Southern	**	Annual Maintenance/renewals/upgrades	$ 3,520,000	$ 430,000	$ 3,950,000
		**	System/Software Enhancements	5,382,000	800,000	6,182,000
			Citrix VDI/UX Monitoring Solution	250,000	-0-	250,000
			Phoenix Project	$ 4,327,000	$ 35,217,164	$ 39,544,164
Total Information Technology Purchase Cost FY 2022-23				**$ 13,609,000**	**$ 36,447,164**	**$ 50,056,164**

Version History

This table was created for Committee Members to quickly review changes between the preliminary healthcare budget presented in May '22 and the final budget presented above.

	FY 2022-23		Version △		
Health Care Categories	**Final Draft**	**HCC Assumptions**	**$**	**%**	**Notes**
Global Subcapitation & Capitated Medical Group	$241,909,253	$235,049,678	$6,859,575	2.9%	Updated Capitation to reflect membership trends. Increase is tied to delayed start of membership redetermination from January 2023 to April 2023.
Inpatient Hospital	$958,300,571	$957,800,170	$500,402	0.1%	Slight adjustment to account for current Inpatient trends, immaterial to overall surplus.
Physician Services	$507,499,341	$470,217,033	$37,282,308	7.9%	Increase in American Indian Health Service expense to reflect current trends and higher reimbursement rate.
Long Term Care	$381,730,849	$381,308,096	$422,753	0.1%	Slight increase, immaterial to overall surplus
Pharmacy	$0	$0	$0	0.0%	No changes.
Ancillary Services	$475,713,353	$468,434,596	$7,278,757	1.6%	Increased mental health services cost to reflect current trends .
Other Medical	$123,242,544	$99,980,759	$23,261,785	23.3%	Increased transportation to account for higher fuel costs along with increases to Quality Assurance due to higher projected employee cost.
Quality Improvement Programs	$80,186,040	$80,186,040	$0	0.0%	No changes.
Total Health Care Expense	**$2,768,581,951**	**$2,692,976,371**	**$75,605,580**	**2.8%**	

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan Of California
For the Period Ending April 30, 2022

Financial Analysis for the Current Period

Total (Deficit) Surplus

For the month ending April 30, 2022, PHC reported a net deficit of $18.0 million, reducing the year-to- date surplus to $116.3 million. Significant variances are explained below.

Revenue

Total Revenue is lower than budget by $41.7 million for the month and greater than budget by $49.2 million for the year-to-date. The unfavorable variance for the month is due to a $58.5 million retroactive adjustment to CY 2022 revenue in anticipation of DHCS rate decreases in the upcoming rate schedule update. The favorable year-to-date variance is primarily related to CY 2021 favorability related to COVID-19 impacts along with considerations for the delay in the pharmacy carve-out. Also contributing to the favorable variance are prior period adjustments for maternity kick and Indian Health Service programs, both of which have offsets in healthcare costs. Additionally, Other Revenue includes year-to-date revenue of $8.2 million for the Behavioral Health Integration (BHI) Incentive Program and $4.7 million for the COVID-19 vaccine incentive; corresponding expenses are being recorded in Healthcare Investment Funds.

Healthcare Costs

Total Healthcare Costs are lower than budget by $9.5 million for the month and $45.9 million for the year-to-date. Long Term Care and Inpatient Hospital FFS are collectively $54.6 million favorable for the year-to-date due to prior period IBNR adjustments and lower than budgeted expenses. Hospital Stop- Loss is $18.6 million favorable year-to-date due primarily to FY 2019-20 stop-loss expense true-up and lower than budgeted stop-loss expenses for FY 2021-22. Physician and Ancillary expenses are $14.3 million favorable for the year-to-date due to prior period IBNR adjustments. PCP, ancillary, and hospital capitation expenses are collectively $6.2 million favorable for the year-to-date due to lower than budgeted expenses. Transportation expense is $16.7 million unfavorable year-to-date due to higher than anticipated utilization specific to drug rehabilitation trips and specialty visits. Pharmacy expenses are $4.7 million unfavorable year-to-date due to higher than budgeted cost and unbudgeted true-up of prior year pharmacy expense for Kaiser's whole child model population. Healthcare Investment Funds expenses are $5.1 million unfavorable year-to-date due to unbudgeted BHI Incentive Program and COVID-19 vaccine incentive expenses, offsets mentioned in revenue above. Global Subcapitation is $26.6 million unfavorable year-to-date due to unbudgeted prior period expense true-ups for maternity kick, higher than budgeted global subcap rates for CY 2022, adult age band catch-up accrual, and CY 2021 rate updates.

Administrative Costs

Total administrative costs are lower than budget by $2.5 million for the month and $10.4 million for the year-to-date. This positive variance continues to primarily be in Employee expenses due to the greater number of open positions than originally anticipated. Lower depreciation costs and building repairs and maintenance, which contribute to the positive variance in Occupancy, continues to be attributed to the planned capital and IT projects that have yet to take place.

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan Of California
For the Period Ending April 30, 2022

Balance Sheet

Total Cash & Cash Equivalents decreased by $125.8 million for the month. $278.9 million in State Capitation payments and $1.2 million in Drug Medi-Cal payments were received during the month; in addition, $6.1 million in transfers between cash and Board Designated Reserves were recorded during the month. These payments were offset by $211.4 million in healthcare cost payments, $2.6 million in Drug Medi-Cal payments, $141.5 million in directed payment disbursements, $41.6 million in MCO quarterly tax payments, and $15.1 million in administrative and capital costs. The remaining difference can be attributed to interest and other revenues.

General Statistics

Membership

Membership had a total net increase of 6,483 members for the month.

Utilization Metrics and High Dollar Case

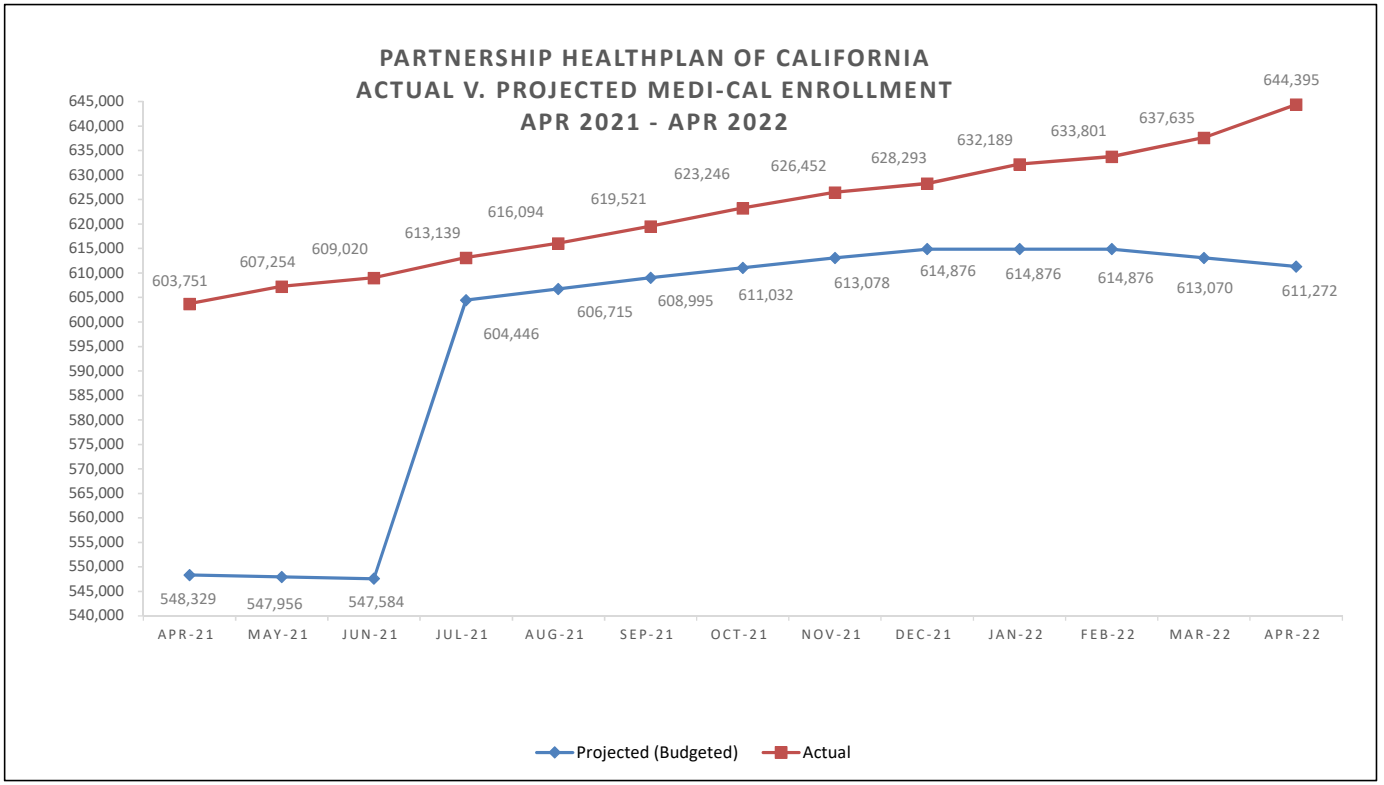
For the fiscal year 2021/22 through April 30, 2022, 377 members reached the $250,000 threshold with an average cost of $457,485. For fiscal year 2020/21, 510 members reached the $250,000 threshold with an average cost per case was $491,243. For fiscal year 2019/20, 443 members reached the $250,000 threshold with an average claims cost of $484,885.

Current Ratio/Required Reserves

Current Ratio Including Required Reserves	**1.79**
Current Ratio Excluding Required Reserves:	**1.26**
Required Reserves:	**$543,390,579**
Total Fund Balance:	**$766,955,361**

Days of Cash on Hand

Including Required Reserves:	**119.58**
Excluding Required Reserves:	**77.24**



Member Months by County:

County	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Solano	119,971	120,604	120,997	121,963	122,560	123,349	124,247	125,202	125,748	126,876	127,721	128,602	130,389
Napa	31,144	31,392	31,532	31,637	31,786	31,879	31,874	32,186	32,223	32,566	32,447	32,696	33,096
Yolo	55,239	55,646	55,623	56,116	56,290	56,687	57,644	58,371	58,386	58,531	58,770	59,008	59,247
Sonoma	114,542	115,779	116,329	117,149	118,045	118,578	119,138	119,850	120,345	121,061	121,635	122,221	123,035
Marin	42,763	43,137	43,322	43,642	43,883	44,239	44,637	44,731	44,833	45,288	45,344	45,716	46,275
Mendocino	38,196	38,305	38,504	38,627	38,773	38,942	39,128	39,272	39,266	39,507	39,422	39,655	40,143
Lake	32,390	32,520	32,605	32,826	32,933	33,083	33,137	33,281	33,340	33,552	33,537	33,682	33,892
Del Norte	11,947	12,040	12,069	12,089	12,147	12,138	12,175	12,166	12,271	12,233	12,245	12,323	12,378
Humboldt	56,835	57,014	57,052	57,391	57,547	57,895	58,203	58,217	58,347	58,779	58,818	59,127	59,837
Lassen	7,952	7,986	8,002	8,045	8,129	8,186	8,189	8,264	8,343	8,413	8,383	8,459	8,616
Modoc	3,729	3,722	3,708	3,760	3,761	3,785	3,809	3,803	3,820	3,871	3,883	3,896	3,981
Shasta	65,446	65,488	65,653	66,074	66,323	66,734	66,922	67,042	67,225	67,304	67,413	67,990	68,974
Siskiyou	18,552	18,540	18,506	18,691	18,733	18,826	18,926	18,830	18,859	18,921	18,911	18,900	19,094
Trinity	5,045	5,081	5,118	5,129	5,184	5,200	5,217	5,237	5,287	5,287	5,272	5,360	5,438
All Counties Total	**603,751**	**607,254**	**609,020**	**613,139**	**616,094**	**619,521**	**623,246**	**626,452**	**628,293**	**632,189**	**633,801**	**637,635**	**644,395**

Medi-Cal Region 1: Solano, Napa, Yolo & Marin; Medi-Cal Region 2: Sonoma, Mendocino & Rural 8 Counties

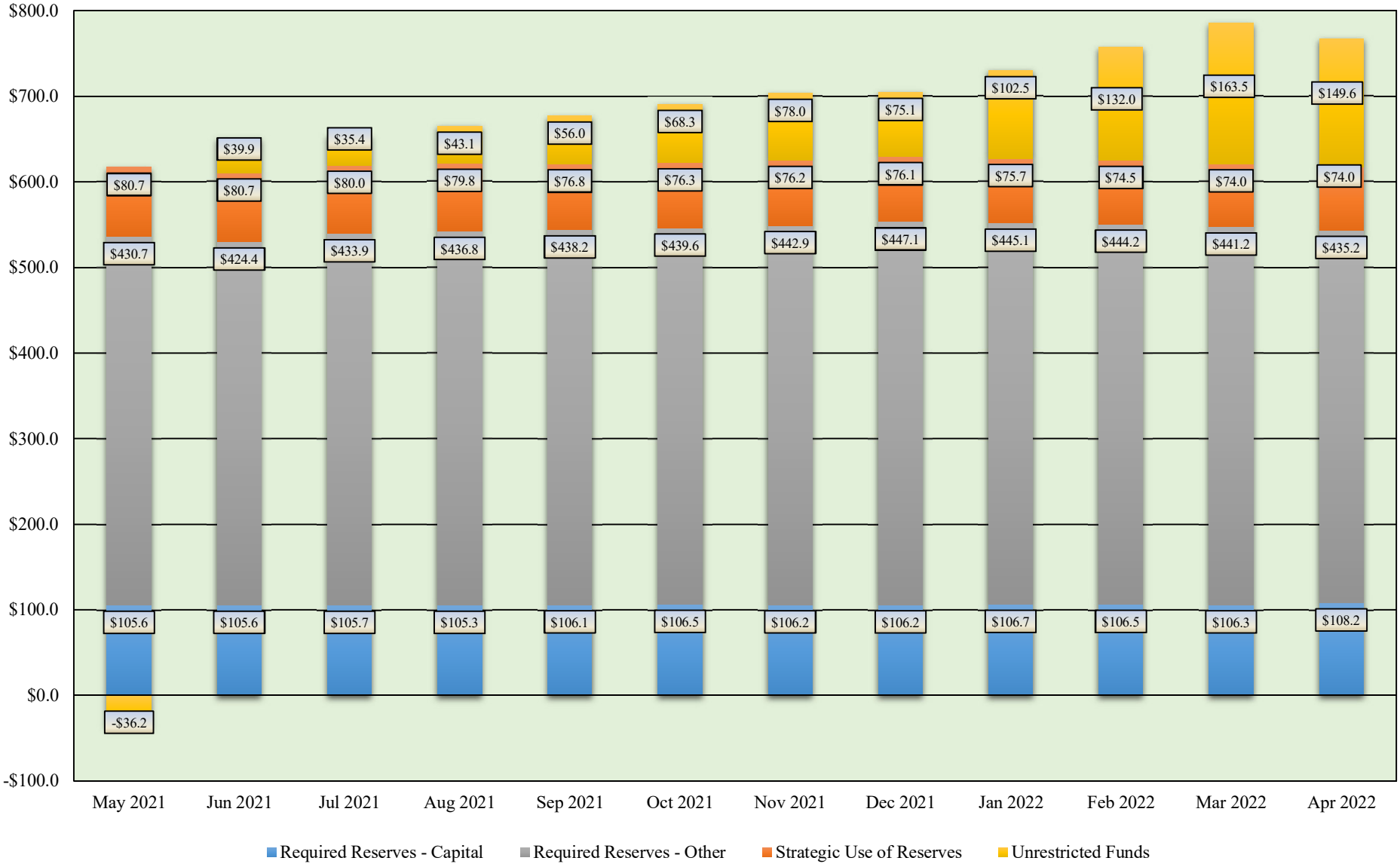
Partnership HealthPlan of California
Comparative Financial Indicators Monthly Report
Fiscal Year 2021 - 2022 & Fiscal Year 2020 - 2021

FINANCIAL INDICATORS	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22			YTD	Avg / Month As of Apr-22
Total Enrollment	612,565	615,504	619,135	622,749	625,752	627,918	632,226	633,903	637,424	643,907			6,271,083	627,108
Total Revenue	285,770,409	290,492,773	289,217,239	289,434,715	295,168,702	291,059,764	280,860,131	279,174,488	277,787,868	221,339,724			2,800,305,813	280,030,581
Total Healthcare Costs	258,057,572	256,910,666	252,438,582	251,402,013	258,737,530	263,716,815	230,109,224	227,347,263	219,750,868	215,289,340			2,433,759,872	243,375,987
Total Administrative Costs	9,527,532	9,674,878	10,915,842	10,456,654	10,013,386	12,195,146	11,432,906	10,800,639	16,431,194	10,231,596			111,679,773	11,167,977
Medi-Cal Hospital & Managed Care Taxes	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167	13,854,167			138,541,670	13,854,167
Total Current Year Surplus (Deficit)	4,331,138	10,053,062	12,008,648	13,721,881	12,563,619	1,293,636	25,463,834	27,172,419	27,751,639	(18,035,379)			116,324,498	11,632,450
Total Claims Payable	479,612,906	469,987,817	490,436,456	489,196,877	474,284,933	488,534,512	474,970,355	492,259,098	538,975,371	558,387,815			558,387,815	495,664,614
Total Fund Balance	654,962,002	665,015,064	677,023,711	690,745,593	703,309,212	704,602,848	730,066,681	757,239,100	784,990,740	766,955,361			766,955,361	713,491,031
Reserve Fund - Required Reserves	433,909,347	436,773,283	438,173,175	439,588,278	442,927,577	447,118,437	445,125,440	444,244,504	441,232,366	435,169,278			435,169,278	440,426,168
Reserve Fund - Capital Assets	105,684,355	105,331,238	106,055,796	106,519,267	106,191,511	106,189,354	106,721,219	106,521,169	106,252,966	108,221,301			108,221,301	106,368,818
Reserve Fund - Strategic Use of Reserves	80,012,212	79,785,705	76,769,579	76,300,252	76,231,209	76,149,155	75,717,707	74,488,498	73,989,726	73,956,826			73,956,826	76,340,087
Unrestricted Fund Balance	35,356,088	43,124,838	56,025,161	68,337,796	77,958,915	75,145,902	102,502,315	131,984,929	163,515,682	149,607,956			149,607,956	90,355,958
Fund Balance as % of Reserved Funds	105.71%	106.93%	109.02%	110.98%	112.47%	111.94%	116.33%	121.11%	126.31%	124.23%			124.23%	114.50%
Current Ratio	1.15:1	1.16:1	1.16:1	1.19:1	1.20:1	1.17:1	1.19:1	1.26:1	1.23:1	1.26:1			1.26:1	1.20:1
Medical Loss Ratio w/o Tax	94.94%	92.93%	91.76%	91.34%	92.11%	95.29%	86.64%	86.16%	83.75%	104.62%			91.70%	91.70%
Admin Ratio w/o Tax	3.51%	3.50%	3.97%	3.80%	3.56%	4.41%	4.30%	4.09%	6.26%	4.97%			4.21%	4.21%
Profit Margin Ratio	1.52%	3.46%	4.15%	4.74%	4.26%	0.44%	9.07%	9.73%	9.99%	-8.15%			4.15%	4.15%

FINANCIAL INDICATORS	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	YTD	Avg / Month As of Jun-21
Total Enrollment	556,087	563,455	569,392	574,604	579,254	583,912	588,652	593,177	596,201	601,587	606,935	608,597	7,021,853	585,154
Total Revenue	244,622,822	258,045,152	257,210,637	268,252,952	261,036,547	260,390,466	266,550,404	280,192,651	270,995,801	280,012,525	287,059,375	271,418,148	3,205,787,480	267,148,957
Total Healthcare Costs	228,533,285	240,676,950	241,362,720	247,291,936	246,025,716	239,273,022	247,842,498	255,154,457	241,380,692	245,272,242	245,019,491	179,666,787	2,857,499,796	238,124,983
Total Administrative Costs	10,312,618	9,352,080	10,205,235	10,149,122	9,951,801	11,135,881	10,084,463	10,394,568	11,620,169	10,791,482	10,521,875	9,504,028	124,023,322	10,335,277
Medi-Cal Hospital & Managed Care Taxes	12,073,441	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	12,468,750	149,229,691	12,435,808
Total Current Year Surplus (Deficit)	(6,296,521)	(4,452,629)	(6,826,068)	(1,656,856)	(7,409,720)	(2,487,187)	(3,845,308)	2,174,876	5,526,190	11,480,051	19,049,259	69,778,582	75,034,671	6,252,889
Total Claims Payable	401,791,137	412,650,255	443,747,870	454,556,100	443,896,724	465,413,310	498,051,908	533,566,353	511,412,385	524,307,516	540,428,719	459,028,387	459,028,387	474,070,889
Total Fund Balance	569,299,672	564,847,043	558,020,975	556,364,119	548,954,399	546,467,212	542,621,904	544,796,781	550,322,971	561,803,022	580,852,281	650,630,864	650,630,864	564,581,770
Reserve Fund - Required Reserves	385,127,705	388,857,534	392,130,843	397,251,115	402,055,814	404,937,855	409,782,082	416,395,226	421,825,722	426,777,482	430,741,070	424,393,928	424,393,928	408,356,365
Reserve Fund - Capital Assets	106,003,559	105,914,664	106,538,718	106,279,522	106,095,318	106,918,382	107,015,106	106,595,855	105,296,542	104,979,446	105,564,656	105,550,369	105,550,369	106,062,678
Reserve Fund - Strategic Use of Reserves	85,732,498	84,460,474	84,275,330	83,096,409	82,803,306	82,590,776	82,439,453	81,423,816	81,052,937	81,038,133	80,724,657	80,743,188	80,743,188	82,531,748
Unrestricted Fund Balance	(7,564,090)	(14,385,629)	(24,923,916)	(30,262,927)	(42,000,039)	(47,979,801)	(56,614,736)	(59,618,116)	(57,852,230)	(50,992,038)	(36,178,101)	39,943,378	39,943,378	(32,369,020)
Fund Balance as % of Reserved Funds	98.69%	97.52%	95.72%	94.84%	92.89%	91.93%	90.55%	90.14%	90.49%	91.68%	94.14%	106.54%	106.54%	94.58%
Current Ratio	1.09:1	1.08:1	1.07:1	1.07:1	1.05:1	1.04:1	1.02:1	1.02:1	1.02:1	1.03:1	1.04:1	1.16:1	1.16:1	1.06:1
Medical Loss Ratio w/o Tax	98.06%	97.76%	98.36%	96.49%	98.80%	96.37%	97.90%	95.68%	93.76%	92.11%	89.67%	69.76%	93.61%	93.61%
Admin Ratio w/o Tax	4.42%	3.80%	4.16%	3.96%	4.00%	4.48%	3.98%	3.90%	4.51%	4.05%	3.85%	3.69%	4.06%	4.06%
Profit Margin Ratio	-2.57%	-1.73%	-2.65%	-0.62%	-2.84%	-0.96%	-1.44%	0.78%	2.04%	4.10%	6.64%	25.71%	2.34%	2.34%

Partnership HealthPlan of California
Fund Balance Comparison
(in Millions of Dollars)

For the Past 12 Months Ending April 30, 2022



PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Membership and Financial Summary
For The Period Ending April 30, 2022

CURRENT MONTH	PRIOR MONTH	INC / DEC	MEMBERSHIP SUMMARY	CURRENT YTD AVG	PRIOR YTD AVG	VARIANCE
643,907	637,424	6,483	**Total Membership**	627,108	580,632	46,476

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	FINANCIAL SUMMARY	ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD
221,339,724	262,990,037	(41,650,313)	**Total Revenue**	2,800,305,813	2,751,136,718	49,169,095
215,289,340	224,782,155	9,492,815	**Total Healthcare Costs**	2,433,759,872	2,479,686,557	45,926,685
10,231,596	12,699,340	2,467,744	**Total Administrative Costs**	111,679,773	122,077,568	10,397,795
13,854,167	14,617,064	762,897	**Medi-Cal Managed Care Tax**	138,541,670	142,317,611	3,775,941
(18,035,379)	**10,891,478**	**(28,926,857)**	**Total Current Year Surplus (Deficit)**	**116,324,498**	**7,054,982**	**109,269,516**
104.62%	90.50%		**Medical Loss Ratio (HC Costs as a % of Rev, excluding Managed Care Tax)**	91.70%	95.05%	
4.97%	5.11%		**Admin Ratio (Admin Costs as a % of Rev, excluding Managed Care Tax)**	4.21%	4.68%	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of April 30, 2022

	April 2022	March 2022
A S S E T S		
Current Assets		
Cash &Cash Equivalents	**793,880,293**	**919,704,699**
Receivables		
Accrued Interest	72,100	76,500
State DHS - Cap Rec	217,250,790	271,675,544
Other Healthcare Receivable	17,165,272	14,284,160
Miscellaneous Receivable	2,348,912	4,872,756
Total Receivables	**236,837,074**	**290,908,960**
Other Current Assets		
Payroll Clearing	3,721	2,391
Prepaid Expenses	3,485,166	3,938,169
Total Other Current Assets	**3,488,887**	**3,940,560**
Total Current Assets	**1,034,206,254**	**1,214,554,219**
Non-Current Assets		
Fixed Assets		
Motor Vehicles	154,341	154,341
Furniture & Fixtures	7,518,859	7,518,859
Computer Equipment - HP	541,886	541,886
Computer Equipment	20,453,491	20,453,491
Computer Software	20,714,113	20,462,331
Leasehold Improvements	962,374	962,374
Land	6,767,292	6,767,292
Building	55,932,088	55,932,088
Building Improvements	30,342,041	30,250,112
Accum Depr - Motor Vehicles	(144,668)	(143,654)
Accum Depr - Furniture	(7,057,551)	(7,028,840)
Accum Depr - Comp Equip - HP	(541,886)	(541,886)
Accum Depr - Comp Equipment	(19,377,725)	(19,122,387)
Accum Depr - Comp Software	(19,069,946)	(18,880,151)
Accum Depr - Leasehold Improvements	(962,374)	(962,374)
Accum Depr - Building	(8,940,562)	(8,821,049)
Accum Depr - Bldg Improvements	(9,166,170)	(9,008,796)
Construction Work-In-Progress	30,095,697	27,719,329
Total Fixed Assets	**108,221,300**	**106,252,966**
Other Non-Current Assets		
Deposits	64,230	38,899
Board-Designated Reserves	434,869,278	440,932,366
Knox-Keene Reserves	300,000	300,000
Prepaid - Other Non-Current	2,414,927	2,209,037
Net Pension Asset	7,231,258	7,231,258
Deferred Outflows Of Resources	930,354	930,354
Total Other Non-Current Assets	**445,810,047**	**451,641,914**
Total Non-Current Assets	**554,031,347**	**557,894,880**
Total Assets	**1,588,237,601**	**1,772,449,099**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of April 30, 2022

	April 2022	March 2022
LIABILITIES & FUND BALANCE		
Liabilities		
Current Liabilities		
Accounts Payable	107,092,507	126,666,987
Unearned Income	5,214,279	5,657,550
Suspense Account	3,706,216	2,903,106
Capitation Payable	25,473,783	27,725,924
State DHS - Cap Payable	32,633,113	32,633,113
Accrued Healthcare Costs	9,671,049	150,152,542
Claims Payable	172,393,858	153,849,684
Incurred But Not Reported-IBNR	385,993,957	385,125,687
Quality Improvement Programs	77,318,537	100,958,825
Total Current Liabilities	**819,497,299**	**985,673,418**
Non-Current Liabilities		
Deferred Inflows Of Resources	1,784,941	1,784,941
Total Non-Current Liabilities	**1,784,941**	**1,784,941**
Total Liabilities	**821,282,240**	**987,458,359**
Fund Balance		
Unrestricted Fund Balance	**149,607,956**	**163,515,682**
Reserved Funds		
Reserve Fund-Board Designated	419,869,278	425,932,366
Reserve Fund-Board Designated-Infrastructure	15,000,000	15,000,000
Reserve Fund-Board Designated-Capital Assets	108,221,301	106,252,966
Reserve Fund-Strategic Use Of Reserve	73,956,826	73,989,726
Reserve For Restricted Fund-Knox-Keene	300,000	300,000
Total Reserved Funds	**617,347,405**	**621,475,058**
Total Fund Balance	**766,955,361**	**784,990,740**
Total Liabilities And Fund Balance	**1,588,237,601**	**1,772,449,099**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Statement of Cash Flow
For The Period Ending April 30, 2022

	Current Month Activity	Year-To-Date Activity
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash Received From:		
Capitation from California Department of Health Care Service	278,852,248	3,382,511,983
Other Revenues	59,226	2,963,038
Cash Payments to Providers for Medi-Cal Members		
Capitation Payments	(52,051,991)	(433,554,760)
Medical Claims Payments	(159,356,168)	(1,926,145,263)
Drug Medi-Cal		
DMC Receipts from Counties	1,169,506	19,804,314
DMC Payments to Providers	(2,623,992)	(19,987,339)
Cash Payments to Vendors	(187,925,851)	(622,737,087)
Cash Payments to Employees	(7,151,301)	(87,294,895)
Net Cash (Used) Provided by Operating Activities	**(129,028,323)**	**315,559,991**
CASH FLOWS FROM CAPITAL FINANCING & RELATED ACTIVITIES:		
Purchases of Capital Assets	(3,043,610)	(12,150,084)
Net Cash Used by Capital Financial & Related Activities	**(3,043,610)**	**(12,150,084)**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Board-Designated Reserve Transfers	6,063,088	(10,775,350)
Interest and Dividends on Investments	184,439	586,035
Net Cash (Used) Provided by Investing Activities	**6,247,527**	**(10,189,315)**
NET (DECREASE) INCREASE IN CASH & CASH EQUIVALENTS	**(125,824,406)**	**293,220,592**
CASH & CASH EQUIVALENTS, BEGINNING	**919,704,699**	**500,659,700**
CASH & CASH EQUIVALENTS, ENDING	**793,880,293**	**793,880,292**
RECONCILIATION OF OPERATING (LOSS) INCOME TO NET CASH PROVIDED (USED) BY OPERATING ACTIVITIES:		
TOTAL OPERATING (LOSS) INCOME	**(18,215,418)**	**115,754,463**
DEPRECIATION	**751,745**	**7,811,173**
CHANGES IN ASSETS AND LIABILITIES:		
Other Receivables	(357,266)	(3,715,420)
California Department of Health Services Receivable	54,424,754	75,232,357
Other Assets	543,982	2,279,105
Accounts Payable and Accrued Expenses	(161,948,274)	1,717,620
Accrued Claims Payable	19,412,443	99,359,428
Quality Improvement Programs	(23,640,289)	17,121,265
Net Cash Provided (Used) by Operating Activities	**(129,028,323)**	**315,559,991**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

For The Period Ending April 30, 2022

****The Notes to the Financial Statement are an Integral Part of this Statement****

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	ACTUAL MONTH PMPM	BUDGET MONTH PMPM		ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD	ACTUAL YTD PMPM	BUDGET YTD PMPM
643,907	**643,907**	**-**			**TOTAL MEMBERSHIP**	**6,271,083**	**6,271,083**	**-**		
					REVENUE					
220,979,303	262,773,787	(41,794,484)	343.19	408.09	State Capitation Revenue	2,785,494,722	2,748,974,218	36,520,504	444.18	438.36
180,039	101,583	78,456	0.28	0.16	Interest Income	570,035	1,015,830	(445,795)	0.09	0.16
180,382	114,667	65,715	0.28	0.18	Other Revenue	14,241,056	1,146,670	13,094,386	2.27	0.18
221,339,724	**262,990,037**	**(41,650,313)**	**343.75**	**408.43**	**TOTAL REVENUE**	**2,800,305,813**	**2,751,136,718**	**49,169,095**	**446.54**	**438.70**
					HEALTHCARE COSTS					
22,504,466	18,049,920	(4,454,546)	34.95	28.03	Global Subcapitation	217,037,619	190,449,490	(26,588,129)	34.61	30.37
2,427,365	2,593,002	165,637	3.77	4.03	Capitated Medical Groups	23,397,991	24,666,774	1,268,783	3.73	3.93
					Physician Services					
6,167,256	6,414,626	247,370	9.58	9.96	PCP Capitation	60,457,964	61,754,119	1,296,155	9.64	9.85
210,731	209,291	(1,440)	0.33	0.33	Specialty Capitation	2,053,298	2,023,140	(30,158)	0.33	0.32
31,747,866	33,314,769	1,566,903	49.31	51.74	Non-Capitated Physician Services	340,087,391	350,721,464	10,634,073	54.23	55.93
38,125,853	**39,938,686**	**1,812,833**	**59.22**	**62.03**	**Total Physician Services**	**402,598,653**	**414,498,723**	**11,900,070**	**64.20**	**66.10**
					Inpatient Hospital					
17,685,222	18,512,531	827,309	27.47	28.75	Hospital Capitation	171,662,748	177,183,595	5,520,847	27.37	28.25
50,526,549	59,999,974	9,473,425	78.47	93.18	Inpatient Hospital - FFS	547,284,136	597,458,087	50,173,951	87.27	95.27
850,000	1,952,411	1,102,411	1.32	3.03	Hospital Stoploss	300,939	18,858,835	18,557,896	0.05	3.01
69,061,771	**80,464,916**	**11,403,145**	**107.26**	**124.96**	**Total Inpatient Hospital**	**719,247,823**	**793,500,517**	**74,252,694**	**114.69**	**126.53**
31,215,372	29,905,093	(1,310,279)	48.48	46.44	Long Term Care	326,793,451	331,232,482	4,439,031	52.11	52.82
-	-	-	-	-	Pharmacy	183,588,912	178,908,641	(4,680,271)	29.28	28.53
					Ancillary Services					
949,253	1,010,562	61,309	1.47	1.57	Ancillary Services - Capitated	9,616,095	9,736,557	120,462	1.53	1.55
35,705,352	37,409,997	1,704,645	55.45	58.10	Ancillary Services - Non-Capitated	382,333,669	385,969,836	3,636,167	60.97	61.55
36,654,605	**38,420,559**	**1,765,954**	**56.92**	**59.67**	**Total Ancillary Services**	**391,949,764**	**395,706,393**	**3,756,629**	**62.50**	**63.10**
					Other Medical					
1,905,850	2,887,773	981,923	2.96	4.48	Quality Assurance	21,869,850	25,001,309	3,131,459	3.49	3.99
130,154	1,195,318	1,065,164	0.20	1.86	Healthcare Investment Funds	18,606,100	13,553,176	(5,052,924)	2.97	2.16
90,800	111,417	20,617	0.14	0.17	Advice Nurse	843,600	1,114,170	270,570	0.13	0.18
2,125	9,533	7,408	-	0.01	HIPP Payments	37,963	95,330	57,367	0.01	0.02
6,059,376	4,142,635	(1,916,741)	9.41	6.43	Transportation	58,969,999	42,239,805	(16,730,194)	9.40	6.74
8,188,305	**8,346,676**	**158,371**	**12.71**	**12.95**	**Total Other Medical**	**100,327,512**	**82,003,790**	**(18,323,722)**	**16.00**	**13.09**
7,111,603	7,063,303	(48,300)	11.04	10.97	Quality Improvement Programs	68,818,147	68,719,747	(98,400)	10.97	10.96
215,289,340	**224,782,155**	**9,492,815**	**334.35**	**349.08**	**TOTAL HEALTHCARE COSTS**	**2,433,759,872**	**2,479,686,557**	**45,926,685**	**388.09**	**395.43**
					ADMINISTRATIVE COSTS					
6,843,473	7,638,950	795,477	10.63	11.86	Employee	70,419,323	75,888,777	5,469,454	11.23	12.10
18,052	72,687	54,635	0.03	0.11	Travel And Meals	176,059	516,966	340,907	0.03	0.08
1,137,868	1,922,532	784,664	1.77	2.99	Occupancy	11,090,697	16,603,843	5,513,146	1.77	2.65
293,922	376,994	83,072	0.46	0.59	Operational	2,501,160	4,168,359	1,667,199	0.40	0.66
1,230,314	1,698,389	468,075	1.91	2.64	Professional Services	18,512,894	16,275,708	(2,237,186)	2.95	2.60
707,967	989,788	281,821	1.10	1.54	Computer And Data	8,979,640	8,623,915	(355,725)	1.43	1.38
10,231,596	**12,699,340**	**2,467,744**	**15.90**	**19.73**	**TOTAL ADMINISTRATIVE COSTS**	**111,679,773**	**122,077,568**	**10,397,795**	**17.81**	**19.47**
13,854,167	14,617,064	762,897	21.52	22.70	Medi-Cal Managed Care Tax	138,541,670	142,317,611	3,775,941	22.09	22.69
(18,035,379)	**10,891,478**	**(28,926,857)**	**(28.02)**	**16.92**	**TOTAL CURRENT YEAR SURPLUS (DEFICIT)**	**116,324,498**	**7,054,982**	**109,269,516**	**18.55**	**1.11**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
April 30, 2022

1. ORGANIZATION

The Partnership HealthPlan of California (PHC) was formed as a health insurance organization, and is legally a subdivision of the State of California, but is not part of any city, county or state government system. PHC has quasi-independent political jurisdiction to contract with the State for managing Medi-Cal beneficiaries who reside in various Northern California Counties. PHC is a combined public and private effort engaged principally in providing a more cost-effective method of healthcare. PHC began serving Medi-Cal eligible persons in Solano in May 1994. That was followed by Napa in March of 1998, Yolo in March of 2001, Sonoma in October 2009, Marin and Mendocino in July 2011, and eight Northern Counties in September 2013. Beginning July 2018 and in accordance with direction from the Department of Health Care Services (DHCS), PHC has consolidated its reporting from these fourteen counties into two regions; these are in alignment with the two DHCS rating regions.

As a public agency, the HealthPlan is exempt from state and federal income tax.

2. SUMMARY OF SIGNIFICANT ACCOUNTING POLICIES

ACCOUNTING POLICIES:
The accounting and reporting policies of PHC conform to generally-accepted accounting principles and general practices within the healthcare industry.

PROPERTY AND EQUIPMENT:
Effective July 2015, property and equipment totaling $10,000 or more are recorded at cost; this includes assets acquired through capital leases and improvements that significantly add to the productive capacity or extend the useful life of the asset. Costs of maintenance and repairs are expensed as incurred. Depreciation for financial reporting purposes is provided on a straight-line method over the estimated useful life of the asset. The costs of major remodeling and improvements are capitalized as building or leasehold improvements. Leasehold improvements are amortized using the straight-line method over the shorter of the remaining term of the applicable lease or their estimated useful life. Building improvements are depreciated over their estimated useful life.

INVESTMENTS:
PHC investments can consist of U.S. Treasury Securities, Certificates of Deposits, Money Market and Mutual Funds, Government Pooled Funds, Agency Notes, Repurchase Agreements, Shares of Beneficial Interest and Commercial Paper and are carried at fair value.

BOARD-DESIGNATED & KNOX KEENE RESERVES:

In April 2004, PHC's Board established a policy to set aside in a reserve account a designated amount that represents the Knox-Keene Tangible Net Equity (TNE) requirement. This policy was subsequently revised and reflected on the balance sheet since July 2012. Based on this policy and as of April 2022, PHC has Board-Designated and Knox-Keene Reserves of $543.1 million and $0.3 million respectively. To account for the Board approved Strategic Use of Reserves (SUR) initiatives, which includes funding for the Wellness & Recovery program, $74.0 million has been set aside as a "Reserve Fund-Strategic Use of Reserve." The amount represents the net amount remaining of all of the SUR projects that have been approved to date; this balance is periodically adjusted as projects are completed.

3. STATE CAPITATION REVENUE

Medi-Cal capitation revenue is based on the monthly capitation rates, as provided for in the State contract, and the actual number of Medi-Cal eligible members. Capitation revenues are paid by the State on a monthly basis in arrears based on estimated membership. As such, capitation revenue includes an estimate for amounts receivable from or refundable to the State for projected changes in membership and trued up monthly through a State reconciliation process. These estimates are continually monitored and adjusted, as necessary, as experience develops or new information becomes known.

4. HEALTHCARE COST

PHC continues to develop completion factors to calculate estimated liability for claims incurred but not reported. These factors are reviewed and adjusted as more historical data become available. Budgeted capitation revenues and healthcare costs are adjusted each month to reflect changes in enrollee counts.

5. QUALITY IMPROVEMENT PROGRAM

PHC maintains quality incentive contracts with acute care hospitals and primary care physicians. As of April 2022, PHC has accrued a Quality Incentive Program payout of $77.3 million.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
April 30, 2022

6. ESTIMATES

Due to the nature of the operations of the Partnership HealthPlan, it is necessary to estimate amounts for financial statement presentation. Substantial overstatement or understatement of these estimates would have a significant impact on the statements. The items estimated through various methodologies are:

- Value of Claims Incurred But Not Received
- Quality Incentive Payouts
- Earned Capitation Revenues
- Total Number of Members
- Retro Capitation Expense for Certain Providers

7. COMMITMENTS AND CONTINGENCIES

In the ordinary course of business, the HealthPlan is party to claims and legal actions by enrollees, providers, and others. After consulting with legal counsel, HealthPlan management is of the opinion any liability that may ultimately be incurred as a result of claims or legal actions will not have a material effect on the financial position or results of the operations of the HealthPlan.

8. UNUSUAL OR INFREQUENT ITEMS REPORTED IN CURRENT MONTH'S FINANCIAL STATEMENTS

During the month, an adjustment to revenue was recorded retroactive to calendar year 2022 in anticipation of DHCS rate decreases in the upcoming rate schedule update.

Partnership HealthPlan of California
Investment Schedule
April 30, 2022

Name of Investment	Investment Type	Yield to Maturity	Trade Date	Maturity Date	Call Date	Face Value	Market Value	Credit Rating Agency	Credit Rating
FUNDS HELD FOR INVESTMENT:									
Highmark Money Market	Cash & Cash Equiv	NA	Various	NA	NA	NA	$ 1,533,293	NA	NR
Certificate of Deposit for Knox Keene	Cash & Cash Equiv	0.00015	NA	1/4/2022	NA	NA	$ 300,000	NA	NR
FUNDS HELD FOR OPERATIONS:									
Merrill Lynch Institutional	Cash for Operations	NA	NA	NA	NA	NA	$ 66,649,001		
Merrill Lynch MMA - Checking	Cash for Operations	NA	NA	NA	NA	NA	$ 185,177		
UB - General, MMA, and Sweeps	Cash for Operations	NA	NA	NA	NA	NA	$ 1,043,743,164		
Government Investment Pools (LAIF)	Cash for Operations	NA	NA	NA	NA	NA	$ 75,000,000		
Government Investment Pools (County)	Cash for Operations	NA	NA	NA	NA	NA	$ 40,542,674		
West America Payroll	Cash for Operations	NA	NA	NA	NA	NA	$ 1,092,961		
Petty Cash	Cash for Operations	NA	NA	NA	NA	NA	$ 3,300		
GRAND TOTAL:							$ 1,229,049,570		

Required Reserves (Liquid)

Board Designated Assets	$	434,869,278
Knox Keene Reserves	$	300,000
Total Required Reserves (Liquid)	**$**	**435,169,278**

Cash on Hand / Cash Days Available:

Including Required Reserves	$	1,229,049,570	
Excluding Required Reserves	$	793,880,292	
Cash Days Available incl. Required Reserves			**119.58**
Cash Days Available excl. Required Reserves			**77.24**

Partnership HealthPlan of California
Investment Yield Trends

FISCAL YEAR 21/22		JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	YTD
Interest Income		69,194	34,507	35,073	48,030	35,292	32,599	43,164	43,000	49,137	180,039			570,035
Cash & Investments at Historical Cost	(1)	492,803,755	513,054,483	588,066,155	570,252,227	294,587,864	673,772,755	780,352,876	677,905,415	919,704,699	793,880,293			630,438,052
Computed Yield	(2)	0.17%	0.08%	0.08%	0.10%	0.10%	0.08%	0.07%	0.07%	0.07%	0.25%			
Total Rate of Return	(3)	0.17%	0.12%	0.10%	0.10%	0.11%	0.10%	0.09%	0.09%	0.08%	0.11%			
CA Pooled Money Investment Account (PMIA)	(4)	0.22%	0.22%	0.21%	0.20%	0.20%	0.21%	0.23%	0.28%	0.37%	0.52%			

FISCAL YEAR 20/21		JUL	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APR	MAY	JUN	YTD
Interest Income		101,518	79,393	129,142	85,682	69,555	60,493	95,805	55,872	54,937	85,764	51,531	41,924	911,616
Cash & Investments at Historical Cost	(1)	447,722,427	457,223,207	608,616,971	474,773,196	430,208,837	457,366,473	747,219,094	482,418,564	609,864,227	566,842,230	657,099,091	500,659,700	536,667,835
Computed Yield	(2)	0.27%	0.21%	0.29%	0.19%	0.18%	0.16%	0.19%	0.11%	0.12%	0.17%	0.10%	0.09%	
Total Rate of Return	(3)	0.27%	0.24%	0.25%	0.24%	0.23%	0.22%	0.21%	0.20%	0.19%	0.19%	0.18%	0.17%	
CA Pooled Money Investment Account (PMIA)	(4)	0.92%	0.78%	0.69%	0.62%	0.58%	0.54%	0.46%	0.41%	0.36%	0.34%	0.32%	0.26%	

NOTES:

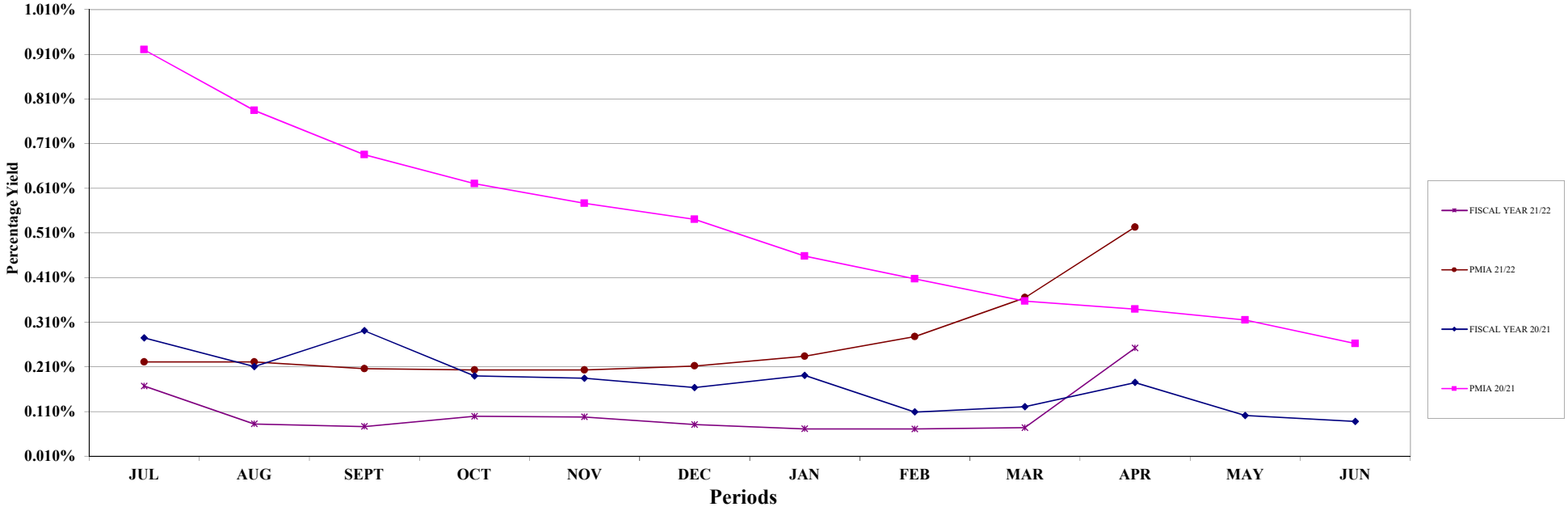
(1) Investment balances include Restricted Cash and Board Designated Reserves
YTD for Cash & Investments is average year-to-date

(2) Computed yield is calculated by annualizing the current month's interest divided by the current month's average balance.

(3) Total Rate of Return is computed based on year-to-date interest income annualized divided by an average of the fiscal year's portfolio's market value at month-end.

(4) LAIF limits the amount a single government entity can deposit into LAIF; currently that amount is set at $75 million.

Partnership HealthPlan of California
Investment Yield Trends



Operations Report

Sonja Bjork, Chief Operating Officer
June 22, 2022

Claims

Claims Department backlog and Recovery plan

The Claims Department has increased its focus on routine claims and CIF processing to minimize late payments, accrued interest and provider dissatisfaction. In early April, the Claims Team was met with quite a sizeable backlog as a result of the system disruption. Over the course of 10 weeks, the team increased staffing and worked many overtime hours, including most evenings and weekends. We strove to reduce the inventory backlog and return to our normal turnaround times of processing and payment within 20-30 days. Our Claims Customer Service team has responded to provider claim status calls within service level standards and our Claims Resolution Team has responded to all escalated concerns and scheduled outreach trainings as necessary. We have resumed all normal functions in the department and claim inventory and call volume have returned to normal levels.

Provider Operations Meetings

One area that makes PHC unique is our commitment to outreach, education and training for our providers, trading partners and stakeholders. In collaboration with Provider Relations and Health Services Departments, the Claims Resolution Coordinators continued participation in all scheduled Provider Operations Meetings over the last 2 months. In addition to fielding claims questions, the CRCs typically share provider scorecards, which are used to give providers a quarterly snapshot of their claims performance and "billing health." Each scorecard provides: total number of claims billed, paid and denied; total charge amounts billed, amounts paid and amounts denied; top three reasons for denial. Since our reporting capabilities have now been restored, the CRC team has been able to produce and distributed all overdue provider scorecards.

Configuration

Diabetes Education Benefit

Medi-Cal coverage of diabetes education (G0108) is currently limited to one (1) hour in the first continuous 12 months and two (2) hours in subsequent years. PHC's clinical leadership determined that we should expand this coverage in order to promote utilization of this benefit for our members who have diabetes. While this will not address the shortage of certified diabetes educators, it will make referrals easier and will promote ongoing use of the benefit. Effective 7/1/2022, limits for G0108 will increase to 8 hours per rolling 12 months before a TAR will be required. Our CMO has recommended the same change to DHCS.

Project Phoenix

Several of the Configuration staff recently attended the virtual Summer Customer Conference hosted by HealthEdge. This conference included updates on various products in the HRP ecosystem. HE provided updates on Wellframe, Guiding Care, Source and Provider Data Management in addition to HRP (Health Rules Payor). It was interesting to compare the non-HRP products to the ones that PHC currently uses. In terms of HRP, the update provided focuses primarily on upcoming performance enhancements which we look forward to utilizing.

Health Services

Care Coordination

The Care Coordination Team continues to plan for the implementation of Enhanced Case Management and Community Supports services in seven additional counties. This is part of the schedule for Phase II of the DHCS CalAIM initiative. Our efforts will include ongoing recruitment and facilitating providing appropriate orientation and training of new providers. Additional CalAIM activities involve having our own PHC staff participate in the “Coach Model” training sponsored by the Camden Coalition.

Population Health

We are pleased to have hired a new Senior Health Educator who will join our team at the end of June. The work of the Population Health team was on hold during the system disruption and we have now been able to resume phone outreach to our members. Our current campaigns are: Growing Together Prenatal & Post-partum outreach; Well Child Visit Birthday Club with northern region providers; Healthy Toddlers/Kids Growing Together (for new members). In addition to the existing campaigns the team has added members with a diagnosis of diabetes or asthma to their outreach. These members are offered “healthy lifestyle coaching” to improve their conditions. For example, we work with those with diabetes to make sure they are connected to their PCP and complete all needed lab work. For those with asthma, our coaches provide education on approaches to reduce asthma “attacks” and ED visits.

The team attended and represented PHC at many events this month:

Solano HOPE event: Geared towards those who are homeless or at risk of homelessness.

Redding Health Fair Expo: Connected with many PHC members and provided information on our health plan and the available benefits.

Juneteenth: Attended events in multiple communities in our service area to talk with members and provide health plan and benefit information.

Utilization Management

The UM Team was notified that one of our contracting skilled nursing facilities was decertified by the California Department of Public Health. PHC was notified retrospectively and after the facility was purchased by new owners who are working to correct the previous deficiencies. This decertification impacted 33 PHC Members.

As of 6/13/2022 three members were transferred to another skilled nursing facility, six members have appealed to the State for approval to stay at the facility under the new ownership, and three experienced a decline in their condition and were admitted to the acute hospital. Placement efforts continue for the remaining 24 members. Unfortunately, many skilled nursing facilities have been experiencing COVID outbreaks and staffing shortages, preventing them from accepting new admissions.

Member Services

Improvement to Interpreting Services

As many of you are aware, In October 2021, PHC transitioned to a new interpreting services provider, AMN HealthCare. Through AMN, we were able to equip our providers with on-demand video remote interpreting (VRI) to provide greater access than the traditional face-to-face solution. This transition has been well received and has achieved high satisfaction marks from providers. Through this transition we also incorporated a much needed utilization tracking process by implementing intake flows that capture meaningful data points: PHC Provider #, CIN #, provider site and location). The data captured has driven PHC's internal analysis as well as supported the continued growth of PHC's interpreting footprint.

While the tracking included in the transition has helped our initial phase of identifying where the needs are in our service areas, we have received feedback from our provider network that the current intake process is lengthy and may result in increased wait times. While the average wait time aggregate report shows AMN has been able to maintain, on average, very low wait times of 17 seconds, there are instances where calls have exceeded service level agreements. In response, PHC and AMN will be implementing an Interactive Voice Response (IVR) phone tree in lieu of a live operator. This new process will significantly reduce wait times and provide a quicker turnaround time to interpreters. In addition, we have also reduced the number of intake questions which will further expedite time to the actual service. The enhancements are being communicated to our providers and will be in effect as of July 1.

Southwest Region

Regional staff and the executive team have participated in regularly scheduled Joint Leadership Initiative meetings. These meetings provide the opportunity for leadership of PHC to meet with some of our major providers to discuss priorities and challenges with an overarching focus on quality improvement. One theme emerging from these meetings is the extreme difficulty recruiting and maintaining clinical staff at clinics, especially in the more rural areas of the network. Clinics are struggling with multiple vacancies and report that traditional recruitment methods have not been successful in filling vacancies. The ongoing shortages place even great stress on existing staff. Clinics are looking at creative ways to recruit additional staff and expand the use of telehealth for a portion of their visits or as bridge strategy while vacancies are filled. All providers appreciate Partnership's Provider Recruitment and Retention program as a helpful tool in recruitment. These severe staffing shortages do impact each organization's ability to focus on quality improvement.

The Southwest regional leaders participated in the annual Wellville conference in Lake County as part of the Hope Rising team. This very engaging conference brings together the five Wellville project teams from across the country: Clatsop County, Oregon; Muskegon County, Michigan; North Harford, Connecticut; Spartanburg, South Carolina; and Lake County, California. The Hope Rising team were excellent hosts and showcased many unique and interesting aspects of the region. There was a focus on the intense challenges faced by members of the local Native American tribes and their members. This set the stage for honest and direct conversations about how we can best work together to improve the health of the community as a whole.

Northern Region

The northern and other regional leadership have all contributed to our CalAIM implementation efforts. This involves reaching out to potential providers for the enhanced case management benefit and for Community Support services. Another focus was on encouraging a wide variety of organizations to participate in the CalAIM Grant Program. Applications for funding for the second phase of the program were due June 10, 2022 and awards will be announced July 13, 2022.

We are going through a leadership change in the northern region. The Eureka Regional Office Manager position is vacant and we are seeking strong applicants for this important role.

News Updates
June 2022

PHC Press Releases:

PHC's Sonja Bjork Named to Commission that Advises Congress on Medicaid and Children's Health Insurance Issues

May 12, 2022

Partnership HealthPlan of California (PHC) congratulates Chief Operating Officer Sonja Bjork for her appointment to the Medicaid and CHIP Payment and Access Commission (MACPAC), which advises Congress, the Secretary of the U.S. Department of Health and Human Services, and the states on issues affecting Medicaid and the State Children's Health Insurance Program (CHIP). Sonja was appointed after an extensive nomination process, which included numerous letters of support.

PHC Mentioned:

3 Health Data Hacks affect 1.4 million individuals

Gov Info Security

May 24, 2022

Hacking incidents recently reported as major data breaches by three different types of health sector entities - a children's hospital, a managed care plan and a government contractor - have in total compromised the sensitive information of more than 1.4 million individuals.

Over 850,000 Individuals Affected by Partnership HealthPlan of California Cyberattack

HIPAA Journal

May 24, 2022

In March 2022, Partnership HealthPlan of California (PHC) announced that third-party forensic specialists had been engaged to help restore the functionality of its IT systems following a cyberattack.

Solano expands eligibility for Pfizer vaccine booster does to ages 5-11

Times-Herald

May 23, 2022

The Solano County Department of Health and Social Services, Public Health Division, in accordance with state and national guidance, is expanding the Pfizer COVID-19 booster doses to individuals age 5 to 11.

Class action lawsuit alleges NorCal health care provider's negligence led to data breach

Times-Standard

May 9, 2022

On Thursday, a Eureka-based law firm filed a class-action lawsuit against a Northern California healthcare provider, accusing it of failing to protect sensitive user data and neglecting to disclose when the data had been hacked in a timely manner to its users.

Press Release: GAO Makes MACPAC Appointments and Reappointments
GAO.gov
May 2, 2022
WASHINGTON, D.C. — Gene L. Dodaro, Comptroller General of the United States and head of the U.S. Government Accountability Office (GAO), today announced the appointment of four new members to the Medicaid and CHIP Payment and Access Commission (MACPAC). He also reappointed two members.

JUNE 2022 - BOARD: Legislative Update

STATE BUDGET

Overall Budget (AB 154)

The 2022-23 budget includes total spending of just over $300 billion, of which an estimated $236 billion is from the General Fund. The budget includes total reserves of $37.8 billion in 2022-23, including $3.5 billion in the regular operating reserve. Over $49 billion is projected surplus, in which 94% will be allocated for one-time spending.

Medi-Cal Budget Highlights

- 2022-23 May Revision includes $135.5 billion ($36.6 billion General Fund) which is:
  - $13.6 billion ($11.5 billion General Fund) higher than the revised 2021-22 projections of $121.9 billion ($25.1 billion General Fund)
  - The May Revision assumes caseload increased 6.6% from 2020-21 to 2021-22 and will increase by 0.6% from 2021-22 to 2022-23.
- Total projected enrollment: The 2022-23 projected caseload is 14.46 million.

Legislature's Budget Highlights

- *Medi-Cal For All, Regardless of Immigration Status.* Expands Medi-Cal to all eligible Californians regardless of immigration status. Currently, income eligible young adults 25 and younger and those 50 and older have access to full scope Medi-Cal. This action will expand access to ages 26 through 49 beginning no later than January 1, 2024.
- *Workforce development.* $532.5 million over four years for workforce development, including behavioral health, public health, primary care, clinic, and reproductive health.
- *Repeal rate reductions.* Rather than restoring 2011 rate cuts for some providers (as proposed by Administration), repeals rate cuts for all remaining providers.
- *Health Equity and Racial Justice Fund.* $75 million annually for this new fund to support CBOs to reduce health disparities and address public health impacts of systemic racism.
- *Continuous Eligibility.* Includes continuous Medi-Cal eligibility for children ages 0 to 5 ($10 million in 2022-23, $20 million ongoing).
- *Reduce share of cost (SOC) requirements for seniors in Medi-Cal.* $31 million to reduce SOC requirements for SPDs by increasing the Medi-Cal Maintenance Need Income Level.
- *SNF Payment Reform.* Sets aside funding for SNF financing reform but defers action to resolve necessary statutory changes.
- *Hospital and nursing facility retention payments.* Sets aside funding but defers action to resolve statutory changes necessary for the proposal.

JUNE 2022 - BOARD: Legislative Update

LEGISLATIVE BILLS

AB 2724 (Arambula) - Medi-Cal: alternate health care service plan (Kaiser Direct Contract).

Major Provisions:

1. Allows DHCS enter into a no-bid direct contract with Kaiser as a MCMC plan. Kaiser must meet all standards and requirements of the 2024 Medi-Cal contract, except with respect to enrollment, as for other MCMC plans.
2. Requires Kaiser, in addition to the comprehensive risk contract, to enter into a memorandum of understanding (MOU) with DHCS to memorialize any standards or requirements that are in addition to or different than those imposed on other MCMC plans.
3. Provides generous flexibility for future Kaiser expansion beyond their commercial footprint, without stakeholder or legislative discussion.
4. Other than a Knox-Keene License (KKL), there are no guardrails to define Kaiser's service area – brick-and-mortar vs. provider contract.
5. Expands the Kaiser's participation in the CCS Whole Child Model, and requires Kaiser to meet the requirements of plans participating in that model.
6. Requires Kaiser to work with FQHCs in Kaiser's service areas selected by Kaiser and DHCS, at the request of the FQHC, to provide assistance with population health management and clinical transformation.
7. Requires DHCS and Kaiser to identify the highest need specialties and geographic areas where Kaiser will provide, using Kaiser's physicians, out-patient specialty care and services to address related needs, including but not limited to, diagnostic testing and outpatient procedures for Medi-Cal beneficiaries who are not Kaiser enrollees.

LHPC Proposed Amendments Highlights: Although most amendments simply mirror DHCS language used to communicate the framework of the proposed deal, DHCS refuses to accept any LHPC amendments.

- Carve-out COHS plans from the state direct contract.
- Specifically identify counties that Kaiser will be eligible for a direct contract – counties in which Kaiser has a current KKL.
- Require legislative approval and stakeholder process in order to expand the Kaiser contract.
- Default enrollment does not result in total Kaiser growth greater than 25% over the contract term.
- Involve other MCPs in the development of default enrollment caps, not just based on Kaiser's own reporting of its capacity.
- Requires DHCS to go back to the legislature at the end of the five-year contract term to propose a new enrollment limit
- Requires that Kaiser utilize Kaiser providers for primary care assignment.

Position: Oppose, unless COHS counties are carved-out of the direct Kaiser contract

AB 1355 (Levin) - Medi-Cal: Independent Medical Review (IMR) System.
Requires DHCS to establish an IMR system for the Medi-Cal program, commencing on January 1, 2023, which models the IMR system required by Knox-Keene. Allows a Medi-Cal beneficiary to apply for an IMR within six months of receipt of a notice of adverse benefits determination or notice of action if there is any denial, modification, or delay based on medical necessity involving a disputed health care service.

Position: Watch

AB 2402 (Blanca Rubio) - Medi-Cal: continuous eligibility.
Makes a child under five years of age in the Medi-Cal program, the Medi-Cal Access for Infants Program (MCAIP), and the County Children's Health Initiative Matching Program (CCHIP) continuously eligible for Medi-Cal, including without regard to income until the child reaches five years of age. Prohibits a redetermination of Medi-Cal eligibility from being conducted before a child reaches five years of age, unless specified conditions are met. From July 2020 – June 2021 nearly 50,000 children under the age of 6 who previously had Medi-Cal coverage in the last 12 months, re-enrolled into the Medi-Cal program.

Position: Support

SB 966 - (Limon) Federally qualified health centers and rural health clinics: visits.
Permits federally qualified health centers (FQHCs) and rural health clinics (RHCs) to bill Medi-Cal for face-to-face services provided by an associate clinical social worker (ACSW) or associate marriage and family therapist (AMFT) when supervised by a licensed behavioral health practitioner.

Position: LHPC - Support