Board of Commissioners Meeting Agenda

June 25, 2025: 10:00 a.m. – 2:00 p.m.

In-person Locations:

Partnership Offices

4605 Business Center Drive, Fairfield, CA (Conference Center)

2525 Airpark Dr., Redding, CA

1036 Fifth Street, Eureka, CA

495 Tesconi Circle, Santa Rosa, CA

249-299 Nevada Street, Auburn, CA

External Sites

Plumas Bank Chico located at 900 Mangrove Ave, Chico, CA

Plumas District Hospital Satellite Office located at 80 Main Street, Quincy CA

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 24, 2025. Comments received will be read during the meeting.

10:00AM – Opening			
1.1 **Call to Order**			*Chair*
1.2 **Roll Call**			*Clerk*
1.3	***ACTION:*** Approval of Agenda and Board Meeting Minutes for April 23, 2025	1-9	*Chair*
1.4	***ACTION:*** Resolution to Approve the Commissioner Appointment of Lisa Davies to the Partnership Board as a Placer County Representative	10-11	*Sonja Bjork*
1.5	***ACTION:*** Resolution to Approve the Commissioner Appointment of Dr. Seth Kaufman to the Partnership Board as a Solano County Representative	12-13	*Sonja Bjork*
1.6	***ACTION:*** Resolution to Approve the Commissioner Appointment of Jennifer Malone to the Partnership Board as a Sierra County Representative	14-15	*Sonja Bjork*
1.7	***ACTION:*** Resolution to Approve the Commissioner Appointment of Nolan Sullivan	16-17	*Sonja Bjork*

	to the Partnership Board as a Sonoma County Representative		
1.8 **Commissioner Comment**			*Chair*
1.9 **Public Comment & Correspondence** *Clerk*			
10:30AM – Reports			
1.10	***INFORMATION:*** Overview of Partnership Maternity Care Initiatives		*Dr. Colleen Townsend*
1.11	***INFORMATION:*** Association For Community Affiliated Plans (ACAP) 101 Presentation		*Enrique Martinez-Vidal*
1.12	***INFORMATION:*** CEO Report	18-21	*Sonja Bjork*
11:15AM– Consent Calendar			
2 & 3	***ACTION:*** Consent Calendar ▪ **2.1** Resolution to Ratify the Preliminary Health Care Expense Budget ▪ **3.1** Resolution to Accept all Advisory Committee Minutes, Partnership Policies and Program Descriptions Approved by PAC ▪ **3.2** Resolution to Accept Physician Advisory Committee Membership Changes ▪ **3.3** Resolution to Approve Utilization Management Program Description, MPUD3001	22-32 33-34 35-36 37-119	*Chair*
PAC Approved Policy Updates Community Advisory Committee – June 2025 Finance Committee – May 2025 Finance Committee – June 2025 Physician Advisory Committee for May 2025 Physician Advisory Committee for June 2025 Quality and Utilization Advisory Committee (Q/UAC) – May 2025 Quality and Utilization Advisory Committee (Q/UAC) – June 2025			
11:20AM – Regular Agenda Items			
4.1	***ACTION:*** Resolution to Approve Final Budget for Fiscal Year 2025-2026	120-139	*Jennifer Lopez*

4.2	***ACTION:*** Resolution to Approve Q12025 Compliance Dashboard	140-142	*Danielle Ogren*
11:40AM-12:00PM – Lunch			
12:00PM – Regular Reports			
5.1	***INFORMATION:*** Metrics and Financial Update	143-156	*Written Report*
5.2	***INFORMATION:*** Operations Update	157-158	*Wendi Davis*
5.3	***INFORMATION:*** Legislative & Media Update	159-164	*Dustin Lyda*
5.4	***INFORMATION:*** CMO Report on Quality	165-168	*Dr. Moore*
5.5	***INFORMATION:*** Health Services Update	169-175	*Katherine Barresi*
5.6	***INFORMATION:*** Federal and State Policy Update	176-178	*Amy Turnipseed*
12:50PM – Education Sessions			
6.1	***INFORMATION:*** Employee Survey		*Naomi Gordon*
6.2	***INFORMATION:*** Grievance & Appeals Update		*Kory Watkins*
1:30PM – Closed Session			
7.1	Action Pursuant to Government Code §54957(b)(1) ***PUBLIC EMPLOYEE PERFORMANCE EVALUATION*** Title: Chief Executive Officer		*Full Board, Sonja Bjork, CEO, Naomi Gordon, Sr. Director of Human Resources, and Ashlyn Scott, Board Clerk*
2:00PM – Adjournment			

Upcoming Meetings:

08/27/2025 – August Board Meeting
10/22/2025 – October Board Meeting
12/03/2025 – December Board Meeting

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.

MINUTES OF THE MEETING OF
PARTNERSHIP HEALTHPLAN OF CALIFORNIA BOARD OF COMMISSIONERS

In-Person Location:

Hotel Winters, Orchard Ballroom, 12 Abbey Street, Winters, CA 95694

Remote Participation Available via Webex Link

On
April 23, 2025

Members Present: Jonathon Andrus, Jayme Bottke, Gena Bravo, Ranell Brown, Brion Burkett, Christopher Champlin, Cathryn Couch, Emery Cowan, Dean Germano, Ryan Gruver, Liz Hamilton, JoDee Johnson, Dave Jones, Liz Lara-O'Rourke, Ian Lloyd, Phuong Luu, M.D., Andrew Miller, M.D., Robert Oldham, M.D., Jonathan Porteus, PhD, Tiffany Rowe, Stacy Sphar, DNP, Nancy Starck, Kim Tangermann (Chair), Pedro Toledo (8:08 AM arrival), Dr. Lisa Warhuss, Jennifer Yasumoto

Members Excused: Darcie Antle, Christy Coleman, Elizabeth Kelly, Scott Kennelly, Kathryn Powell, Jim Yoder

Members Absent: Belle Knight, Nunie Matta

Staff: Leigha Andrews, Katherine Barresi, Sonja Bjork, Mark Bontrager, Tina Buop, Wendi Davis, Naomi Gordon, Curtis Hardwick, Mohamed Jalloh, PharmD, Vicky Klakken, John Lemoine, Jennifer Lopez, Dustin Lyda, Robert Moore, M.D., Tommee Naenphan, Kathryn Power, Dr. DeLorean Ruffin, Tim Sharp, Rebecca Stark, Nancy Steffen, Amy Turnipseed, Colleen Valenti,

Guests: Donnell Ewert, Cesar Orozco, Dr. Aimee Sisson

AGENDA ITEM	DISCUSSION	MOTION / ACTION
1.1 Call to Order	Commissioner Kim Tangermann, Board Chair, called the bi-monthly meeting to order and welcomed everyone to the meeting. 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	None

	reminder, Commissioner Tangermann read the Partnership Mission Statement: "to help our members, and the communities we serve, be healthy." She also stated that members of the public would have an opportunity to speak at designated times throughout the agenda.	
1.2 Roll Call	Colleen Valenti, Assistant Clerk of the Commission, called the roll indicating there was a quorum.	None
1.3 Approval of Agenda and the Board Meeting Minutes for February 26, 2025	Chairwoman Tangermann asked if anyone had changes for the agenda or corrections to the February 26, 2025 minutes. Hearing no requests for modification, she asked for a motion to approve the agenda and minutes.	*Commissioner Burkett moved to approve the agenda and minutes as presented, seconded by Commissioner Couch.* ***ACTION SUMMARY:*** *Yes: 27* *No: 0* *Abstention: 0* *Excused: 6 (*Antle, Coleman, Kelly, Kennelly, Powell, Yoder) **MOTION CARRIED**
1.4 Resolution to Approve the Lassen County Board Appointment of Ian Lloyd	Sonja Bjork, Chief Executive Officer, introduced Ian Lloyd, Women, Infants and Children (WIC) Director at Northeastern Rural Health Clinics, who the Lassen County Board of Supervisors appointed to the Partnership Board of Commissioners. Chairwoman Tangermann requested a motion to approve Mr. Lloyds's appointment.	*Commissioner Jones moved to approve the resolution as presented, seconded by Commissioner Starck.* ***ACTION SUMMARY:*** *Yes: 28* *No: 0* *Abstention: 0* *Excused: 6* (Antle, Coleman, Kelly, Kennelly, Powell, Yoder) *Absent: 2* (Knight, Matta) **MOTION CARRIED**
1.5 Public Comment & Correspondence	Chairwoman Tangermann asked if there were any public comments or correspondence. There was none.	None
3 Consent Calendar	Chairwoman Tangermann stated that all items on the consent calendar would be approved with one motion unless someone requests to pull an item for further discussion.	*Commissioner Germano moved to approve Resolutions 2.1, 3.1, 3.2, 3.3, 3.4, 3.5 and 3.6 as presented,*

	Hearing no requests, she asked for a motion to approve resolutions 2.1, 3.1, 3.2, 3.3, 3.4, 3.5 and 3.6. **Consent Calendar** ▪ **2.1** Resolution to Approve Commendations and Appreciation for Commissioner Nolan Sullivan's Service to Partnership ▪ **3.1** Resolution to Accept all Committee Minutes, Policy & Program Updates Approved by PAC ▪ **3.2** Resolution to Approve Physician Advisory Committee Membership Changes ▪ **3.3** Resolution to Approve the Cultural & Linguistic Program Description, as Approved by PAC ▪ **3.4** Resolution to Approve the Care Coordination Program Description, MPCD2013, as Approved by PAC ▪ **3.5** Resolution to Approve the Proposed Measure Changes to the Hospital Quality Improvement Program (HQIP) as Approved by PAC ▪ **3.6** Resolution to Approve the Proposed Measure Changes to the Perinatal Quality Improvement Program (PQIP) as Approved by PAC	*seconded by Commissioner Andrus.* ***ACTION SUMMARY:*** *Yes: 28* *No: 0* *Abstention: 0* *Excused: 6* (Antle, Coleman, Kelly, Kennelly, Powell, Yoder) *Absent: 2* (Knight, Matta) **MOTION CARRIED**
4.1 Resolution: Approve Budget Assumptions for Fiscal Year 2025-26	Ms. Lopez presented the Fiscal Year 2025–2026 Budget Assumptions to the Committee, marking the first step in the three-part budget approval process. A draft Health Care Expense Budget will be shared with the Finance Committee in May, followed by the Final Budget presentation to both the Finance Committee and full Board in June. Ms. Lopez emphasized that due to ongoing federal and state budget uncertainty, Partnership will likely need to bring a mid-year budget revision to the Finance Committee and Board for approval. We are also awaiting the release of the Governor's May Budget Revision for further details on Medicaid funding. We will make every effort to incorporate any relevant updates from the May Revise into the May Finance Committee packet. ***Outlook for 2025-26*** **–** In the Governor's proposed FY 2025–26 January Budget, the state projected a $16.5 billion surplus, with a total budget of $322.3 billion, including $228.9 billion from the General Fund. The proposal includes $17 billion in reserve deposits, however, despite the planned deposits, the budget also includes a $7.1 billion withdrawal from the Budget Stabilization Account. The budget also proposed $188.1 billion in total Medi-Cal funding ($42.1 billion from the General Fund), and a 3.09% decrease in enrollees from the previous year. Since the release of the initial budget, the wildfires in Los Angeles have added significant and unforeseen recovery costs. Additionally, growing concerns about a potential recession and ongoing market volatility may substantially impact California's revenue from personal income taxes derived from capital gains. As a result, we anticipate increased state scrutiny of health plan rates and expenditures, with a likely focus on identifying areas for potential funding reductions. Despite so much uncertainty, DHCS is still moving forward with new benefits such as Transitional	*Commissioner Jones moved to approve Resolution 4.1 as presented, seconded by Commissioner Andrus.* ***ACTION SUMMARY:*** *Yes: 28* *No: 0* *Abstention: 0* *Excused: 6* (Antle, Coleman, Kelly, Kennelly, Powell, Yoder) *Absent: 2* (Knight, Matta) **MOTION CARRIED**

Rent, which is expected to be implemented by January 1, 2026. In November 2024, California voters approved Proposition 35, permanently extending the Managed Care Organization (MCO) Tax and dedicating its revenue to increase Medi-Cal provider payments starting in 2025. The measure requires DHCS to consult with a Governor- and Legislature-appointed stakeholder advisory committee before making any changes to provider payments. The first stakeholder meeting was held on April 14, 2025, but final decisions on 2025–2026 investments are not expected until late 2025.

DHCS will continue applying quality withholds to Managed Care Plans, currently withholding 1% of Partnership's revenue rates. These funds can be earned back by meeting established quality benchmarks. However, given that much of Partnership's service area is rural and has historically struggled with quality performance, this withhold presents a financial risk to overall revenue. Additionally, DHCS continues to issue monetary sanctions to plans that fail to meet quality targets. Partnership has received quality sanctions over the past two fiscal years. Additionally, DHCS has finalized its Community Reinvestment policy, included in the 2024 contract amendment. This policy requires plans with net profits to reinvest 5% to 7.5% into approved community projects. Plans that have received quality sanctions may be required to contribute additional reinvestment funding.

Enrollment – Following the January 2024 10-county expansion, Partnership's membership has remained relatively flat. To align with the Governor's January budget, we are assuming a 3% decline in membership for the next fiscal year—from the current 904,000 members to approximately 870,000 in June 2026. However, given recent recession forecasts, Partnership will revisit its membership assumptions before finalizing the budget. Historically, Medi-Cal plan enrollment tends to increase during economic downturns.

Revenue – Partnership will review CY 2024 and draft CY 2025 revenue levels to determine the most appropriate baseline for budgeting. Revenue projections for the upcoming fiscal year will incorporate assumptions related to enrollment, member acuity, and other emerging factors. Additional revenue assumptions will be applied to the second half of the fiscal year, based on prior-year trends, as updated rates will not be available until later in the calendar year. Staff will also consider known and reasonably estimable program updates and efficiency factors used in previous cycles.

As of January 1, 2025, Partnership assumed responsibility for the California Children's Services (CCS) program in the 10 expansion counties. This change extends CCS responsibilities to all counties in our service area, resulting in both increased revenue and corresponding expenses.

The budget will include CY 2024 Medi-Cal TRI program revenue and expenses. However, due to limited information on CY 2025 and 2026 TRI allocations through Proposition 35, these will not be included in the June budget. DHCS has also not finalized details for the new transitional rent benefit. Partnership will assess whether sufficient information is available to include estimated

revenue and costs in the June budget; if not, these items will be addressed in an off-cycle budget review.

Interest rates currently sit at 4.33%, and we are monitoring any upcoming changes from the Federal Reserve. Partnership receives rental income from 11 tenants in Fairfield, four in Auburn, two in Eureka, and one each in Redding, Napa, and Chico. There are 10 additional leasable spaces, with two currently pending.

Health Care Costs – For FY 2025–26, healthcare cost projections are based on historical trends and emerging data. Projections for the expansion counties will be further refined using actuarial analysis, draft rate estimates, and actual claims experience available before budget finalization. Partnership continues to closely monitor healthcare costs and membership trends and will adjust budget assumptions as new information becomes available.

Administrative Costs – Partnership will continue hiring staff to meet regulatory requirements outlined in the 2024 DHCS contract amendment. Additional staffing is also needed to prepare for the Medicare D-SNP launch in January 2026. New capital purchase recommendations—primarily for IT and Facilities—will be included in the final detailed capital expenditures budget.

Reserves – Maintaining adequate reserves is essential to prepare for potential financial challenges. The state requires health plans to hold reserves equivalent to two months of State Capitation Revenue. In addition, Partnership allocates funds for the Strategic Use of Reserves (SUR), which covers Board-approved projects with expenses not yet incurred. Given current economic conditions and uncertainty around potential federal Medicaid changes, revisions to the Board-designated reserve policy may be proposed in the coming months.

Off-Cycle Budget – Due to ongoing uncertainty around federal Medicaid changes, state budget responses, TRI rate updates for CY 2025–2026, and the Medicare D-SNP bid process, Partnership staff anticipate preparing an off-cycle budget to address any significant programmatic or cost changes that arise after the June budget is finalized.

Commissioner Gruver noted that DHCS cited factors in terms of Medi-Cal cost increases year over year, one of which was 3.6B due to MCO tax changes. Commissioner Gruver asked if Proposition 35 is driving these increases in Medi-Cal costs statewide. Ms. Lopez replied that in part Proposition 35 led to some of the increases but is also heavily influenced by the pharmacy carveout.

Commissioner Jones commented that it is difficult to predict anything in the current environment and thanked the Finance Department for their work.

Commissioner Germano expressed concern that continued hiring may seem counterintuitive at this time. Ms. Bjork clarified that the organization must fulfill all responsibilities under its contract

	with the state, and these provisions have not changed. As such, staffing remains necessary to support all active programs. While hiring continues, the approach is strategic and measured. For example, in the Health Services department, temporary staff are being hired to support some of the care transition-related work. In certain departments, a mix of temporary and consultant staff is being utilized where appropriate. Departments most affected by membership fluctuations include Member Services and Claims. A decrease in member inquiries or claims results in reduced staffing needs in these areas, which typically have higher turnover and consist of more entry-level roles. When necessary, staffing reductions are managed through attrition, choosing not to refill vacated positions. The organization prioritizes internal recruitment and cross-training, aiming to promote from within whenever possible.	
5.1 Information: Metrics and Financial Update	Written report included in the packet.	None
Adjournment	Chairwoman Tangermann adjourned the meeting at 8:33 A.M.	None

Respectfully submitted by:
Colleen Valenti, Assistant Board Clerk

Board Approval Date:

Signed: _____
Colleen Valenti, Assistant Board Clerk

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
1.4

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Placer County Board of Supervisors

Topic Description:
Lisa Davies, Chief Executive Officer at Chapa-De Indian Health Auburn, was appointed by the Placer County Board of Supervisors to the Partnership HealthPlan of California Commission (known as the Board).

Ms. Davies' term commences on June 25, 2025, and concludes on June 24, 2029.

Reason for Resolution:
To obtain Board approval to appoint Lisa Davies to the Partnership Board as a Placer County Representative.

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

Requested Action of the Board:
Based on the recommendation of the Placer County Board of Supervisors, the Board is asked to approve the new appointment of Lisa Davies to the Partnership Board.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
1.4

Resolution Number:
25-

IN THE MATTER OF: APPROVING THE NEW PLACER COUNTY APPOINTMENT OF LISA DAVIES TO THE PARTNERSHIP BOARD

Recital: Whereas,

A. Each county board of supervisors is responsible for appointing representatives to the Partnership Board of Commissioners.

B. Placer County has a vacancy on the Partnership Board.

C. The Board has authority to approve appointed Board members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Placer County appointment of Lisa Davies to the Partnership Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 25th day of June, 2025 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
1.5

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Solano County Board of Supervisors

Topic Description:
Dr. Seth Kaufman, Vice President, Chief Medical Officer and Chief Quality Officer at NorthBay Health, was appointed by the Solano County Board of Supervisors to the Partnership HealthPlan of California Commission (known as the Board).

Dr. Kaufman's term commences on June 24, 2025, and concludes on June 23, 2029.

Reason for Resolution:
To obtain Board approval to appoint Dr. Seth Kaufman to the Partnership Board as a Solano County Representative.

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

Requested Action of the Board:
Based on the recommendation of the Solano County Board of Supervisors, the Board is asked to approve the new appointment of Dr. Seth Kaufman to the Partnership Board.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
1.5

Resolution Number:
25-

IN THE MATTER OF: APPROVING THE NEW SOLANO COUNTY APPOINTMENT OF DR. SETH KAUFMAN TO THE PARTNERSHIP BOARD

Recital: Whereas,

A. Each county board of supervisors is responsible for appointing representatives to the Partnership Board of Commissioners.

B. Solano County has a vacancy on the Partnership Board.

C. The Board has authority to approve appointed Board members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Solano County appointment of Dr. Seth Kaufman to the Partnership Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 25th day of June, 2025 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
1.6

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Sierra County Board of Supervisors

Topic Description:
Jennifer Malone, Chief Ececutive Officer at Western Sierra Medical Clinic, was appointed by the Sierra County Board of Supervisors to the Partnership HealthPlan of California Commission (known as the Board).

Ms. Malone's term commences on June 25, 2025, and concludes on June 24, 2029.

Reason for Resolution:
To obtain Board approval to appoint Jennifer Malone to the Partnership Board as the Sierra County Representative.

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

Requested Action of the Board:
Based on the recommendation of the Sierra County Board of Supervisors, the Board is asked to approve the new appointment of Jennifer Malone to the Partnership Board.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
1.6

Resolution Number:
25-

IN THE MATTER OF: APPROVING THE NEW SIERRA COUNTY APPOINTMENT OF JENNIFER MALONE TO THE PARTNERSHIP BOARD

Recital: Whereas,

A. Each county board of supervisors is responsible for appointing representatives to the Partnership Board of Commissioners.

B. Sierra County has a vacancy on the Partnership Board.

C. The Board has authority to approve appointed Board members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Sierra County appointment of Jennifer Malone to the Partnership Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 25th day of June, 2025 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
1.7

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Sonoma County Board of Supervisors

Topic Description:
Nolan Sullivan, Sonoma County Director of Health and Human Services, was appointed by the Sonoma County Board of Supervisors to the Partnership HealthPlan of California Commission (known as the Board).

Mr. Sullivan's term commences on June 25, 2025, and concludes on May 20, 2029.

Reason for Resolution:
To obtain Board approval to appoint Nolan Sullivan to the Partnership Board as a Sonoma County Representative.

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

Requested Action of the Board:
Based on the recommendation of the Sonoma County Board of Supervisors, the Board is asked to approve the new appointment of Nolan Sullivan to the Partnership Board.

BOARD MEMBER APPOINTMENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
1.7

Resolution Number:
25-

IN THE MATTER OF: APPROVING THE NEW SONOMA COUNTY APPOINTMENT OF NOLAN SULLIVAN TO THE PARTNERSHIP BOARD

Recital: Whereas,

A. Each county board of supervisors is responsible for appointing representatives to the Partnership Board of Commissioners.

B. Sonoma County has a vacancy on the Partnership Board.

C. The Board has authority to approve appointed Board members.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To approve the new Sonoma County appointment of Nolan Sullivan to the Partnership Board.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 25th day of June, 2025 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Board Clerk

Report from the Chief Executive Officer

June 25, 2025

1. **State & Federal Developments**: Amidst the evolving federal and state policy and funding proposals, Partnership continues to advocate for the preservation of Medicaid. I sent a letter to the Senate leadership regarding the steep cuts in the budget resolution and the harmful impact they would have on the health care delivery system in the communities we serve. The health plan associations we belong to have sent similar letters. We have also continued our targeted media campaign about the importance of MediCal. The spots were created from the provider and member stories in the video we shared at the April board retreat.

   The news that CMS shared the data of Medicaid beneficiaries with the Department of Homeland Security has been prominent in both regular news outlets as well as social media. The California Department of Health Care Services issued a press release regarding the issue (attached). To date, DHCS has not yet received a response from CMS with clarification regarding what data was shared and how it will be used. The CEOs of the local health plans met with Director Michelle Baass and she gave her assurance that we will be updated when DHCS receives information or clarification from CMS. In addition, DHCS is developing an FAQ for members regarding this issue.

   In the meantime, our member facing teams have talking points in case any members call in with concerns about utilizing the benefits they are eligible for. We have provided them with referral sources for members who have immigration questions and have updated these resources on our external website under each counties' Community Resources page. When the DHCS Frequently Asked Questions document becomes available, we will share that with our staff and members as well.

2. **Calendar Year 2024 Voluntary Rate Range Program**: Partnership continues to facilitate our counties and district hospitals' participation in the Voluntary Rate Range Program. Funds are intended for entities with taxing authority to cover uncompensated costs of managed care benefits/services. At this time we are still working with eligible providers on the required contracts and working to address questions as they arise. The next step will likely occur in late 2025, when participating entities send their intergovernmental transfers (IGT) to DHCS. While the exact date of the CY 2024 Voluntary Rate Range Program payments is unknown at this time, based on prior period timelines, we anticipate payment in December of 2025. We will continue to keep participating providers apprised as we learn more on timelines.

3. **Behavioral Health Call Center & Member Experience** – Partnership is still on track to begin operating the Behavioral Health Access Line and Call Center beginning this early Fall. The Behavioral Health teams have been engaged jointly with Carelon, our provider network, IT staff, and other internal stakeholders to implement the de-delegation process for Carelon and transition these services to Partnership operations. Keen attention and emphasis are being placed on the member's experience when developing workflows. When a member is screened and is in need of mild-to-moderate mental health services, the goal is for Partnership's behavioral health call center to have the ability to make an appointment, in near real-time, for the member while they are on the phone.

4. **MediCare DSNP Update** – Partnership will implement its Partnership Advantage MediCare DSNP line of business on January 1, 2027 rather than our planned launch date of January 1, 2026. We continue to work on transitioning from our antiquated core system to a new one and we recently discovered serious issues that must be addressed before we convert. Our core system is what we utilize for claims processing, member eligibility, capitation, primary care assignment and so much more. Without the new system in place, we are unable to perform all the important functions needed for a DSNP product. We have informed DHCS of our need to delay and expect to receive a Corrective Action Plan in the next few weeks. The internal teams are currently gathering information that will help us set new timelines for both of these important projects.

5. **Memorada of Understanding "The MOU Project" –** The health plan's 2024 contract with DHCS requires a multitude of MOUs with counties and other entities. Over the past year and a half we have been working diligently to fulfill this requirement. I am happy to report additional progress. Two counties now have six signed MOUs in place: Humboldt and Mendocino. Lassen, Siskiyou and Yolo are close behind with four signed MOUs. Most counties have at least two or three completed with more in progress. Two counties do not yet have any signed MOUs: Shasta and Tehama. The purpose of this endeavor is to ensure that health plans work closely with certain county departments. These include the local health department, the mental health plan, child welfare, California Children's Services (Whole Child Model), the Drug MediCal Organized Delivery System and more. The terms of each MOU require regular meetings, exchange of information, some prescribed agenda items and a requirement to post information on our Partnership website. We very much appreciate the efforts of our county partners to get these agreements signed. We send updates to DHCS, who monitors our progress.

DHCS NEWS RELEASE

STATEMENT FROM THE DEPARTMENT OF HEALTH CARE SERVICES ON THE FEDERAL USE OF MEDI-CAL DATA AND MEMBER PRIVACY

SACRAMENTO — The California Department of Health Care Services (DHCS) is firmly committed to protecting the privacy and well-being of all Medi-Cal members. Recent reports have raised serious concerns about how federal agencies may be using Medicaid data, including the personal data of all 15 million Californians covered by Medi-Cal. We want to clarify what we know and the actions we are taking.

We are aware of reports that the federal Centers for Medicare & Medicaid Services (CMS) or the U.S. Department of Health and Human Services may have shared the personal data of Medi-Cal members with the Department of Homeland Security. Upon learning of these reports, DHCS reached out to CMS requesting information to confirm whether this occurred and on exactly what data was shared, to which agencies, and why. DHCS has not received confirmation that such sharing occurred, nor do we know what data may have been involved or for what purpose. We are actively seeking answers from our federal partners.

As required by federal law, DHCS submits monthly reports to CMS through the Transformed Medicaid Statistical Information System (T-MSIS). These reports include demographic and eligibility information, such as name, address, date of birth, Medicaid ID, Social Security number (if provided), and broad immigration status, for every Medi-Cal member. Data submitted to CMS, including through T-MSIS, is considered sensitive and confidential. CMS is legally required to protect the confidentiality and security of Medicaid data.

In addition, last month, DHCS responded to a federal data request to demonstrate that federal Medicaid funds were claimed only as permitted and allowable by federal rules. To be

clear: DHCS has not provided CMS with any additional or new demographic information beyond what is routinely reported.

We take any potential misuse of Medi-Cal data seriously and are deeply concerned about the possibility of information being used outside the scope of the Medicaid program administration. Any such disclosure would be unprecedented and a grave betrayal of public trust. This is concerning for all Californians covered by Medi-Cal, and especially concerning for our immigrant and American mixed-status families. DHCS is working closely with state leaders, legal experts, and community organizations to understand the situation, provide accurate information, and support affected communities.

For individuals with unsatisfactory immigration status (UIS) or others seeking support:

- The California Department of Social Services' Immigration Services Bureau offers a list of qualified nonprofits (https://www.cdss.ca.gov/inforesources/immigration/contractor-contact-information) that serve individuals with UIS.
- Additional resources, including information about legal assistance and mental health resources, are available on the Immigration and California Families webpage (https://www.ca.gov/immigration/).
- Contact your local embassy or consulate for legal assistance or guidance.

We are committed to transparency, privacy, and ensuring that all Californians, regardless of immigration status, feel safe accessing the care they need. We will continue to engage with community partners, share updates, and defend the rights and privacy of all Medi-Cal members.

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: June 18, 2025
Board Meeting Date: June 25, 2025

Agenda Item Number:
2.1

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
The Finance Committee and Partnership Staff

Topic Description:
On April 23, 2025, the Board approved Budget Assumptions for Fiscal Year (FY) 2025-2026 and directed staff to prepare a full operational budget. The Preliminary Health Care Expense Budget for FY 2025-2026 is being presented to the Finance Committee today for approval. The final budget (health care, administrative, and operations) is presented to the Finance Committee and full Board for approval in June.

Reason for Resolution:
The purpose of this resolution is to present the Preliminary Health Care Expense Budget for FY 2025-2026 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 Partnership staff, the Board is asked to ratify the Preliminary Health Care Budget for FY 2025-2026.

AGENDA REQUEST FOR RATIFICATION
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:**
Meeting Date: June 18, 2025 2.1
Board Meeting Date: June 25, 2025

Resolution Number:
25-

IN THE MATTER OF: RATIFYING THE FINANCE COMMITTEE'S APPROVAL OF THE PRELIMINARY HEALTH CARE EXPENSE BUDGET FOR FY 2025-2026

Recital: Whereas,

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

B. In prior meetings, Partnership 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 2025-2026.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 25th day of June 2025 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

FY 2025-26

Preliminary Health Care Budget

May 2025

Introduction

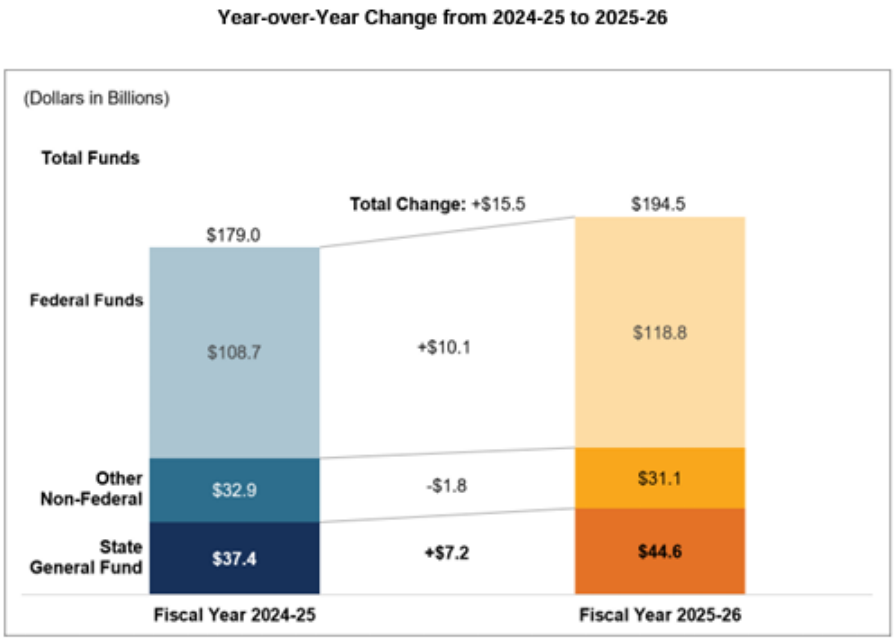
Each year, starting in January, Partnership HealthPlan of California (Partnership) begins building the annual budget for Board of Commissioner review and approval in June. As part of this process, Partnership presents to the Finance Committee and the Board key components of the budget development for review and approval. Specifically, in April the draft budget assumptions were presented and approved. The next phase of the process is to present and seek approval from the Finance Committee on the preliminary health care expense budget. In June, the final budget including previously reviewed components and a fully developed administrative budget are presented to the Board for final review and approval. This document outlines the fiscal year (FY) 2025-26 State Outlook, federal proposal that may affect Medi-Cal, and the Plan's preliminary health care expense budget in the major expense categories. Partnership staff will continue to make refinements to the health care expense budget, estimates may materially change prior to the final presentation of the full operating budget in June 2025.

FY 2025-26 State Outlook – May Revise

As of the May Revise the State presented a total budget of $321.9 billion total fund ($226.4 billion State General Fund) for FY 2025-26. The May Revise solves for a $12 billion deficit for FY 2025-26, in January, the Governor's Budget estimated a $16.5 billion surplus. The May Revise reserve balance reflects $15.7 billion in deposits, of which:

- $11.2 billion in the Budget Stabilization Account, an increase of $300 million from the January Budget.
- $4.5 billion in the Special Fund for Economic Uncertainties, no change from the January Budget.
- The January Budget earmarked a $1.5 billion deposit into the Public School System Stabilization Account, the May Revise no longer reflects this deposit.

The State budget summary specifically calls out Medi-Cal as a key factor in statewide expenditure growth. The below Department of Health Care Services (DHCS) budget chart[1], outlines the May Revise year-over-year Medi-Cal program estimated expenditures.



[1] https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2025_May_Estimate/MAY-2025-Medi-Cal-Local-Assistance-Estimate.pdf

As displayed above, $194.5 billion total fund ($44.6 billion General Fund) was requested to operate the Medi-Cal program for FY 2025-26, this is a $6.4 billion total fund ($2.5 billion General Fund) increase from the January Budget. The budget further assumes 14.8 million individuals would receive coverage through the Medi-Cal program, which is a 2.4% increase from the January Budget.

Significant May Revise Budget details that affect the Medi-Cal program are highlighted below.

- **Proposition 35 (Prop 35)** – As part of the May Revise, DHCS issued an updated Prop 35 Spending Plan for calendar year (CY) 2025 and 2026. The updated spending plan proposes to sweep and repurpose Prop 35 investments that are funded with Managed Care Organization (MCO) tax revenue. The revised spending plan for CY 2025 proposes to:
    - Keep the CY 2024 Targeted Rate Increase (TRI) investments intact.
    - Sweep nearly $1.2 billion in investments to offset the State General Fund, these funds were previously earmarked for Medi-Cal provider rate increases.
    - Shift $455 million to directed payment programs, it is anticipated these funds would be used to offset the non-federal share that is self-financed by providers for these programs.
    - Repurpose $390 million in Prop 35 investments for new proposals such as the development of flexible housing subsidy pools for rental assistance and housing supports and repurposing reproductive health investments for Department of Health Care Access and Information (HCAI) loan repayment and scholarships.

  The revised spending plan is not aligned with the parameters approved by California voters through Prop 35 which dedicated MCO tax revenues to increasing provider payment levels (in specified categories) for contracted Medi-Cal providers for CY 2025 and beyond. If legislature the approves the new spending plan it is more than likely to be challenged in court.

- **Unsatisfactory Immigration Status (UIS) Membership Changes Age 19+**
    - Enrollment Freeze: The May Revise proposes a UIS enrollment freeze for individuals age 19+ effective January 1, 2026. Currently UIS members make up just over 10% of Partnership's overall membership. If the freeze is enacted, UIS members will continue to have access to restricted-scope coverage through the Medi-Cal Fee-for-Service program for emergency and pregnancy related services.
    - Institute Medi-Cal Premiums: As of January 1, 2027, the Administration proposes to institute a $100 monthly premium for all UIS members age 19+ who are enrolled in full scope Medi-Cal. Should the institution of these premiums be included in the final budget, approximately 90,000 Partnership members could be subject to these annual premiums.
    - Full Scope Dental Benefit Elimination: In addition to the enrollment freeze and proposed premiums, the May Revise proposes to eliminate full scope Dental for UIS members age 19. However, UIS members will continue to have access to emergency dental services covered under restricted-scope Medi-Cal.

- **Eliminate Long-Term Care Services for UIS Members** – The May Revise proposes to eliminate long-term care services for UIS members. It is unclear how DHCS proposes to handle UIS members currently residing in long-term care facilities. Further, the proposed policy does not specify whether skilled nursing facility services are part of this benefit elimination.

- **Eliminate Prospective Payment System (PPS) funding for State-Only Services for UIS Members** – The May Revise proposes to eliminate PPS rate funding for Federally Qualified Health Centers

and Rural Health Clinics for state-only-funded services for UIS members. Instead, clinics would be reimbursed at the Medi-Cal Fee Schedule rate or the applicable Medi-Cal managed care rate.

- **Eliminate Proposition 56 Provider Supplemental Payments** – The May Revise proposes to eliminate $504 million in Proposition 56 supplemental payments for dental, family planning, and women's health providers statewide.

- **Eliminate the Skilled Nursing Facility Workforce and Quality Incentive Program (SNF WQIP)** – The May Revise proposes to eliminate the SNF WQIP directed payment program that provides enhanced funding to contracted SNFs and to suspend the requirement to maintain a backup power system for no fewer than 96 hours. This would eliminate $168.2 million in existing SNF supplemental funding statewide.

- **Changes to the Medi-Cal Minimum Loss Ratio (MLR)** – The May Revise proposes to increase the Medi-Cal Managed Care Plan MLR from 85% to 90%. This could put further strain on plan finances and could dampen the amount of funding that will be dedicated to Community Reinvestments.

- **Other Medi-Cal Proposals**
    - Reinstate the Asset Test for Medi-Cal Eligibility – This policy is proposed to be implemented for the Seniors and Persons with Disabilities population no sooner than January 1, 2026, and would limit assets to $2,000 for an individual and $3,000 for a couple. This could result in coverage loss for about 112,000 beneficiaries statewide by full implementation.
    - Eliminate Certain Over-the-Counter Drugs and Glucagon-Like Pepticde-1 (GLP-1) Drugs – This policy would eliminate Medi-Cal coverage of COVID-19 antigen tests, over-the-counter vitamins, certain antihistamines including dry eye products, and GLP-1s prescribed for weight loss effective January 1, 2026.
    - Elimination of the Acupuncture Benefit – This policy would eliminate the optional benefit Acupuncture effective January 1, 2026.
    - Implement Hospice Utilization Management – This policy would impose prior authorization requirements for hospice services.

- **Non-Medical Notable Budget Proposals**
    - In-Home Support Services (IHSS) Program Changes – The budget proposes to limit IHSS provider overtime and travel expenses and eliminate IHSS coverage for UIS members age 19+.
    - Creation of a new California Housing and Homelessness Agency – The Governor proposes to establish this new agency and cited the new agency would create a more integrated and effective administrative framework for addressing the State's housing and homelessness issues. The budget included $4.2 million ($4 million General Fund) in FY 2025-26 for this new office.

Despite the State's budgetary condition, DHCS and the Governor remain focused on California Advancing and Innovating Medi-Cal (CalAIM) and transforming Medi-Cal as noted in our April assumptions.

In previous times of budgetary hardship, the State has implemented a variety of cost cutting measures in the Medi-Cal program outside of the budget. Based on this history, we expect:

- The DHCS will continue to focus on cost-effective spending in managed care and expect pressures to be amplified.

- As noted in our prior budget, Partnership has faced increased scrutiny from DHCS on contracted heath care cost levels, some of which resulted in prior year's downward rate adjustments.

House Energy and Commerce Committee Proposal

On May 11, 2025, the House Energy and Commerce Committee (House) released its federal proposal to cut an estimated $715 billion from Medicaid, Medicare, and health care marketplaces over a 10-year period. The House proposal includes:

- **Freeze on Provider Taxes** – State imposed provider taxes would be frozen at their current levels and State's would be prohibited from establishing any new provider taxes. The Congressional Budget Office (CBO) projects that a moratorium on new taxes would recoup roughly $87 billion.
- **Limit Medicaid Directed Payments to the Medicare Payment Levels**– The House bill proposes to limit Medicaid directed payments to Medicare funding levels. The bill provides a hold harmless clause for current approved directed payments that exceed the limit. Currently a subset of the TRI procedure codes and certain hospital directed payments exceed the proposed limit. While the hold-harmless provision will ensure the funding levels are maintained, outyear program increases would be limited.
- **Medicaid Work Requirements** – Mandates every State to install a work requirement for certain beneficiaries. Able-bodied adults without any dependents would have to work at least 80 hours a month or perform other activities such as community service. It would not apply to pregnant women and only adults from 19 to 64. Tribal members are also exempt as well as those with serious medical conditions. At this time, the bill would give States until January 1, 2029, to implement. The CBO has projected that these work requirements will save $301 billion over the next decade. Partnership currently serves 355,000 members who are non-disabled adults between the ages of 19 to 64 who may be subject to these new requirements.
- **Changes to Medicaid Eligibility Verification –** Requires eligibility verification for the adult expansion population to occur every 6 months instead of annually. Implementation would be October 1, 2027. The CBO has this scored this proposal as saving over $49 billion. Nearly 30% of Partnership's current membership could be subject to these new requirements.
- **Federal Medical Assistance Percentage (FMAP) Penalty for State's who cover UIS Members** – State's who continue to cover individuals regardless of immigration status will have their federal match for the adult expansion population reduced by 10%. The FMAP penalty would be implemented October 1, 2027. The CBO has preliminary scored this proposal as $11 billion in savings. It is currently estimated California could lose over $3 billion in federal funding annually with the implementation of this policy.

Centers for Medicare and Medicaid Services (CMS) - Notice of Proposed Rulemaking

On May 12, 2025, CMS issued a Medicaid proposed rule aimed at adjusting the approval of provider tax waivers to ensure that they are broad based and generally redistributive. In short, the proposed rule would:

- Prohibit states from taxing Medicaid businesses at higher rates than non-Medicaid businesses.
- Maintain statistical testing while adding safeguards.
- Provide a transition timeline based on the age of existing waivers.

Currently, 48 states have at least one provider tax in place. Per the proposed rule, States may be provided up to 3 years to come into compliance with these new provisions based on the age of the approved waiver. However, it is unclear if California qualifies for the compliance implementation runway.

In California, the two largest provider tax programs are the MCO Tax and the Hospital Quality Assurance Fee (HQAF) program. The MCO tax proceeds fund TRI and Prop 35 directed payment investments while the HQAF funds the Private Hospital Directed Payment (PHDP) program. Currently the MCO Tax and the HQAF programs tax Medicaid provider utilization at a higher rate than non-Medicaid provider utilization. If the rule passes, we do not know how California would adjust the MCO Tax and HQAF taxing tiers. This proposal in combination with the House Budget Resolution are anticipated to have significant impacts on our providers. Ultimately this change will require the MCO Tax and the HQAF taxing tiers to be redesigned (and renegotiated with the providers that are taxed), it is anticipated tax tier changes would result in less funding for these programs.

Given the timing of finalizing the State's May Revision and the release of the House Budget Resolution and the CMS Proposed Rule it is unclear and how the State will react to the proposed federal Medicaid changes in the final enacted budget. Depending on the timing of federal action it is likely additional budget solutions will be proposed by the Governor after the enactment of the FY 2025-26 State budget.

Partnership FY 2025-26 Health Care Expenses

As noted in our April assumptions, while there is looming uncertainty, Partnership is dedicated to continue providing care to our members based on the current set of Medi-Cal benefits and services. Partnership FY 2025-26 budget will assume costs and membership for these members and services. However, Partnership staff expect to complete an off-cycle budget to account for any Medi-Cal program changes that may occur subsequent to the finalization and approval of Partnership's budget in June of 2025.

Health care cost projections for FY 2025-26 will be based on the Plan's historical claims experience for currently covered Medi-Cal members and benefits. At this time, Partnership anticipates utilizing cost experience from January 2023 through December 2024 for our respective counties which serve as the base data for budget development. Health care cost projections for the expansion counties may be further augmented based on actuarial analysis, draft rate projections, and actual claims experience received prior to budget finalization. Completion factors will be incorporated where appropriate to account for incurred but not yet reported claims. Partnership continues to closely monitor health care costs and membership changes and will adjust our budget methodology based on emerging information.

The base period costs will be adjusted for:

- Reasonable assumptions regarding underlying utilization trends based on internal analysis and a review of DHCS trends used in developing Plan capitation rates.
- Anticipated impacts of case management, utilization management, and specific disease management programs from year-to-year, or newly developed programs.
- Changes in provider contracting such as new payment amendments.

As noted in the April assumptions, Partnership will assess whether we have enough details to estimate the associated revenue and costs of the new transitional rent benefit for inclusion in our final June budget. If not, Partnership will include transitional rent along with CY 2025 and CY 2026 Prop 35 investments in our off-cycle budget review.

Considerations and estimates by cost category are presented in more detail below.

Inpatient Hospital

2025-26: $1.6 billion | 2024-25 Δ: -$-55.7 million or -3.3%

The Inpatient Hospital line item includes inpatient fee-for-service (FFS), hospital capitation, and stop loss expenses. The year-over-year decrease is primarily due to emerging trends from more comprehensive claims data in the expansion region. However, establishing reliable trends in this new region will take several years. With the implementation of the Whole Child Model program in our expansion region effective January 1, 2025, and the new statewide Medicare Buy-In program, further adjustments may be required for the final budget.

With the overall uncertainty in Medicaid and with the State' budgetary condition, Partnership must continue to be prudent in controlling health care expenses through appropriate medical management and sound contracting decisions. As contract requests are evaluated it is imperative to recognize other hospital revenue sources that are afforded to contracted providers in Medi-Cal managed care, such as the PHDP program and the District Hospital Directed Payment (DHDP) program. As of CY 2025 the PHDP and the DHDP programs grew significantly to account for the cost pressures hospitals are currently facing. Partnership is an outlier with our inpatient contracting levels in comparison to other Medi-Cal plans across the state. The state's actuaries assess the reasonableness of Partnership's contracting levels inclusive of the hospital directed payments.

Partnership staff are continuing to evaluate our budget assumptions and the final inpatient hospital expense will be presented in June. As a reminder, Partnership has faced increased scrutiny from DHCS on contracting heath care costs levels, some of which resulted in downward inpatient rate adjustments.

Physician Services

2025-26: $1.1 billion | 2024-25 Δ: $115.5 million or 12.1%

Physician Services includes Proposition 56 payments (Prop 56), specialty capitation, primary capitation, and physician FFS expenses. FFS expenses are increasing year-over-year due to a ramp up in utilization and recent contracting increases. Additionally, annual Tribal OMB rates and utilization for Indian Health Service (IHS) reimbursement have significantly increased. Over the next several weeks, Partnership staff will refine assumptions as additional run-out of paid claims data becomes available.

Effective January 1, 2024, the Prop 56 physician supplemental payment program transitioned into TRI. In CY 2024, TRI increased eligible contracted providers minimum reimbursement levels to at least 87.5% of the lowest Medicare locality in the state for certain Medi-Cal services. The CY 2024 TRI payment levels will continue for FY 2025-26. Details surrounding the final CY 2025 and CY 2026 provider investments through Prop 35 will not be known until the State's final budget is enacted.

Long-Term Care

2025-26: $703.9 million | 2024-25 Δ: $69 million or 10.9%

As explained in prior year budget cycles, the Long-Term Care expense category is challenging to budget for due to the timing and complexity of the retroactive DHCS rate increases. The rates are often released months after their effective date, more recently with multiple versions. This requires Partnership staff to complete an in-depth analysis to calculate and correct prior payments. Pursuant to Assembly Bill (AB) 86, DHCS has established the Workforce Standards Program. Facilities that opted-in receive an enhanced per diem. DHCS annual facility per diem rate increases, along with SB525 impacts, are driving the overall year-over-year increase.

Ancillary Services

2025-26: $1.1 billion | 2024-25 Δ: $121.4 million or 12.3%

Ancillary Services is comprised of FFS and capitated ancillary services, Enhanced Case Management (ECM), and Community Supports. The budget assumes increases tied to FFS utilization and unit cost increases specific to emergency department, outpatient hospital services, ECM, and Community Supports.

Other Medical

2025-26: $497.8 million | 2024-25 Δ: $63 million or 14.5%

The Other Medical category includes transportation, quality assurance, health care investment fund, nurse advice line, and the DHCS voluntary rate range program. As of April 2024, transportation benefits were directly coordinated by Partnership. The in-house administration of the non-medical and non-emergency medical transportation benefits continues to provide greater access and better customer service to our members and providers. Increases in utilization and the rural nature of the counties we serve are the main drivers for the year-over-year increase. The quality assurance and medical administrative expenses costs were held constant from the prior year; Staff will provide updated cost assumptions for these expense categories in the June budget.

DHCS Facility Directed Payment Programs

2025-26: $1.4 billion | 2024-25 Δ: $673.3 million or 89.4%

The following facility directed payments are included in this category: PHDP program, DHDP program, SNF WQIP, Designated Public Hospital Enhanced Payment program, and the Designated Public Hospital Quality Improvement program. The significant increase of the statewide pools for the PHDP program and the DHDP program are the primary driver of the year-over-year increase.

Quality Improvement Programs (Incentives)

2025-26: $89.2 million | 2024-25 Δ: $-10.8 million or -10.8%

The year-over-year decrease in QIP expenses is due to the conclusion of the Specialty Quality Access Incentive program on December 31, 2024. This program was sunset in conjunction with the CY 2024 TRI investments. Partnership continues to invest in quality improvement programs to enhance performance on quality metrics prioritized by the DHCS Quality Withhold Incentive program to provide quality, equitable and cost-effective care to our members. As in previous periods, incentive funding remains contingent on final revenue projections.

Dual Special Needs Plan (D-SNP)

The plan has undertaken significant efforts to operationalize our D-SNP by January 2026. Due the timing of finalizing our CMS bid submission, the anticipated costs for the D-SNP program have not been included in this version of the budget. Staff will incorporate D-SNP estimated costs in the final June budget. In addition to increased health care expenses, Partnership anticipates increased staffing costs, consulting costs, and capital costs associated with D-SNP systems and infrastructure needs.

Off-Cycle Budget

Due to the uncertainty regarding potential federal Medicaid program changes, the corresponding State's Budgetary reaction – Partnership staff expect to complete an off-cycle budget to account for material programmatic changes and cost changes that occur subsequent to the finalization of Partnership's budget in June.

Health Care Budget FY 2025-26 to FY 2024-25 Comparison

Health Care Categories	Budget FY 2025-26	Budget FY 2024-25	Y-o-Y △ $	Y-o-Y △ %
Inpatient Hospital	$1,643,371,839	$1,699,095,856	($55,724,017)	(3.3%)
Physician Services	$1,070,203,028	$954,692,536	$115,510,492	12.1%
Long Term Care	$703,914,904	$634,948,033	$68,966,871	10.9%
Ancillary Services	$1,105,418,263	$984,036,185	$121,382,078	12.3%
Other Medical	$497,756,774	$434,793,058	$62,963,716	14.5%
DHCS Facility Directed Payment Programs	$1,426,708,534	$753,440,101	$673,268,433	89.4%
Quality Improvement Programs	$89,200,000	$100,009,080	($10,809,080)	(10.8%)
Total Health Care Expense	**$6,536,573,342**	**$5,561,014,849**	**$975,558,493**	**17.5%**

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
3.1

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Partnership Advisory Groups and Committees

Topic Description:
Partnership HealthPlan of California has a number of advisory groups and committees established by the Commission (known as the Board) with direct reporting responsibilities. These are the Compliance / Governance Committee, Consumer Advisory Committee, Finance Committee, Personnel Committee, Physician Advisory Committee and Strategic Planning Committee.

The Physician Advisory Committee (PAC) has responsibility for oversight and monitoring of quality and cost-effectiveness of medical care provided to Partnership's members. A number of other advisory groups and committees have direct reporting responsibilities to PAC. These include the Credentials Committee, Internal Quality Improvement Committee, Member Grievance Review Committee, Over/Under Utilization Workgroup, Pediatric Quality Committee, Peer Review Committee, Pharmacy & Therapeutics Committee, Population Health Management & Health Equity Committee, Member Grievance Review Committee, Quality/Utilization Advisory Committee, Substance Use Services Internal Quality Improvement Subcommittee and Provider Engagement Group.

The Board is responsible for reviewing and accepting all minutes and packets approved by the various advisory groups and committees, and approving the policies, program descriptions, and QIP changes that were approved by the PAC, in April through June 2025.

Reason for Resolution:
To provide the Board the opportunity to review and accept Partnership advisory committee minutes and packets. In addition, to provide the Board with all Partnership policy and program description changes approved and recommended by PAC.

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

Requested Action of the Board:
Based on the recommendation of Partnership's advisory groups & committees, the Board is asked to accept receipt of all Partnership's committee minutes and committee packets and to approve all policy and program description changes approved by PAC, linked in the agenda.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
3.1

Resolution Number:
25-

IN THE MATTER OF: ACCEPTING ALL PARTNERSHIP HEALTHPLAN OF CALIFORNIA ADVISORY COMMITTEE MINUTES AND COMMITTEE PACKETS AND TO APPROVE POLICY AND PROGRAM DESCRIPTION CHANGES APPROVED BY THE PHYSICIAN 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 Partnership committee minutes and packets and to review and approve all policy and program description changes approved by PAC.

Now, Therefore, It Is Hereby Resolved As Follows:

1. To accept receipt of all Partnership committee minutes and committee packets.
2. To obtain approval for policy and program description changes approved and recommended by PAC.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 25th day of June 2025 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners

ABSTAINED: Commissioners

ABSENT: Commissioners

EXCUSED: Commissioners

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
3.2

Resolution Sponsor:
Dr. Moore, CMO, Partnership HealthPlan of CA

Recommendation by:
The Physician Advisory Committee (PAC)

Topic Description:
Dr. Steven Gwiazdowski resigns his position as PAC Chairperson but will remain on the committee as a voting member.

Angela Brennan, D.O., volunteers to serve as PAC Chairperson. Dr. Brennan has been a dedicated PAC voting member since August 2019 and treating Partnership members at NorthBay Health for several years.

Reason for Resolution:
To accept the resignation of Dr. Steven Gwiazdowski as Chair of PAC and the appointment of Dr. Angela Brenna as Chair of PAC.

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

Requested Action of the Board:
Based on the recommendation from the Physician Advisory Committee, the Board is asked to accept the resignation of Dr. Steven Gwiazdowski as Chair of PAC and the appointment of Dr. Angela Brenna as Chair of PAC.

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
3.2

Resolution Number:
25-

IN THE MATTER OF: APPROVING PHYSICIAN ADVISORY COMMITTEE MEMBERSHIP CHANGES

Recital: Whereas,

A. Dr. Steven Gwiazdowski has resigned as Chairperson of PAC.
B. Dr. Angela Brennan was appointed as Chairperson of PAC.
C. The Board has authority to approve advisory committee membership changes.

Now, Therefore, It Is Hereby Resolved as Follows:

1. To accept the resignation of Dr. Steven Gwiazdowski as Chair of the Physician Advisory Committee and the appointment of Dr. Angela Brenna as Chair of Physician Advisory Committee..

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 25th day of June 2025 by motion of Commissioner, seconded by Commissioner, and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

CONSENT AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
3.3

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

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

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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 25, 2025

Agenda Item Number:
3.3

Resolution Number:
25-

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

Recital: Whereas,

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

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

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 25th day of June 2025 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

Partnership HealthPlan of California

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

MPUD3001

May ~~2024~~2025

Table of Contents

PROGRAM PURPOSE

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

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

Partnership 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, Partnership outlines the structure of our measurement and management of utilization of health care services within our system.

The Partnership 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 resides within the Health Services Department, which consists of six (6) teams including:

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

The Partnership 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.

Partnership 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. Partnership 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 Partnership 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 Partnership 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 medically necessary 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, which is defined as "reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury," and that those services are 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. Other examples of service-types requiring medical necessity review include (but are not limited to):
  - Services where continuing previously established care is necessary
  - Pharmaceuticals covered under Partnership's medical benefit
  - Out-of-network services that are only covered in clinically appropriate circumstances

- Educates members, practitioners, providers and internal staff about Partnership'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 their assigned activities and responsibilities, including approval authority and the involvement of the designated physician.

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 Chief Health Services Officer, the Senior Director of Care Management, and the Director(s) and 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
- In collaboration with the Health Equity Officer (HEO), oversees Quality Improvement and Health Equity Transformation Program (QIHETP) operations and serves as Co-Chair of the Quality Improvement and Health Equity Committee (QIHEC)
- 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 Partnership 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 Chief Health Services Officer and appropriate committees

Medical Director – MD/DO

The Medical Director is a physician who oversees the appropriateness and quality of care delivered through Partnership and the cost-effective utilization of services.

- Coordinates with the Directors, Associate Directors, and Managers of UM to provide daily support and appropriate direction to staff on issues pertaining to UM
- Serves on the Quality/Utilization Advisory Committee, Pharmacy & Therapeutics Committee, Credentials Committee and Internal Quality Improvement Committee as requested by the CMO/ may work with community provider committees and advisory boards on medical issues and policies
- Supervises and evaluates other Medical Directors as assigned (direct reports)

Medical Director for Quality - MD/DO

The Medical Director for Quality is a physician who provides clinical and operational guidance for Quality and Performance Improvement activities and is responsible for supervision and oversight of the Quality Assurance & Patient Safety, Clinical Quality & Patient Safety and Quality Measurement–HEDIS teams. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

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

- Serves as the Committee Vice Chair for the Quality/Utilization Advisory Committee (Q/UAC)
- Serves as the Chair for the Peer Review Committee
- Regularly attends the Credentials Committee
- Regularly attends the Physician Advisory Committee (PAC)
- Regularly attends the Internal Quality Improvement (IQI) Committee
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC)

- Evaluates the appropriateness and quality of medical care delivered through Partnership in all regions
- Participates in enterprise-wide projects that require physician involvement, especially as related to Quality and Performance Improvement activities
- Assists with 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 Partnership members
- Other duties as assigned by the Senior Director of Quality or by the Chief Medical Officer

Medical Director of Medicare Services – MD/DO

The Medical Director of Medicare Services is a physician that oversees the appropriateness and quality of care delivered through Partnership and the cost-effective utilization of services. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

- Participates in Medicare Dual Special Needs Plan (D-SNP) policy, strategy and tactical activities, with the Medicare leads in other departments
- Providing medical leadership for Partnership's Medicare activities, including utilization management, quality, care coordination, pharmacy grievances, and compliance activities
- Assists with 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 Partnership members
- Other duties, as assigned

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 Partnership 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 Partnership 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 Partnership 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 Partnership's behavioral health activities including substance use services and the activities of Partnership'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 Partnership's 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 Partnership's delegated managed behavioral health organization(s)
- Oversees and monitors functions of Partnership's delegated managed behavioral health organization(s)
- Serves on Quality/Utilization Advisory Committee; Quality Improvement and Health Equity Committee (QIHEC); 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 Partnership Pharmacy management team, Partnership 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 Global Medi-Cal Drug Utilization Review (DUR) Board and the Pediatric Quality Committee (PQC)
- Drug utilization review
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC)
- 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

Chief Health Services Officer - RN

Provides executive leadership on current and new Health Services programs, operations, projects, policies and procedures to ensure high quality results across the continuum. 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 including daily support and appropriate direction to staff on issues pertaining to UM.
- Provides after-hours clinical coverage for providers requesting authorization for services pursuant to health plan policies and procedures.
- Reports to the Q/UAC on Health Services activities
- Coordinates departmental UM and Quality Improvement efforts
- Oversees the design and implementation of Quality Improvement and UM programs in order to meet Medicare Model of Care standards as well as National Commission on Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) accreditation for both Medi-Cal and future Medicare lines of business (D-SNP).
- Has a lead role in regulatory audits (DHCS, DMHC, CMS, NCQA)
- Collaborates with providers and facilities
- Monitors and analyzes 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)

Director of Health Equity – MD/DO/PharmD/RN

The Director of Health Equity serves as the Health Equity Officer (HEO) and is responsible for the co-implementation, co-supervision, co-oversight and evaluation of the Quality Improvement and Health Equity Transformation Program (QIHETP). This position provides guidance and overall direction of QIHETP activities and has the authority to make decisions based on the health equity annual plan. The assigned activities for this position include but are not limited to:

- Assuring that the QIHETP program fulfills its purpose, works towards measurable goals, and remains in compliance with regulatory requirements.
- In collaboration with the Chief Medical Officer (CMO); oversees QIHETP program operations and assists in the development and coordination of QIHETP policies and procedures.
- Serves as a Co-Chair for the Quality Improvement, Health Equity Committee (QIHEC) and the Population Needs Assessment (PNA) committee and regularly attends the Quality/Utilization Advisory Committee (Q/UAC) as a standing member
- Guides and assists in the development and revision of QIHETP medical policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for QIHEC review
- Other duties as assigned the Chief Executive Officer (CEO)
- Provides guidance to in staff trainings and on-site continuing education regarding diversity, equity, and inclusion and health equity
- Provides support for obtaining recommended accreditations that support diversity, equity, inclusion, and health equity (e.g. NCQA Health Equity Accreditation)

Senior Director of Care Management- RN

Under the direction of the Chief Health Services Officer, this position is responsible for setting and carrying out the overarching strategic direction and goals of the Utilization Management and Care Coordination Departments. This position maintains and oversees proper delivery, coordination and execution of all related services and activities to improve the health outcomes of members and has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Oversees and manages a large team of clinical and non-clinical staff while working in cross collaboration with both Medical Directors and other senior departmental leaders
- Responsible for overseeing the operations, programming and alignment of Utilization Management and Care Coordination department programs and activities
- Proactively works with key internal and external stakeholders to implement policies, procedures and/or initiatives that fulfill the organization's goals, strategic priorities and mission
- Provides clinical leadership in the design and implementation of programs and procedures for all lines of business; demonstrates decisiveness and communicates decisions and rationale clearly
- Stays abreast of health care policies, regulations and changes as they relate to those issued by CMS, DHCS, NCQA and/or other associated agencies
- Utilizes data to analyze and support quality patient outcomes and ongoing evaluation of the organization's Care Coordination and Utilization Management programs; ensuring effective and efficient health and quality outcomes, improving care coordination and meeting requirements of contracts

Director of Utilization Management - RN

Under the direction of the Senior Director of Care Management, this position is responsible for the day-to-day implementation of Partnership's UM Program and 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
- Provides day to day direction to UM Associate Directors, Managers and Supervisors ~~within~~ 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
- Participates in clinical audits of health services programs and services; oversees the nursing component of the audits and assists with development of corrective action plans when necessary
- Reports to the Q/UAC on UM activity
- Collaborates with providers and facilities
- Develops recommendations for program improvements
- Coordinates activities with Quality Improvement, Care Coordination, Population Health, Health Equity, Enhanced Health Services, 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

Director of ~~Utilization Management Strategies- RN~~Enhanced Health Services

Under the direction of the Chief Health Services Officer, 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:

- Serves as Director ~~for the Community Supports Initiative~~of CalAIM program
- Responsible for oversight of h~~H~~ousing and i~~I~~ncentive payment p~~P~~rograms
- Responsible for connecting with Street Medicine programs
- 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 Chief Health Services Officer 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 Enhanced Care Management (ECM) and Community Support (CS) 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 Partnership UM policies and procedures in collaboration with the Chief Health Services Officer as appropriate.
- Develops expertise in housing services funded through the Medi-Cal program including 1915(c) Home and Community Based Services Waivers and other Medicaid housing related opportunities such as Assisted Living Waivers.

- Leads Partnership discussions regarding state and federal housing/homeless policy, legislative, and regulatory strategy and implementation, and oversee and support regional and local policy initiatives, with a strong economic equity lens.
- Works with local agencies, state networks, and community organizations to identify issues and develop consensus positions on policy issues.
- Carries out research and policy analyses on issues and opportunities related to state housing policy and low-income housing programs, gathers member input, and establishes policy priorities and a legislative and regulatory agenda on an annual and ongoing basis.
- Interacts with housing advocacy groups and other organizations to identify emerging issues and opportunities.

Associate Director of Utilization Management - RN

Under the direction of the Director of Utilization Management, 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
- Provides day to day direction to UM Managers and Supervisors 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 Care Coordination, Population Health, 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.

Associate Director of Enhanced ~~Care Management Operations~~Health Services

Under the direction of the Director of ~~Utilization Management Strategies~~Enhanced Health Services, is responsible for managing the ~~Medi-Cal Enhanced Care Management (ECM) benefit~~CalAIM program. Provides strategic support and management/supervisory support for the CS and ECM staff, including but not limited to, strategic goal setting, program planning, budget/account management, and supervision of team members.

- Participates in internal and external meetings, providing input and guidance to community stakeholders and partners regarding the ~~ECM benefit~~CalAIM program
- Fosters cross-departmental collaboration in shared operational activities related to the ECM benefit and CS services (ex: Provider Relations, Care Coordination, Claims, etc.)
- In collaboration with Provider Relations, prepares and reviews provider and member education materials related to ~~the ECM benefit~~CalAIM
- Ensures timely monitoring and oversight of Partnership-contracted ECM and CS providers, pursuant to DHCS regulations and Partnership policies and procedures
- Identifies trends, patterns and/or opportunities for enhancements to workflows, tools and/or systems to promote efficiency, cost, and quality of ECM and CS services
- As directed, prepares or provides updates on DHCS deliverables and reports associated with ~~the ECM benefit~~CalAIM, including but not limited to the DHCS Model of Care template, DHCS ECM Exception Request(s), and/or DHCS ECM and CS reporting guidelines
- Maintains knowledge of ~~ECM benefit~~CalAIM requirements and shares updates with appropriate internal/external stakeholders, as necessary

~~*Associate Director of Housing and Incentive Programs*~~

~~Under the direction of the Director of Utilization Management Strategies, administers housing programs for Partnership HealthPlan of California; represents the Plan with existing and emerging housing providers including counties and Continuums of Care for the Plan's member counties; advocate for, promotes and makes recommendations regarding housing and related services for Partnership members experiencing homelessness, or at risk of homelessness. This position tracks and oversees state DHCS grant programs and initiatives that are to be administered by Partnership, in coordination with other departments such as Behavioral Health, at the direction of the CEO. Assigned activities include:~~

- ~~Develops expertise in the existing resources and safety net housing needs in each county served by Partnership.~~
- ~~Develops expertise in housing services funded through the Medi-Cal program including 1915(c) Home and Community Based Services Waivers and other Medicaid housing related opportunities such as Assisted Living Waivers.~~
- ~~Leads Partnership discussions regarding state and federal housing/homeless policy, legislative, and regulatory strategy and implementation, and oversee and support regional and local policy initiatives, with a strong economic equity lens.~~
- ~~Works with local agencies, state networks, and community organizations to identify issues and develop consensus positions on policy issues.~~
- ~~Carries out research and policy analyses on issues and opportunities related to state housing policy and low-income housing programs, gathers member input, and establishes policy priorities and a legislative and regulatory agenda on an annual and ongoing basis.~~
- ~~Interacts with housing advocacy groups and other organizations to identify emerging issues and opportunities.~~
- ~~Represents Partnership in various community planning and collaboration efforts.~~

Associate Director of Utilization Management Regulations

Under the direction of the Director of Utilization Management, provides oversight of the UM Program to ensure compliance with regulatory requirements including, but not limited to, requirements of DHCS, CMS, 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.
- Prepares and presents the annual evaluation, program description to IQI and Q/UAC
- 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 Director of Utilization Management, ~~Chief Health Services Officer, and the Chief Medical Officer or physician designee,~~ and prepares information for the Delegation Oversight Review Sub-Committee (DORS) and NCQA Steering Committee.
- Collaborates with Department leaders 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 Partnership staff and providers with the interpretation of Partnership 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

Senior Manager of Justice Involved Programs – RN

Under the direction of the Director of Enhanced Health Services, is responsible for working directly with justice-involved agencies and providers who serve justice-involved members in Partnership HealthPlan of California's county network. The assigned activities include:

- Serves as the Justice Liaison for the HealthPlan
- Facilitates communication with external stakeholders including: network providers, county staff, state prison system, probation offices, police/sheriff departments and other stakeholders as appropriate
- Oversees and develops a system for care coordination for this designated population on behalf of the HealthPlan, ensuring providers and staff are capable of serving this member population.
- Serves as the HealthPlan lead for oversight of any applicable MOUs between the HealthPlan and other entities as directed by DHCS and supports MOU activities and requirements to ensure HealthPlan compliance.
- Establishes systems to ensure connections with county mental health plans for the delivery of specialty mental health services on behalf of this specific population.
- Serves as a point of escalation for care managers if they face operational obstacles when working with County and/or community partners.

Manager of Utilization Management - 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, Chief Health Services Officer, Directors of UM, 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
- 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

Manager of Long Term Support Services (LTSS) – RN

Provides leadership and clinical oversight for operational aspects of Utilization Management for Long Term Support Services (LTSS); including the responsibility for providing daily oversight, leadership, support and management of assigned staff. Collaborates with departmental and Health Services leadership to oversee and monitor the provision of LTSS benefits and services; coordinating with Partnership providers and/or community stakeholders as necessary. This position has the authority to make decisions on coverage not relating to medical necessity.

- Provides day-to day direction to licensed clinical staff regarding utilization review, care coordination, discharge planning, and other services across the continuum of care for members in need of LTSS
- Ensures compliance with regulatory/accreditation requirements related to UM by collaborating with other departments and maintaining survey and audit readiness
- Leads, develops and operationalizes evidence-based best practices and activities to address LTSS benefits and/or services (ex: Transitional Care Services, facility placements, care coordination, etc.)

- Identifies and incorporates quality-monitoring activities to improve the quality of care, outcomes, and/or costs for members receiving one or more LTSS (ex: Skilled Nursing, Community Based Adult Services, In-Home Support Services, etc.)

Clinical ~~Team~~ Manager, Enhanced Health Services - RN~~CalAIM Justice Liaison, ECM Program~~
Assists the Director and Associate Director of ~~Utilization Management Strategies and Associate Director of~~ Enhanced Health Services (EHS)~~Care Management (ECM) Operations~~ in the development, implementation, ~~and/or expansion of the Medi-Cal ECM benefit and collaborating strategic initiatives.~~ management and evaluation of an effective and systematic CalAIM Program. Provides day-to-day guidance to nursing staff and manages all aspects of utilization review activities and is available to staff on-site or by telephone. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Monitors for consistent application of UM criteria by EHS staff for each level and type of EHS decision
- Participates in staff trainings and on-site continuing education
- Provides recommendations for interventions designed to improve utilization management issues
- Coordinates implementation of interventions
- Oversees auditing and oversight of CalAIM providers
- ~~This position is responsible for serving as Partnership's Justice Liaison~~
- ~~Communicates with network providers and other stakeholders in the Partnership service area to coordinate this work~~
- ~~Provides clinical oversight activities and program support to ECM providers~~
- Collaborates with departmental leadership to oversee and maintain a cohesive team with a high level of productivity, accuracy and quality to achieve goals and objective
- Maintains updated policies and procedures, workflows, documentation, desktops, reports, etc.
- Fosters cross-departmental leadership in shared operational activities related to the CalAIM initiatives. (ex: Provider Relations, Utilization Management, Claims, etc.)
- Maintains knowledge of the CalAIM initiatives and shares updates with appropriate internal /external stakeholders when necessary

Manager of Utilization Management Operations
Responsible for the operational aspects of Utilization Management, including responsibility for providing daily oversight, leadership, support, and management of assigned staff. Ensures compliance with established criteria, regulations, standards, best practices and Health Plan benefits. The assigned activities include:

- Provides daily operations oversight and direction to the team Supervisor(s) and Data Coordinators
- Manages day to day functions including coordination of assignments, monitoring of call volume and adherence to Partnership 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

Senior Programmer Analyst
This position supports the design, development, and documentation of Partnership's core claims processing, TAR processing, and claims processing platforms. Provides technical support and problem resolution to UM Department end users.

- Maintains in-depth knowledge of various Partnership systems
- Tests, schedules, and implements new releases and upgrades of software
- Tests, schedules, and implements interface changes to systems, when needed
- Supports development of business requirements for various system implementations
- Uses sound technical judgment and makes appropriate systems decisions
- Assists in development and maintenance of policies and procedures to document new and changed elements of UM Operations

Inpatient/Outpatient/LTSS Nurse Supervisor UM - RN

This position is responsible for the daily mentorship and oversight of the staff assigned to inpatient, ~~or~~ outpatient or LTSS 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 or LTSS 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

Clinical Supervisor of ~~Utilization Management Strategies~~Enhanced Health Services - RN

Provides daily supervision and program support to designated staff. Assists departmental leadership in developing and maintaining a cohesive team with a high level of productivity, accuracy and quality to achieve goals and objectives

- Provides daily leadership, direction, resources, training, evaluation, coverage, and program support to assigned staff
- Performs supervisory functions such as timecard management, directing work activities, conducting annual reviews and training to staff
- Maintains active participation with inbound and outbound provider reporting and other related duties, adjusting assignments as necessary to meet business needs and/or regulations
- Facilitates meetings with Partnership providers and/or external community partners as necessary
- Supports organizational collaboration and communication regarding CalAIM initiatives through active collaboration

Inpatient/Outpatient Nurse Lead UM - RN/ LVN

This position is responsible for assisting with oversight of daily operations of the inpatient or outpatient review process (as assigned). This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Provides direction and support, to staff concerning daily assignments.
- Participates in interview process and provides training in inpatient or outpatient review for new hires.
- Evaluates appropriateness of care through interpretation of benefits as outlined in Title 22, Medi-Cal Provider Manual using Partnership policies and procedures, and InterQual criteria.
- Documents and maintains patient-specific records in the data collection software system.
- Assists in the refinement/improvement of the Health Services programs. Participates in continuous process improvement endeavors.
- Works with other Partnership departments to resolve issues relating to authorization of medical services.
- Participates in Inter-rater Reliability studies, reviewing medical records as assigned.

- Communicates regularly with the UM Team Manager and works collaboratively to resolve issues.

Nurse Coordinator/ UM II - RN/ LVN

Work collaboratively with all levels of UM leadership and other Partnership 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
- 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 Partnership 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 – Pharm.D., RPh

[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.

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

- Communicates and educates prescribers on TAR processes, TAR determination, and Partnership medication coverage policies
- Provides oversight to the pharmacy technician staff in the daily TAR review process
- Participates 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 in the development of technician drug review guidelines and creation of authorization criteria for medical benefit medications
- 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
- Ensures 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)
- Other duties as assigned by the Pharmacy Services Director

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 Partnership 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 Partnership 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 Partnership 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

Policy Analyst

This position is responsible for drafting, editing, reviewing, auditing, tracking, monitoring and maintaining utilization management policies and procedures for Partnership. Under the supervision of the Associate Director of Utilization Management Regulations, ensures compliance with governing rules, regulations, and/or accreditation standards.

- Prepares UM policies and/or related materials for appropriate committees' review and attends meetings of the Internal Quality Improvement Committee and Quality/Utilization Advisory Committee.
- Performs policy research to analyze current and/or new regulations by applicable Partnership regulators and/or accrediting agencies (ex: DHCS, DMHC, CMS, NCQA, etc.)
- Reviews both draft and final All Plan Letters (APLs) and/or regulatory changes and supports leaders with the research, planning, implementation and/or operational readiness submissions across the organization.
- Participates in audits with Partnership's regulatory and/or accreditation bodies by preparing policies, documents and/or reports as needed.
- Conducts analysis, collects information, and evaluates impact of regulatory and compliance issues to inform auditing and monitoring activities.
- Analyzes the impact of new programs/benefits and efficacy of existing processes, policies, procedures and trainings.

Program Manager I – (Regulatory/Delegation)

Under the direction of the Associate Director of UM Regulations, assigned activities include:

- Responsible for day to day duties associated with oversight of UM delegated entities
- Responsible for successful implementation of new activities and processes with delegated entities
- Identifies and resolves issues and concerns with UM delegation to ensure risk is mitigated in a timely manner and recommends solutions to Leadership for final decision, as necessary
- 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

Program Manager I – (EHS~~CalAIM CS/ECM~~)

Under the direction of an Associate Director of ~~CalAIM (CS/ECM),~~Enhanced Health Services, develops, implements, improves, and manages assigned programs related to CalAIM. Participates in the design, implementation, and/or expansion of strategic programs and departmental initiatives. Supports the development and execution of program goals, outcome measures, and program reporting.

- Creates and delivers CalAIM program information and reports to both internal and external stakeholders
- Supports the development and execution of strategies to engage stakeholders.
- Responsible for program evaluation and continuous improvement activities
- Responsible for successful implementation of CalAIM activities.
- Reviews program data accuracy, completeness, and required submissions.

Program Manager I – (LTSS)

Under the direction of the Manager of Long Term Support Services (LTSS), supports operational aspects of Utilization Management related to LTSS including monitoring and reporting of the provision of LTSS benefits and services. Assigned activities include:

- Serves as the In-Home Supportive Services (IHSS) Specialist
- Serves as the Community Provider Advisory Council (CPAC) Coordinator
- Facilitates Point Click Care discharge reporting
- Monitors and tracks Letters of Agreement (LOAs)
- Coordinates with Health Analytics for Dashboard reporting
- Coordinates Critical Incident Review
- Creates specialized documents (Desktops, Info sharing with facilities and other departments, etc)
- Acts as a point of contact for the team for additional reporting needs

Project Coordinator II - (EHS~~CalAIM CS/ECM~~)
Under the direction of an Associate Director of Enhance Health Services~~CalAIM (CS/ECM)~~, provides coordination and implementation support of defined tasks for CalAIM programs. Conducts business analysis to evaluate programs, exercises independent judgement in leading assigned projects, tracks and reports data to a higher complexity level, coordinates daily activities, communicates program status to stakeholders.

- Coordinates, facilitates, and leads both internal and external meetings for CalAIM Providers.
- Supports the successful implementation of CalAIM projects.
- Customarily and regularly compiles, reviews and analyzes project data and results.
- Develops expertise in program focus areas and stays informed of key developments and training/development opportunities within our network and across the healthcare industry, maintains accurate provider listing for CalAIM Providers.

Project Coordinator I - (EHS~~CalAIM CS/ECM~~)
Under the direction of an Associate Director of ~~CalAIM (CS/ECM),~~Enhanced Health Services, provide coordination and implementation support of defined tasks for CalAIM program.

- Coordinates and facilitates both internal and external meetings for CalAIM Providers.
- Develops and publishes agendas, meeting minutes, and necessary documentation
- Attends project meetings, follows up on assigned tasks, and communicates the status of projects to the supervisor
- Manages, tracks, and processes CS or ECM referrals

Health Services Analyst I
Performs routine and ad-hoc reporting and data management for internal and external users; assists in maintaining reporting systems within the department. Prepares, analyzes, reports, and manages data used for both plan-wide and regional decision making for evaluating performance in key quality measures and the effective use of health plan resources on a routine and ad hoc basis. Works collaboratively with departments company-wide to identify data needs, develop and maintain data queries and tools, and complete accurate reporting to support performance and process improvements.

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 Partnership's educational programs are documented. Maintains organized electronic versions of all continuing education records.

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.

Executive Assistant to the Chief Health Services Officer - Administrative
Provides administrative support to the Chief Health Services Officer. Manages appointment calendar, develops agendas, organizes meetings and executes minutes for designated meetings.

Health Services Administrative Assistant II – UM, EHS - Administrative
Provides administrative support to the Utilization Management Director and/or other UM Leadership. Manages appointment calendars, coordinates setup and executes minutes for designated meetings.

Health Services Administrative Assistant I – UM - Administrative

Provides administrative support to UM Leadership. Manages appointment calendars and works closely with the Information Technology Department to ensure appropriate electronic functioning for the Utilization Management Department.

Health Services Administrative Assistant I – 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.

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 Partnership 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 Partnership UM Departmental policies and procedures
- Participates in staff trainings and on-site continuing education

Coordinator II - Administrative
Under the direction of applicable UM/ ~~CalAIM~~ EHS leadership:

- Serves as a resource to other departments who have inquiries into the UM/ CalAIM process
- Responsible for the input of data and information concerning UM/ CalAIM 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
- Responsible for clerical processing of appeals (as applicable) 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

Coordinator I - Administrative

Under the direction of applicable UM/ ~~CalAIM~~ EHS leadership - responsible for the input of data and information concerning UM/CalAIM 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
- Responsible for clerical processing of appeals (as applicable) 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

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 as follows: consumers, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health Departments. The Commission meets six times a year.

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

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 needed. Voting membership includes external Primary Care Providers (PCPs), board certified high-volume specialists, ~~and~~ behavioral health practitioners and non-physician clinicians. A voting provider member of the committee chairs the PAC. The Partnership Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer, Medical Director for Quality, Regional Medical Director(s), Clinical Director of Behavioral Health, Chief Health Services Officer and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, and Pharmacy departments attend the PAC meetings regularly. Other Partnership 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 Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external providers who are contracted primary care providers (PCPs) and board certified specialists in the areas of internal medicine, family medicine, pediatrics, OB/GYN, neonatology, behavioral health, and representatives from other high volume specialties. The Partnership Chief Medical Officer (CMO) (chair of the committee), Clinical Director of Behavioral Health, Health Equity Officer, Medical Director for Quality, Manager, Patient Safety-Quality Investigations, 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 Partnership 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 at least quarterly to the Commission. 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
- Approving and ensuring implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives
- Providing oversight of delegated activities

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee is chaired by Partnership's Chief Medical Officer (CMO), or designee such as the Director of Pharmacy, and is comprised of Partnership's Pharmacy Director, Associate and Regional Medical Directors, Partnership staff and 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 Partnership's Drug Utilization Review (DUR) Board to review Partnership's DUR program and activities and make recommendations where necessary to improve Partnership's drug utilization. The P&T meets quarterly, providing regular activity reports and recommendations to the PAC, the approval authority for P&T related activities.

Quality Improvement and Health Equity Committee (QIHEC)

The Quality Improvement and Health Equity Committee (QIHEC) is responsible for analyzing and evaluating the results of Quality Improvement (QI) and Health Equity activities including annual review of the results of performance measures, utilization data, grievance and appeal data, consumer satisfaction surveys, and findings and activities of other Partnership specific committees. (e.g. ~~Consumer~~ Community Advisory Committee, Population Needs Assessment (PNA) Committee, etc). This committee shall also be responsible for instituting actions to address health equity performance deficiencies, including policy recommendations, and ensuring appropriate follow-up of identified performance deficiencies.

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

Substance Use Services Internal Quality Improvement Subcommittee (SUIQI)

A committee comprised of appropriate Partnership and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the Partnership'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 overuse, underuse, 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, Senior Director of Behavioral Health, Senior Manager of Behavioral Health and representatives from the Provider Relations, Member Services, Claims, Compliance, Behavioral Health and Quality Improvement Departments.

~~Consumer~~ Community Advisory Committee (CAC)

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

UTILIZATION MANAGEMENT PROGRAM SCOPE

UM activities are developed, implemented and conducted by the Partnership Health Services Department under the direction of the Chief Medical Officer and the Chief Health Services Officer. 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 Partnership guidelines, Partnership 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 Partnership 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
- Residential Substance Use Disorder (SUD) treatment
- Behavioral Health Therapy (BHT)
- Community Supports
- Enhanced Care Management
- 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 Partnership 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 Partnership's Pharmacy Program because the pharmacy benefit is carved-out to State Medi-Cal through the Medi-Cal Rx Program.

Out of Scope for Partnership 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 Managed Care Plan (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 Partnership 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 Partnership Pharmacy & Therapeutics (P&T) Committee, or as required by State Policy (All Plan Letters), or in accordance with Partnership case-by-case review guideline (below) when Partnership criteria are not yet established. Timeliness standards mirror those for UM Program Timeliness (see page 26).
- Case-by-case review shall consider:
  - The member's individual medical needs (allergies, disease history, treatment history, concurrent medications, concurrent disease states, contraindications) and assessment of access and local delivery system
  - 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.
- AB 1114 Pharmacist Services pursuant to APL 22-012 *Revised* "Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX" (12/30/2022)
- 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 Non-Specialty Mental Health Services (NSMHS) needs that require mild to moderate mental health treatment are served by Partnership's delegated managed behavioral healthcare organization (MBHO), Carelon Behavioral Health, at (855) 765-9703.
- Members determined to require Specialty Mental Health Services (SMHS) for moderate to severe mental health conditions are referred to the County ~~Mental~~ Behavioral Health Plan (B~~M~~HP) in the Member's county of eligibility. 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.
- DHCS requires Managed Care Plans (MCPs) and B~~M~~HPs to use specific Screening and Transition of Care Tools for members under age 21 (youth) and for members age 21 and over (adults) to determine the appropriate mental health delivery system referral for members who are not currently receiving mental health services when they contact the MCP or B~~M~~HP seeking mental health services. These tools can be found on the DHCS website on this page: https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx

County ~~Mental~~ Behavioral 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 Partnership delegated contractor(s) 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~~ Behavioral Health Plan or Partnership's delegated contractor, Carelon Behavioral Health, for telephone consultation. For detailed referral and consultation procedures, PCPs can refer to Partnership Policy MPCP2017 Scope of Primary Care—Behavioral Health and Indications for Referral Guidelines.

Partnership 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 Partnership's provider network. Partnership 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 Partnership 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, Partnership ensures direct access to an initial mental health assessment by a licensed mental health provider within the Partnership 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.

Partnership 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~~ Behavioral Health plan and Partnership HealthPlan of California (Partnership) or its delegated contractor, Carelon Behavioral Health, both parties will participate in a dispute resolution process as defined in Partnership Policy ADM52 Dispute Resolution Between Partnership and MHPs in Delivery of Behavioral Health Services. This is consistent with the dispute resolution process outlined by State regulations and the individual County/Partnership Memoranda of Understanding.

Triage and Referral for Mental Health

Partnership monitors the triage and referral protocols for the delegated MBHO services provider(s) to assure they are appropriately implemented, monitored and professionally managed. Protocols employed by delegates must be clinically based and accepted industry practices. Protocols shall outline the level of urgency and appropriateness of the care setting.

Triage and referral decisions are performed by the Care Coordination team of the delegated MBHO services provider with oversight by Partnership's Behavioral Health Clinical Director. Partnership and its delegate work collaboratively with the respective County ~~Mental~~ Behavioral Health Plans to coordinate and ensure members receive care at the appropriate level in a timely manner.

Substance Use Disorder Treatment Services/ Wellness & Recovery Program

Partnership works to ensure that members receive effective and appropriate behavioral health care services for both mental health and substance use disorders. Partnership provides Substance Use Disorder (SUD) treatment services as outlined in the Regional Drug Medi-Cal Model (Regional Model). SUD services are administered either by Partnership or through individual counties not participating in the Regional Model. Partnership

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, and naloxone). *Partnership is financially responsible for the dispensing of these medications when services occur in a contracted Narcotic Treatment Program (NTP)/ Opioid Treatment Program (OTP) facility. When MAT is prescribed outside of a NTP/OTP (e.g. dispensed through a pharmacy) the medications will be authorized through the state Medi-Cal Rx program.*
- Care Coordination
- Recovery services (aftercare)

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

Partnership has provided benefits for Behavioral Health Therapy for children diagnosed with Autism Spectrum Disorder (ASD) since September 2014. Effective July 1, 2018, Partnership 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.

Partnership will provide medically necessary BHT services covered under Medicaid 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) 23-010 *Revised*.

- Additional detailed information regarding the BHT benefit can be found in the following Partnership 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

Partnership 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, Partnership 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, Partnership 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 Partnership 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 Partnership UM department by fax or through Partnership'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 Partnership 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. Partnership 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 Partnership's Online Services (OLS) portal (or by fax or mail). Partnership 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 Partnership's network. 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 Partnership 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 Partnership 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. Partnership 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, Partnership conducts several committees for the purpose of hearing and incorporating practitioner input in the development of medical policy. Partnership, through the Physician Advisory Committee (PAC), the Quality/ Utilization Advisory Committee, and the Pharmacy and Therapeutics Committee (P&T) , 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, Partnership 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 Partnership 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 Partnership 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.

Partnership 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 Partnership 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

Partnership 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. Partnership measures the timeliness of decisions from the date when the organization receives the request from the member or PCP, even if the Partnership does not have all the information necessary to make a decision. Partnership documents the date when the request is received and the date a decision is rendered in the UM documentation system.

Partnership 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.

Partnership 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 Partnership 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 Partnership 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). Partnership 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~~ Community 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)

Partnership 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
- Behavioral Health (BH) 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 Partnership 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.

Partnership'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

Partnership 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.).
- After normal business hours, Members and Providers may contact the Partnership voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
- After normal business hours, members may contact the advice nurse line at (866) 778-8873 for assistance with clinical concerns.
- Practitioners, both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
    - Partnership has a dedicated after-hours phone number local (707) 430-4808 or toll free (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's Chief Medical Director or physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership

clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a member whose emergency medical condition is stabilized.

- Partnership UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- Partnership maintains a toll free number (800) 863-4155 that is available to both members and practitioners.
- Members can view information about Partnership's language assistance services and disability services in the Member Handbook which is made available to members upon enrollment and is always viewable online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf
  Additionally, Partnership provides annual written notice to Members about our language assistance services and disability services (e.g. TTY for hearing impaired) in our Member Newsletter.

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

No Cost Linguistic Services:

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
- Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for Partnership Members according to regulatory timeframes, and into other languages or alternative formats upon request. Alternative m~~M~~aterial formats ~~are also available~~ include audio, large print and electronically for members with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. Auxiliary aids are also available upon request. Please refer to MCND9002 Cultural and Linguistic Program Description for more information. The organization may continue to provide translated materials in other languages represented by the population at the discretion of Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735-2929 or 711]

Partnership regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. (See policy MCND9002 *Cultural and Linguistic Program Description*)

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 which is defined as "reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury." ~~(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
- When out-of-network services are not clinically appropriate
- 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.

Partnership 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. Partnership monitors over and under-utilization through the Over/Under Utilization Workgroup which reviews annual utilization patterns. Decisions made by Partnership'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 Partnership'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 Partnership policy MCUP3037 *Appeals of Utilization Management/ Pharmacy Decisions* for a full description of the process.

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/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
- Member utilization data
- Provider prescribing data

EVALUATION OF NEW MEDICAL TECHNOLOGY

Partnership 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, Partnership has the option of adding to this basic package of benefits for its members.

Partnership's Policy MCUP3042 *Technology Assessment* outlines the steps taken during the determination process. The Partnership 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 Partnership.

- Providers to whom UM activities have been delegated are responsible for reporting results and analyses to Partnership on a quarterly or annual basis. Reports are summarized for review and evaluation by Partnership'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. Partnership 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 Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer. Partnership 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 Partnership staff. For non-covered entities, Partnership requires Business Associate Agreements (BAA). Additionally, there is training on an annual basis for the Partnership workforce and Partnership providers/networks, and Partnership 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 and securely stored 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.
- Partnership has designated a Privacy Officer responsible to oversee compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal privacy laws.
- Partnership maintains administrative structure, reporting procedures, due diligence procedures, training programs and other methods to ensure effective compliance in use and disclosure of members' Protected Health Information (PHI).

NON-DISCRIMINATION STATEMENT

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

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

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

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

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

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact
- Information written in other languages
- Use of California Relay Services for hearing impaired

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

Partnership 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:

- Chief Health Services Officer
- Director, Pharmacy Services
- Directors of UM
- Associate Directors of UM
- UM Managers

Elements of the program evaluation include an objective assessment of meeting targeted goals to ensure appropriate, efficient utilization of resources/services for Partnership 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, 20254) UM Standards
- 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 Managed Care Plans: https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx

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)*, 11/13/19 *(Amended);* 04/08/20; 06/10/20 (*Amended*); 04/14/21; 01/12/22; 05/11/22; 05/10/23; 05/08/24; 05/14/25

*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

	04/16/2025

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

	05/14/2025

Steven Gwiazdowski, MD — *Date Approved*
Physician Advisory Committee Chairperson

	06/25/2025

Kim Tangermann ———*Date Approved*
Board of Commissioners Chairperson

Partnership HealthPlan of California

UTILIZATION MANAGEMENT PROGRAM DESCRIPTION

MPUD3001

May 2025

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PROGRAM PURPOSE

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

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

Partnership 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, Partnership outlines the structure of our measurement and management of utilization of health care services within our system.

The Partnership 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 resides within the Health Services Department, which consists of six (6) teams including:

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

The Partnership 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.

Partnership 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. Partnership 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 Partnership 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 Partnership 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 medically necessary 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, which is defined as "reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury," and that those services are 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. Other examples of service-types requiring medical necessity review include (but are not limited to):
  - Services where continuing previously established care is necessary
  - Pharmaceuticals covered under Partnership's medical benefit
  - Out-of-network services that are only covered in clinically appropriate circumstances

- Educates members, practitioners, providers and internal staff about Partnership'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 their assigned activities and responsibilities, including approval authority and the involvement of the designated physician.

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 Chief Health Services Officer, the Senior Director of Care Management, and the Director(s) and 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
- In collaboration with the Health Equity Officer (HEO), oversees Quality Improvement and Health Equity Transformation Program (QIHETP) operations and serves as Co-Chair of the Quality Improvement and Health Equity Committee (QIHEC)
- 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 Partnership 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 Chief Health Services Officer and appropriate committees

Medical Director – MD/DO

The Medical Director is a physician who oversees the appropriateness and quality of care delivered through Partnership and the cost-effective utilization of services.

- Coordinates with the Directors, Associate Directors, and Managers of UM to provide daily support and appropriate direction to staff on issues pertaining to UM
- Serves on the Quality/Utilization Advisory Committee, Pharmacy & Therapeutics Committee, Credentials Committee and Internal Quality Improvement Committee as requested by the CMO/ may work with community provider committees and advisory boards on medical issues and policies
- Supervises and evaluates other Medical Directors as assigned (direct reports)

Medical Director for Quality - MD/DO

The Medical Director for Quality is a physician who provides clinical and operational guidance for Quality and Performance Improvement activities and is responsible for supervision and oversight of the Quality Assurance & Patient Safety, Clinical Quality & Patient Safety and Quality Measurement–HEDIS teams. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

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

- Serves as the Committee Vice Chair for the Quality/Utilization Advisory Committee (Q/UAC)
- Serves as the Chair for the Peer Review Committee
- Regularly attends the Credentials Committee
- Regularly attends the Physician Advisory Committee (PAC)
- Regularly attends the Internal Quality Improvement (IQI) Committee
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC)
- Evaluates the appropriateness and quality of medical care delivered through Partnership in all regions

- Participates in enterprise-wide projects that require physician involvement, especially as related to Quality and Performance Improvement activities
- Assists with 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 Partnership members
- Other duties as assigned by the Senior Director of Quality or by the Chief Medical Officer

Medical Director of Medicare Services – MD/DO

The Medical Director of Medicare Services is a physician that oversees the appropriateness and quality of care delivered through Partnership and the cost-effective utilization of services. This physician also has the authority to make decisions based on medical necessity which result in the approval or denial of coverage for UM activities.

- Participates in Medicare Dual Special Needs Plan (D-SNP) policy, strategy and tactical activities, with the Medicare leads in other departments
- Providing medical leadership for Partnership's Medicare activities, including utilization management, quality, care coordination, pharmacy grievances, and compliance activities
- Assists with 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 Partnership members
- Other duties, as assigned

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 Partnership 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 Partnership 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 Partnership 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 Partnership's behavioral health activities including substance use services and the activities of Partnership'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 Partnership's 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 Partnership's delegated managed behavioral health organization(s)
- Oversees and monitors functions of Partnership's delegated managed behavioral health organization(s)
- Serves on Quality/Utilization Advisory Committee; Quality Improvement and Health Equity Committee (QIHEC); 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 Partnership Pharmacy management team, Partnership 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 Global Medi-Cal Drug Utilization Review (DUR) Board and the Pediatric Quality Committee (PQC)
- Drug utilization review
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC)
- 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

Chief Health Services Officer - RN

Provides executive leadership on current and new Health Services programs, operations, projects, policies and procedures to ensure high quality results across the continuum. 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 including daily support and appropriate direction to staff on issues pertaining to UM.
- Provides after-hours clinical coverage for providers requesting authorization for services pursuant to health plan policies and procedures.
- Reports to the Q/UAC on Health Services activities
- Coordinates departmental UM and Quality Improvement efforts
- Oversees the design and implementation of Quality Improvement and UM programs in order to meet Medicare Model of Care standards as well as National Commission on Quality Assurance (NCQA) and Utilization Review Accreditation Commission (URAC) accreditation for both Medi-Cal and future Medicare lines of business (D-SNP).
- Has a lead role in regulatory audits (DHCS, DMHC, CMS, NCQA)
- Collaborates with providers and facilities
- Monitors and analyzes 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)

Director of Health Equity – MD/DO/PharmD/RN

The Director of Health Equity serves as the Health Equity Officer (HEO) and is responsible for the co-implementation, co-supervision, co-oversight and evaluation of the Quality Improvement and Health Equity Transformation Program (QIHETP). This position provides guidance and overall direction of QIHETP activities and has the authority to make decisions based on the health equity annual plan. The assigned activities for this position include but are not limited to:

- Assuring that the QIHETP program fulfills its purpose, works towards measurable goals, and remains in compliance with regulatory requirements.
- In collaboration with the Chief Medical Officer (CMO); oversees QIHETP program operations and assists in the development and coordination of QIHETP policies and procedures.
- Serves as a Co-Chair for the Quality Improvement, Health Equity Committee (QIHEC) and the Population Needs Assessment (PNA) committee and regularly attends the Quality/Utilization Advisory Committee (Q/UAC) as a standing member
- Guides and assists in the development and revision of QIHETP medical policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for QIHEC review
- Other duties as assigned the Chief Executive Officer (CEO)
- Provides guidance to in staff trainings and on-site continuing education regarding diversity, equity, and inclusion and health equity
- Provides support for obtaining recommended accreditations that support diversity, equity, inclusion, and health equity (e.g. NCQA Health Equity Accreditation)

Senior Director of Care Management- RN

Under the direction of the Chief Health Services Officer, this position is responsible for setting and carrying out the overarching strategic direction and goals of the Utilization Management and Care Coordination Departments. This position maintains and oversees proper delivery, coordination and execution of all related services and activities to improve the health outcomes of members and has the authority to make decisions on coverage not relating to medical necessity. Assigned activities include:

- Oversees and manages a large team of clinical and non-clinical staff while working in cross collaboration with both Medical Directors and other senior departmental leaders
- Responsible for overseeing the operations, programming and alignment of Utilization Management and Care Coordination department programs and activities
- Proactively works with key internal and external stakeholders to implement policies, procedures and/or initiatives that fulfill the organization's goals, strategic priorities and mission
- Provides clinical leadership in the design and implementation of programs and procedures for all lines of business; demonstrates decisiveness and communicates decisions and rationale clearly
- Stays abreast of health care policies, regulations and changes as they relate to those issued by CMS, DHCS, NCQA and/or other associated agencies
- Utilizes data to analyze and support quality patient outcomes and ongoing evaluation of the organization's Care Coordination and Utilization Management programs; ensuring effective and efficient health and quality outcomes, improving care coordination and meeting requirements of contracts

Director of Utilization Management - RN

Under the direction of the Senior Director of Care Management, this position is responsible for the day-to-day implementation of Partnership's UM Program and 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
- Provides day to day direction to UM Associate Directors, Managers and Supervisors 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
- Participates in clinical audits of health services programs and services; oversees the nursing component of the audits and assists with development of corrective action plans when necessary
- Reports to the Q/UAC on UM activity
- Collaborates with providers and facilities
- Develops recommendations for program improvements
- Coordinates activities with Quality Improvement, Care Coordination, Population Health, Health Equity, Enhanced Health Services, 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

Director of Enhanced Health Services

Under the direction of the Chief Health Services Officer, 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:

- Serves as Director of CalAIM program
- Responsible for oversight of housing and incentive payment programs
- Responsible for connecting with Street Medicine programs
- Collaborates with the provider relations contracting team to identify strategic opportunities and develops recommendations
- Participates in contract review and negotiations
- In collaboration with the Chief Health Services Officer 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 Enhanced Care Management (ECM) and Community Support (CS) 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 Partnership UM policies and procedures in collaboration with the Chief Health Services Officer as appropriate.
- Develops expertise in housing services funded through the Medi-Cal program including 1915(c) Home and Community Based Services Waivers and other Medicaid housing related opportunities such as Assisted Living Waivers.
- Leads Partnership discussions regarding state and federal housing/homeless policy, legislative, and regulatory strategy and implementation, and oversee and support regional and local policy initiatives, with a strong economic equity lens.
- Works with local agencies, state networks, and community organizations to identify issues and develop consensus positions on policy issues.

- Carries out research and policy analyses on issues and opportunities related to state housing policy and low-income housing programs, gathers member input, and establishes policy priorities and a legislative and regulatory agenda on an annual and ongoing basis.
- Interacts with housing advocacy groups and other organizations to identify emerging issues and opportunities.

Associate Director of Utilization Management - RN

Under the direction of the Director of Utilization Management, 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
- Provides day to day direction to UM Managers and Supervisors 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 Care Coordination, Population Health, 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.

Associate Director of Enhanced Health Services

Under the direction of the Director of Enhanced Health Services, is responsible for managing the CalAIM program. Provides strategic support and management/supervisory support for the CS and ECM staff, including but not limited to, strategic goal setting, program planning, budget/account management, and supervision of team members.

- Participates in internal and external meetings, providing input and guidance to community stakeholders and partners regarding the CalAIM program
- Fosters cross-departmental collaboration in shared operational activities related to the ECM benefit and CS services (ex: Provider Relations, Care Coordination, Claims, etc.)
- In collaboration with Provider Relations, prepares and reviews provider and member education materials related to CalAIM
- Ensures timely monitoring and oversight of Partnership-contracted ECM and CS providers, pursuant to DHCS regulations and Partnership policies and procedures
- Identifies trends, patterns and/or opportunities for enhancements to workflows, tools and/or systems to promote efficiency, cost, and quality of ECM and CS services
- As directed, prepares or provides updates on DHCS deliverables and reports associated with CalAIM, including but not limited to the DHCS Model of Care template, DHCS ECM Exception Request(s), and/or DHCS ECM and CS reporting guidelines
- Maintains knowledge of CalAIM requirements and shares updates with appropriate internal/external stakeholders, as necessary

Associate Director of Utilization Management Regulations

Under the direction of the Director of Utilization Management, provides oversight of the UM Program to ensure compliance with regulatory requirements including, but not limited to, requirements of DHCS, CMS, 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.
- Prepares and presents the annual evaluation, program description to IQI and Q/UAC
- 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 Director of Utilization Management, and prepares information for the Delegation Oversight Review Sub-Committee (DORS) and NCQA Steering Committee.
- Collaborates with Department leaders 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 Partnership staff and providers with the interpretation of Partnership 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

Senior Manager of Justice Involved Programs – RN

Under the direction of the Director of Enhanced Health Services, is responsible for working directly with justice-involved agencies and providers who serve justice-involved members in Partnership HealthPlan of California's county network. The assigned activities include:

- Serves as the Justice Liaison for the HealthPlan
- Facilitates communication with external stakeholders including: network providers, county staff, state prison system, probation offices, police/sheriff departments and other stakeholders as appropriate
- Oversees and develops a system for care coordination for this designated population on behalf of the HealthPlan, ensuring providers and staff are capable of serving this member population.
- Serves as the HealthPlan lead for oversight of any applicable MOUs between the HealthPlan and other entities as directed by DHCS and supports MOU activities and requirements to ensure HealthPlan compliance.
- Establishes systems to ensure connections with county mental health plans for the delivery of specialty mental health services on behalf of this specific population.
- Serves as a point of escalation for care managers if they face operational obstacles when working with County and/or community partners.

Manager of Utilization Management - 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, Chief Health Services Officer, Directors of UM, 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
- 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

Manager of Long Term Support Services (LTSS) – RN

Provides leadership and clinical oversight for operational aspects of Utilization Management for Long Term Support Services (LTSS); including the responsibility for providing daily oversight, leadership, support and management of assigned staff. Collaborates with departmental and Health Services leadership to oversee and monitor the provision of LTSS benefits and services; coordinating with Partnership providers and/or community stakeholders as necessary. This position has the authority to make decisions on coverage not relating to medical necessity.

- Provides day-to day direction to licensed clinical staff regarding utilization review, care coordination, discharge planning, and other services across the continuum of care for members in need of LTSS
- Ensures compliance with regulatory/accreditation requirements related to UM by collaborating with other departments and maintaining survey and audit readiness
- Leads, develops and operationalizes evidence-based best practices and activities to address LTSS benefits and/or services (ex: Transitional Care Services, facility placements, care coordination, etc.)
- Identifies and incorporates quality-monitoring activities to improve the quality of care, outcomes, and/or costs for members receiving one or more LTSS (ex: Skilled Nursing, Community Based Adult Services, In-Home Support Services, etc.)

Clinical Manager, Enhanced Health Services - RN

Assists the Director and Associate Director of Enhanced Health Services (EHS) in the development, implementation, management and evaluation of an effective and systematic CalAIM Program. Provides day-to-day guidance to nursing staff and manages all aspects of utilization review activities and is available to staff on-site or by telephone. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Monitors for consistent application of UM criteria by EHS staff for each level and type of EHS decision
- Participates in staff trainings and on-site continuing education
- Provides recommendations for interventions designed to improve utilization management issues
- Coordinates implementation of interventions
- Oversees auditing and oversight of CalAIM providers
- Collaborates with departmental leadership to oversee and maintain a cohesive team with a high level of productivity, accuracy and quality to achieve goals and objective
- Maintains updated policies and procedures, workflows, documentation, desktops, reports, etc.
- Fosters cross-departmental leadership in shared operational activities related to the CalAIM initiatives. (ex: Provider Relations, Utilization Management, Claims, etc.)
- Maintains knowledge of the CalAIM initiatives and shares updates with appropriate internal /external stakeholders when necessary

Manager of Utilization Management Operations

Responsible for the operational aspects of Utilization Management, including responsibility for providing daily oversight, leadership, support, and management of assigned staff. Ensures compliance with established criteria, regulations, standards, best practices and Health Plan benefits. The assigned activities include:

- Provides daily operations oversight and direction to the team Supervisor(s) and Data Coordinators
- Manages day to day functions including coordination of assignments, monitoring of call volume and adherence to Partnership 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

Senior Programmer Analyst

This position supports the design, development, and documentation of Partnership's core claims processing, TAR processing, and claims processing platforms. Provides technical support and problem resolution to UM Department end users.

- Maintains in-depth knowledge of various Partnership systems
- Tests, schedules, and implements new releases and upgrades of software
- Tests, schedules, and implements interface changes to systems, when needed
- Supports development of business requirements for various system implementations
- Uses sound technical judgment and makes appropriate systems decisions
- Assists in development and maintenance of policies and procedures to document new and changed elements of UM Operations

Inpatient/Outpatient/LTSS Nurse Supervisor UM - RN

This position is responsible for the daily mentorship and oversight of the staff assigned to inpatient, outpatient or LTSS 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, outpatient or LTSS 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

Clinical Supervisor of Enhanced Health Services - RN

Provides daily supervision and program support to designated staff. Assists departmental leadership in developing and maintaining a cohesive team with a high level of productivity, accuracy and quality to achieve goals and objectives

- Provides daily leadership, direction, resources, training, evaluation, coverage, and program support to assigned staff
- Performs supervisory functions such as timecard management, directing work activities, conducting annual reviews and training to staff
- Maintains active participation with inbound and outbound provider reporting and other related duties, adjusting assignments as necessary to meet business needs and/or regulations
- Facilitates meetings with Partnership providers and/or external community partners as necessary
- Supports organizational collaboration and communication regarding CalAIM initiatives through active collaboration

Inpatient/Outpatient Nurse Lead UM - RN/ LVN

This position is responsible for assisting with oversight of daily operations of the inpatient or outpatient review process (as assigned). This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Provides direction and support, to staff concerning daily assignments.
- Participates in interview process and provides training in inpatient or outpatient review for new hires.
- Evaluates appropriateness of care through interpretation of benefits as outlined in Title 22, Medi-Cal Provider Manual using Partnership policies and procedures, and InterQual criteria.
- Documents and maintains patient-specific records in the data collection software system.
- Assists in the refinement/improvement of the Health Services programs. Participates in continuous process improvement endeavors.
- Works with other Partnership departments to resolve issues relating to authorization of medical services.
- Participates in Inter-rater Reliability studies, reviewing medical records as assigned.
- Communicates regularly with the UM Team Manager and works collaboratively to resolve issues.

Nurse Coordinator/ UM II - RN/ LVN

Work collaboratively with all levels of UM leadership and other Partnership 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
- 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 Partnership 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.

[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.

- 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 – Pharm.D., 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.

- Communicates and educates prescribers on TAR processes, TAR determination, and Partnership medication coverage policies
- Provides oversight to the pharmacy technician staff in the daily TAR review process
- Participates 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 in the development of technician drug review guidelines and creation of authorization criteria for medical benefit medications
- 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
- Ensures 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)
- Other duties as assigned by the Pharmacy Services Director

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 Partnership 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 Partnership 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 Partnership 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

Policy Analyst

This position is responsible for drafting, editing, reviewing, auditing, tracking, monitoring and maintaining utilization management policies and procedures for Partnership. Under the supervision of the Associate Director of Utilization Management Regulations, ensures compliance with governing rules, regulations, and/or accreditation standards.

- Prepares UM policies and/or related materials for appropriate committees' review and attends meetings of the Internal Quality Improvement Committee and Quality/Utilization Advisory Committee.
- Performs policy research to analyze current and/or new regulations by applicable Partnership regulators and/or accrediting agencies (ex: DHCS, DMHC, CMS, NCQA, etc.)
- Reviews both draft and final All Plan Letters (APLs) and/or regulatory changes and supports leaders with the research, planning, implementation and/or operational readiness submissions across the organization.
- Participates in audits with Partnership's regulatory and/or accreditation bodies by preparing policies, documents and/or reports as needed.
- Conducts analysis, collects information, and evaluates impact of regulatory and compliance issues to inform auditing and monitoring activities.
- Analyzes the impact of new programs/benefits and efficacy of existing processes, policies, procedures and trainings.

Program Manager I – (Regulatory/Delegation)

Under the direction of the Associate Director of UM Regulations, assigned activities include:

- Responsible for day to day duties associated with oversight of UM delegated entities
- Responsible for successful implementation of new activities and processes with delegated entities
- Identifies and resolves issues and concerns with UM delegation to ensure risk is mitigated in a timely manner and recommends solutions to Leadership for final decision, as necessary
- 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

Program Manager I – (EHS)

Under the direction of an Associate Director of Enhanced Health Services, develops, implements, improves, and manages assigned programs related to CalAIM. Participates in the design, implementation, and/or expansion of strategic programs and departmental initiatives. Supports the development and execution of program goals, outcome measures, and program reporting.

- Creates and delivers CalAIM program information and reports to both internal and external stakeholders
- Supports the development and execution of strategies to engage stakeholders.
- Responsible for program evaluation and continuous improvement activities
- Responsible for successful implementation of CalAIM activities.
- Reviews program data accuracy, completeness, and required submissions.

Program Manager I – (LTSS)
Under the direction of the Manager of Long Term Support Services (LTSS), supports operational aspects of Utilization Management related to LTSS including monitoring and reporting of the provision of LTSS benefits and services. Assigned activities include:

- Serves as the In-Home Supportive Services (IHSS) Specialist
- Serves as the Community Provider Advisory Council (CPAC) Coordinator
- Facilitates Point Click Care discharge reporting
- Monitors and tracks Letters of Agreement (LOAs)
- Coordinates with Health Analytics for Dashboard reporting
- Coordinates Critical Incident Review
- Creates specialized documents (Desktops, Info sharing with facilities and other departments, etc)
- Acts as a point of contact for the team for additional reporting needs

Project Coordinator II - (EHS)
Under the direction of an Associate Director of Enhance Health Services, provides coordination and implementation support of defined tasks for CalAIM programs. Conducts business analysis to evaluate programs, exercises independent judgement in leading assigned projects, tracks and reports data to a higher complexity level, coordinates daily activities, communicates program status to stakeholders.

- Coordinates, facilitates, and leads both internal and external meetings for CalAIM Providers.
- Supports the successful implementation of CalAIM projects.
- Customarily and regularly compiles, reviews and analyzes project data and results.
- Develops expertise in program focus areas and stays informed of key developments and training/development opportunities within our network and across the healthcare industry, maintains accurate provider listing for CalAIM Providers.

Project Coordinator I - (EHS)
Under the direction of an Associate Director of Enhanced Health Services, provide coordination and implementation support of defined tasks for CalAIM program.

- Coordinates and facilitates both internal and external meetings for CalAIM Providers.
- Develops and publishes agendas, meeting minutes, and necessary documentation
- Attends project meetings, follows up on assigned tasks, and communicates the status of projects to the supervisor
- Manages, tracks, and processes CS or ECM referrals

Health Services Analyst I
Performs routine and ad-hoc reporting and data management for internal and external users; assists in maintaining reporting systems within the department. Prepares, analyzes, reports, and manages data used for both plan-wide and regional decision making for evaluating performance in key quality measures and the effective use of health plan resources on a routine and ad hoc basis. Works collaboratively with departments company-wide to identify data needs, develop and maintain data queries and tools, and complete accurate reporting to support performance and process improvements.

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 Partnership's educational programs are documented. Maintains organized electronic versions of all continuing education records.

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.

Executive Assistant to the Chief Health Services Officer - Administrative
Provides administrative support to the Chief Health Services Officer. Manages appointment calendar, develops agendas, organizes meetings and executes minutes for designated meetings.

Health Services Administrative Assistant II – UM, EHS - Administrative
Provides administrative support to the Utilization Management Director and/or other UM Leadership. Manages appointment calendars, coordinates setup and executes minutes for designated meetings.

Health Services Administrative Assistant I – UM - Administrative
Provides administrative support to UM Leadership. Manages appointment calendars and works closely with the Information Technology Department to ensure appropriate electronic functioning for the Utilization Management Department.

Health Services Administrative Assistant I – 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.

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 Partnership 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 Partnership UM Departmental policies and procedures
- Participates in staff trainings and on-site continuing education

Coordinator II - Administrative
Under the direction of applicable UM/ EHS leadership:

- Serves as a resource to other departments who have inquiries into the UM/ CalAIM process
- Responsible for the input of data and information concerning UM/ CalAIM 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
- Responsible for clerical processing of appeals (as applicable) 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

Coordinator I - Administrative
Under the direction of applicable UM/ EHS leadership - responsible for the input of data and information concerning UM/CalAIM 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
- Responsible for clerical processing of appeals (as applicable) 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

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 as follows: consumers, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health Departments. The Commission meets six times a year.

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

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 needed. Voting membership includes external Primary Care Providers (PCPs), board certified high-volume specialists, behavioral health practitioners and non-physician clinicians. A voting provider member of the committee chairs the PAC. The Partnership Chief Executive Officer, Chief Operating Officer, Chief Financial Officer, Chief Medical Officer, Medical Director for Quality, Regional Medical Director(s), Clinical Director of Behavioral Health, Chief Health Services Officer and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, and Pharmacy departments attend the PAC meetings regularly. Other Partnership 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 Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external providers who are contracted primary care providers (PCPs) and board certified specialists in the areas of internal medicine, family medicine, pediatrics, OB/GYN, neonatology, behavioral health, and representatives from other high volume specialties. The Partnership Chief Medical Officer (CMO) (chair of the committee), Clinical Director of Behavioral Health, Health Equity Officer, Medical Director for Quality, Manager, Patient Safety-Quality Investigations, 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 Partnership 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 at least quarterly to the Commission. 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
- Approving and ensuring implementation of evidence-based guidelines and policies of medical practice including preventive, chronic care, and behavioral health initiatives
- Providing oversight of delegated activities

Pharmacy and Therapeutics Committee (P&T)

The P&T Committee is chaired by Partnership's Chief Medical Officer (CMO), or designee such as the Director of Pharmacy, and is comprised of Partnership's Pharmacy Director, Associate and Regional Medical Directors, Partnership staff and 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 Partnership's Drug Utilization Review (DUR) Board to review Partnership's DUR program and activities and make recommendations where necessary to improve Partnership's drug utilization. The P&T meets quarterly, providing regular activity reports and recommendations to the PAC, the approval authority for P&T related activities.

Quality Improvement and Health Equity Committee (QIHEC)

The Quality Improvement and Health Equity Committee (QIHEC) is responsible for analyzing and evaluating the results of Quality Improvement (QI) and Health Equity activities including annual review of the results of performance measures, utilization data, grievance and appeal data, consumer satisfaction surveys, and findings and activities of other Partnership specific committees. (e.g. Community Advisory Committee, Population Needs Assessment (PNA) Committee, etc). This committee shall also be responsible for instituting actions to address health equity performance deficiencies, including policy recommendations, and ensuring appropriate follow-up of identified performance deficiencies.

The QIHEC provides recommendations to the Internal Quality Improvement Committee (IQI) and to the Quality/Utilization Advisory Committee (Q/UAC) Committee. The Q/UAC provides recommendations to the Physician Advisory Committee (PAC). PAC is responsible for oversight and monitoring of the quality and cost-effectiveness of medical care provided to Partnership members and is comprised of the Chief

Medical Officer (CMO) and participating clinician representatives from primary and specialty care disciplines.

Substance Use Services Internal Quality Improvement Subcommittee (SUIQI)
A committee comprised of appropriate Partnership and County staff tracks progress towards successful completion of quality initiatives, surveys, audits, and accreditation for the Partnership'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 overuse, underuse, 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, Senior Director of Behavioral Health, Senior Manager of Behavioral Health and representatives from the Provider Relations, Member Services, Claims, Compliance, Behavioral Health and Quality Improvement Departments.

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

UTILIZATION MANAGEMENT PROGRAM SCOPE

UM activities are developed, implemented and conducted by the Partnership Health Services Department under the direction of the Chief Medical Officer and the Chief Health Services Officer. 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 Partnership guidelines, Partnership 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 Partnership 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
- Residential Substance Use Disorder (SUD) treatment
- Behavioral Health Therapy (BHT)
- Community Supports
- Enhanced Care Management
- 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 Partnership 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 Partnership's Pharmacy Program because the pharmacy benefit is carved-out to State Medi-Cal through the Medi-Cal Rx Program.

Out of Scope for Partnership 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 Managed Care Plan (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 Partnership 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 Partnership Pharmacy & Therapeutics (P&T) Committee, or as required by State Policy (All Plan Letters), or in accordance with Partnership case-by-case review guideline (below) when Partnership criteria are not yet established. Timeliness standards mirror those for UM Program Timeliness (see page 26).
- Case-by-case review shall consider:
  - The member's individual medical needs (allergies, disease history, treatment history, concurrent medications, concurrent disease states, contraindications) and assessment of access and local delivery system
  - 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.
- AB 1114 Pharmacist Services pursuant to APL 22-012 *Revised* "Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal RX" (12/30/2022)
- 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 Non-Specialty Mental Health Services (NSMHS) needs that require mild to moderate mental health treatment are served by Partnership's delegated managed behavioral healthcare organization (MBHO), Carelon Behavioral Health, at (855) 765-9703.
- Members determined to require Specialty Mental Health Services (SMHS) for moderate to severe mental health conditions are referred to the County Behavioral Health Plan (BHP) in the Member's county of eligibility. 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.
- DHCS requires Managed Care Plans (MCPs) and BHPs to use specific Screening and Transition of Care Tools for members under age 21 (youth) and for members age 21 and over (adults) to determine the appropriate mental health delivery system referral for members who are not currently receiving mental health services when they contact the MCP or BHP seeking mental health services. These tools can be found on the DHCS website on this page: https://www.dhcs.ca.gov/Pages/Screening-and-Transition-of-Care-Tools-for-Medi-Cal-Mental-Health-Services.aspx

County Behavioral 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 Partnership delegated contractor(s) 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 Behavioral Health Plan or Partnership's delegated contractor, Carelon Behavioral Health, for telephone consultation. For detailed referral and consultation procedures, PCPs can refer to Partnership Policy MPCP2017 Scope of Primary Care—Behavioral Health and Indications for Referral Guidelines.

Partnership 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 Partnership's provider network. Partnership 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 Partnership 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, Partnership ensures direct access to an initial mental health assessment by a licensed mental health provider within the Partnership 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.

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

Triage and Referral for Mental Health

Partnership monitors the triage and referral protocols for the delegated MBHO services provider(s) to assure they are appropriately implemented, monitored and professionally managed. Protocols employed by delegates must be clinically based and accepted industry practices. Protocols shall outline the level of urgency and appropriateness of the care setting.

Triage and referral decisions are performed by the Care Coordination team of the delegated MBHO services provider with oversight by Partnership's Behavioral Health Clinical Director. Partnership and its delegate work collaboratively with the respective County Behavioral Health Plans to coordinate and ensure members receive care at the appropriate level in a timely manner.

Substance Use Disorder Treatment Services/ Wellness & Recovery Program

Partnership works to ensure that members receive effective and appropriate behavioral health care services for both mental health and substance use disorders. Partnership provides Substance Use Disorder (SUD) treatment services as outlined in the Regional Drug Medi-Cal Model (Regional Model). SUD services are administered either by Partnership or through individual counties not participating in the Regional Model. Partnership

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, and naloxone). *Partnership is financially responsible for the dispensing of these medications when services occur in a contracted Narcotic Treatment Program (NTP)/ Opioid Treatment Program (OTP) facility.*

When MAT is prescribed outside of a NTP/OTP (e.g. dispensed through a pharmacy) the medications will be authorized through the state Medi-Cal Rx program.

- Care Coordination
- Recovery services (aftercare)

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

Partnership has provided benefits for Behavioral Health Therapy for children diagnosed with Autism Spectrum Disorder (ASD) since September 2014. Effective July 1, 2018, Partnership 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.

Partnership will provide medically necessary BHT services covered under Medicaid 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) 23-010 *Revised*.

- Additional detailed information regarding the BHT benefit can be found in the following Partnership 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

Partnership 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, Partnership 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, Partnership 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 Partnership 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 Partnership UM department by fax or through Partnership'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 Partnership 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. Partnership 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 Partnership's Online Services (OLS) portal (or by fax or mail). Partnership 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 Partnership's network. 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 Partnership 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 Partnership 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. Partnership 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, Partnership conducts several committees for the purpose of hearing and incorporating practitioner input in the development of medical policy. Partnership, through the Physician Advisory Committee (PAC), the Quality/ Utilization Advisory Committee, and the Pharmacy and Therapeutics Committee (P&T) , 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, Partnership 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 Partnership 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 Partnership 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.

Partnership 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 Partnership 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

Partnership 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. Partnership measures the timeliness of decisions from the date when the organization receives the request from the member or PCP, even if the Partnership does not have all the information necessary to make a decision. Partnership documents the date when the request is received and the date a decision is rendered in the UM documentation system.

Partnership 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.

Partnership 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 Partnership 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 Partnership 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). Partnership 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 Community 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)

Partnership 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

- Behavioral Health (BH) 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 Partnership 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.

Partnership'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

Partnership 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.).
- After normal business hours, Members and Providers may contact the Partnership voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
- After normal business hours, members may contact the advice nurse line at (866) 778-8873 for assistance with clinical concerns.
- Practitioners, both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
    - Partnership has a dedicated after-hours phone number local (707) 430-4808 or toll free (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's Chief Medical Director or physician

designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a member whose emergency medical condition is stabilized.

- Partnership UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- Partnership maintains a toll free number (800) 863-4155 that is available to both members and practitioners.
- Members can view information about Partnership's language assistance services and disability services in the Member Handbook which is made available to members upon enrollment and is always viewable online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf
  Additionally, Partnership provides annual written notice to Members about our language assistance services and disability services (e.g. TTY for hearing impaired) in our Member Newsletter.

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

No Cost Linguistic Services:

- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact available in all languages spoken by Medi-Cal beneficiaries
- Written information and materials (to include notice of action, grievance acknowledgement and resolution letters) are fully translated by qualified translators into threshold languages for Partnership Members according to regulatory timeframes, and into other languages or alternative formats upon request. Alternative material formats include audio, large print and electronically for members with hearing and/or visual disabilities. Braille versions are available for members with visual disabilities. Auxiliary aids are also available upon request. Please refer to MCND9002 Cultural and Linguistic Program Description for more information. The organization may continue to provide translated materials in other languages represented by the population at the discretion of Partnership, such as when the materials were previously translated or when translation may address Health Equity concerns.
- Use of California Relay Services for hearing impaired [TTY/TDD: (800) 735-2929 or 711]

Partnership regularly assesses and documents member cultural and linguistic needs to determine and evaluate the cultural and linguistic appropriateness of its services. Assessments cover language preferences, reported ethnicity, use of interpreters, traditional health beliefs and beliefs about health and health care utilization. (See policy MCND9002 *Cultural and Linguistic Program Description*)

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 which is defined as "reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness, or injury."

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
- When out-of-network services are not clinically appropriate
- 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.

Partnership 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. Partnership monitors over and under-utilization through the Over/Under Utilization Workgroup which reviews annual utilization patterns. Decisions made by Partnership'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 Partnership'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 Partnership policy MCUP3037 *Appeals of Utilization Management/ Pharmacy Decisions* for a full description of the process.

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/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
- Member utilization data
- Provider prescribing data

EVALUATION OF NEW MEDICAL TECHNOLOGY

Partnership 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, Partnership has the option of adding to this basic package of benefits for its members.

Partnership's Policy MCUP3042 *Technology Assessment* outlines the steps taken during the determination process. The Partnership 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 Partnership.

- Providers to whom UM activities have been delegated are responsible for reporting results and analyses to Partnership on a quarterly or annual basis. Reports are summarized for review and evaluation by Partnership'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. Partnership 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 Partnership Director of Regulatory Affairs and Program Development also serves as the Partnership Privacy Officer. Partnership 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 Partnership staff. For non-covered entities, Partnership requires Business Associate Agreements (BAA). Additionally, there is training on an annual basis for the Partnership workforce and Partnership providers/networks, and Partnership 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 and securely stored 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.
- Partnership has designated a Privacy Officer responsible to oversee compliance with the Health Insurance Portability and Accountability Act (HIPAA) and other state and federal privacy laws.
- Partnership maintains administrative structure, reporting procedures, due diligence procedures, training programs and other methods to ensure effective compliance in use and disclosure of members' Protected Health Information (PHI).

NON-DISCRIMINATION STATEMENT

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

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

Partnership provides free aids and services to people with disabilities to communicate with us, such as:
- Qualified sign language interpreters or Video Remote Interpreters (VRI)
- Written information in other formats (large print, audio, Braille, accessible electronic formats, other formats)

Partnership provides free language services to people whose primary language is not English or those with limited English proficiency (LEP). These services include the following:
- Qualified oral interpreters, Video Remote Interpreters (VRI), sign language interpreters or bilingual providers and provider staff at key points of contact
- Information written in other languages
- Use of California Relay Services for hearing impaired

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

Partnership 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:

- Chief Health Services Officer
- Director, Pharmacy Services
- Directors of UM
- Associate Directors of UM
- UM Managers

Elements of the program evaluation include an objective assessment of meeting targeted goals to ensure appropriate, efficient utilization of resources/services for Partnership 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.

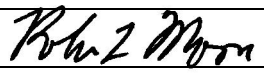
REFERENCES:

- Department of Health Care Services (DHCS) standards
- National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2025) UM Standards
- 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 Managed Care Plans: https://www.dhcs.ca.gov/services/Pages/Medi-CalManagedCare.aspx

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)*, 11/13/19 *(Amended);* 04/08/20; 06/10/20 (*Amended*); 04/14/21; 01/12/22; 05/11/22; 05/10/23; 05/08/24; 05/14/25

*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

	***04/16/2025***
Robert Moore, MD, MPH, MBA *Quality/Utilization Advisory Committee Chairperson*	*Date Approved*
	***05/14/2025***
Steven Gwiazdowski, MD *Physician Advisory Committee Chairperson*	*Date Approved*
	06/25/2025
Kim Tangermann *Board of Commissioners Chairperson*	*Date Approved*

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable) **Agenda Item Number:**
Meeting Date: June 18, 2025 4.1
Board Meeting Date: June 25, 2025

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Finance Committee & Partnership Staff

Topic Description:
On April 23, 2025, the Board approved Budget Assumptions for Fiscal Year 2025-2026 and directed staff to prepare a comprehensive operational budget. in May, a Preliminary Health Care Budget for Fiscal Year 2025–2026 was prepared in accordance with the approved assumptions and the Final Health Care Budget for Fiscal Year 2025–2026 is now presented to the Board for review and approval.

Reason for Resolution:
To give the Board the opportunity to review and approve the Final Budget for Fiscal Year 2025-2026.

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 Partnership Staff, the Board is asked to approve the Final Budget for Fiscal Year 2025-2026.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board / Finance Committee (when applicable)
Meeting Date: June 18, 2025
Board Meeting Date: June 25, 2025

Agenda Item Number:
4.1

Resolution Number:
25-

IN THE MATTER OF: APPROVING THE FINAL BUDGET FOR FY 2025-2026

Recital: Whereas,

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

B. In prior meetings, Partnership 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. The Board hereby approves the Final Health Care Budget for Fiscal Year 2025–2026 as presented.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 25th day of June 2025 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____
Date

ATTEST:

BY: _____
Ashlyn Scott, Clerk

FY 2025-26

Annual Operating & Capital Budget

June 2025

Table of Contents

Introduction

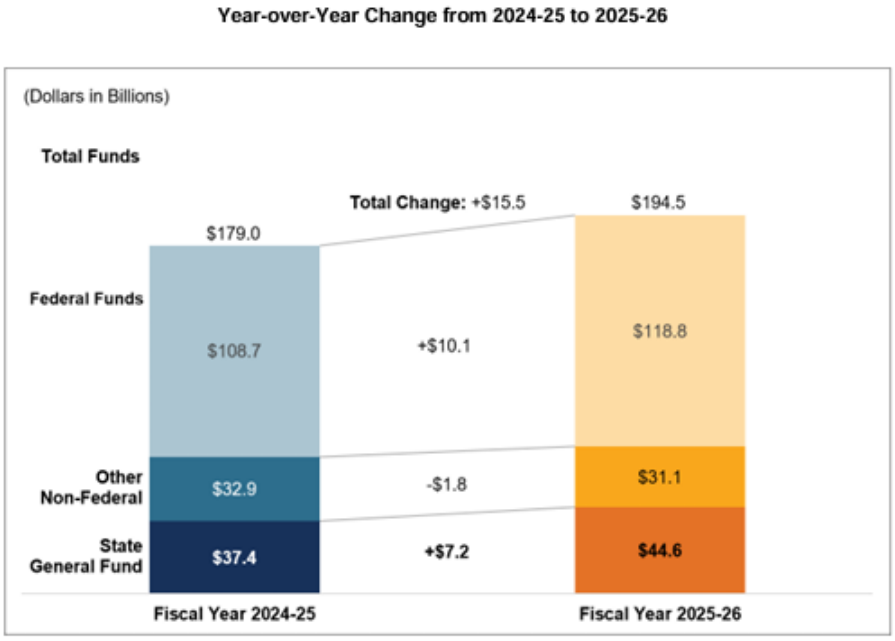
The next phase of the Partnership budget process is to present the 2025-26 Operating & Capital Budget to the Finance Committee and Board of Directors for final consideration and approval. Partnership Staff has consolidated the prior components of the budget into one comprehensive summary. A version history is provided at the conclusion of this report to walk between the healthcare assumptions presented in May 2025 and the final healthcare costs presented below.

Outlook for 2025-26

As of the May Revise the State presented a total budget of $321.9 billion total fund ($226.4 billion State General Fund) for FY 2025-26. The May Revise solves for a $12 billion deficit for FY 2025-26, in January, the Governor's Budget estimated a $16.5 billion surplus. The May Revise reserve balance reflects $15.7 billion in deposits, of which:

- $11.2 billion in the Budget Stabilization Account, an increase of $300 million from the January Budget.
- $4.5 billion in the Special Fund for Economic Uncertainties, no change from the January Budget.
- The January Budget earmarked a $1.5 billion deposit into the Public School System Stabilization Account, the May Revise no longer reflects this deposit.

The State budget summary specifically calls out Medi-Cal as a key factor in statewide expenditure growth. The below Department of Health Care Services (DHCS) budget chart[1], outlines the May Revise year-over-year Medi-Cal program estimated expenditures.



[1] https://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2025_May_Estimate/MAY-2025-Medi-Cal-Local-Assistance-Estimate.pdf

As displayed above, $194.5 billion total fund ($44.6 billion General Fund) was requested to operate the Medi-Cal program for FY 2025-26, this is a $6.4 billion total fund ($2.5 billion General Fund) increase from the January Budget. The budget further assumes 14.8 million individuals would receive coverage through the Medi-Cal program, which is a 2.4% increase from the January Budget.

Significant May Revise Budget details that affect the Medi-Cal program are highlighted below.

- **Proposition 35 (Prop 35)** – As part of the May Revise, DHCS issued an updated Prop 35 Spending Plan for calendar year (CY) 2025 and 2026. The updated spending plan proposes to sweep and repurpose Prop 35 investments that are funded with Managed Care Organization (MCO) tax revenue. The revised spending plan for CY 2025 proposes to:
    - Keep the CY 2024 Targeted Rate Increase (TRI) investments intact.
    - Sweep nearly $1.2 billion in investments to offset the State General Fund. These funds were previously earmarked for Medi-Cal provider rate increases.
    - Shift $455 million to directed payment programs. It is anticipated these funds would be used to offset the non-federal share that is self-financed by providers for these programs.
    - Repurpose $390 million in Prop 35 investments for new proposals such as the development of flexible housing subsidy pools for rental assistance and housing supports and repurposing reproductive health investments for Department of Health Care Access and Information (HCAI) loan repayment and scholarships.

  The revised spending plan is not aligned with the parameters approved by California voters through Prop 35 which dedicated MCO tax revenues to increasing provider payment levels (in specified categories) for contracted Medi-Cal providers for CY 2025 and beyond. If legislature approves the new spending plan, it is more than likely to be challenged in court.

- **Unsatisfactory Immigration Status (UIS) Membership Changes Age 19+**
    - Enrollment Freeze: The May Revise proposes a UIS enrollment freeze for individuals age 19+ effective January 1, 2026. Currently UIS members make up just over 10% of Partnership's overall membership. If the freeze is enacted, UIS members will continue to have access to restricted-scope coverage through the Medi-Cal Fee-for-Service program for emergency and pregnancy related services.
    - Institute Medi-Cal Premiums: As of January 1, 2027, the Administration proposes to institute a $100 monthly premium for all UIS members age 19+ who are enrolled in full scope Medi-Cal. Should the institution of these premiums be included in the final budget, approximately 90,000 Partnership members could be subject to these annual premiums.
    - Full Scope Dental Benefit Elimination: In addition to the enrollment freeze and proposed premiums, the May Revise proposes to eliminate full scope Dental for UIS members age 19. However, UIS members will continue to have access to emergency dental services covered under restricted-scope Medi-Cal.

- **Eliminate Long-Term Care Services for UIS Members** – The May Revise proposes to eliminate long-term care services for UIS members. It is unclear how DHCS proposes to handle UIS members currently residing in long-term care facilities. Further, the proposed policy does not specify whether skilled nursing facility services are part of this benefit elimination.

- **Eliminate Prospective Payment System (PPS) funding for State-Only Services for UIS Members** – The May Revise proposes to eliminate PPS rate funding for Federally Qualified Health Centers and Rural Health Clinics for state-only-funded services for UIS members. Instead, clinics would be reimbursed at the Medi-Cal Fee Schedule rate or the applicable Medi-Cal managed care rate.

- **Eliminate Proposition 56 Provider Supplemental Payments** – The May Revise proposes to eliminate $504 million in Proposition 56 supplemental payments for dental, family planning, and women's health providers statewide.

- **Eliminate the Skilled Nursing Facility Workforce and Quality Incentive Program (SNF WQIP)** – The May Revise proposes to eliminate the SNF WQIP directed payment program that provides enhanced funding to contracted SNFs and to suspend the requirement to maintain a backup power system for no fewer than 96 hours. This would eliminate $168.2 million in existing SNF supplemental funding statewide.

- **Changes to the Medi-Cal Minimum Loss Ratio (MLR)** – The May Revise proposes to increase the Medi-Cal Managed Care Plan MLR from 85% to 90%. This could put further strain on plan finances and could dampen the amount of funding that will be dedicated to Community Reinvestments.

- **Other Medi-Cal Proposals**
    - Reinstate the Asset Test for Medi-Cal Eligibility – This policy is proposed to be implemented for the Seniors and Persons with Disabilities (SPD) population no sooner than January 1, 2026, and would limit assets to $2,000 for an individual and $3,000 for a couple. This could result in coverage loss for about 112,000 beneficiaries statewide by full implementation.
    - Eliminate Certain Over-the-Counter Drugs and Glucagon-Like Pepticde-1 (GLP-1) Drugs – This policy would eliminate Medi-Cal coverage of COVID-19 antigen tests, over-the-counter vitamins, certain antihistamines including dry eye products, and GLP-1s prescribed for weight loss effective January 1, 2026.
    - Elimination of the Acupuncture Benefit – This policy would eliminate the optional benefit Acupuncture effective January 1, 2026.
    - Implement Hospice Utilization Management – This policy would impose prior authorization requirements for hospice services.

- **Non-Medical Notable Budget Proposals**
    - In-Home Support Services (IHSS) Program Changes – The budget proposes to limit IHSS provider overtime and travel expenses and eliminate IHSS coverage for UIS members age 19+.
    - Creation of a new California Housing and Homelessness Agency – The Governor proposes to establish this new agency and cited the new agency would create a more integrated and effective administrative framework for addressing the State's housing and homelessness issues. The budget included $4.2 million ($4 million General Fund) in FY 2025-26 for this new office.

Despite the State's budgetary condition, DHCS and the Governor remain focused on California Advancing and Innovating Medi-Cal (CalAIM) and transforming Medi-Cal as noted in our April assumptions.

In previous times of budgetary hardship, the State has implemented a variety of cost cutting measures in the Medi-Cal program outside of the budget. Based on this history, we expect:

- The DHCS will continue to focus on cost-effective spending in managed care and expect pressures to be amplified.
- As noted in our prior budget, Partnership has faced increased scrutiny from DHCS on contracted heath care cost levels, some of which resulted in prior year's downward rate adjustments.

On June 13, 2025, the State Legislature passed a modified version of the Governor's Budget which.

- Rejected the proposed:
  - Increase to the Medi-Cal Managed Care Plan MLRs to 90%.
  - Elimination of LTC benefits for UIS members.
  - Elimination of Acupuncture Benefit.
  - Elimination of certain Prop 56 supplemental payments for family planning and women's health.
- Reduced the proposed monthly premium amount for UIS members from $100 to $30 a month and modified the age requirement to age 19 to 59.
- Modified the enrollment freeze on full scope UIS members to allow for a six-month enrollment grace period and added provisions to clarify an individual cannot age-out of the program.
- Delayed the elimination of PPS payments to FQHCs and RHCs for UIS member State-only services and the elimination of dental benefits for UIS members to July 1, 2027.
- Approved the Governor's proposed Prop 35 program changes and offsets of the MCO Tax revenue to the State general fund.
- Approved the elimination of the SNF WQIP program.

Over the next two weeks, the Governor and the Legislature will work to negotiate the final FY 2025-26 budget.

Federal Budget Reconciliation Bill

On May 22, 2025, the House of Representatives (House) passed the One Big Beautiful Bill Act (OBBBA) budget reconciliation which is estimated to reduce federal Medicaid spending by $793 billion over a 10-year period. Key Medicaid provisions from OBBBA include:

- **Freeze on Provider Taxes** – State imposed provider taxes would be frozen at their current levels and states would be prohibited from establishing any new provider taxes.
- **Limits Medicaid Directed Payments to the Medicare Payment Levels**– The bill limits Medicaid directed payments to Medicare funding levels. The bill provides a hold harmless clause for current approved directed payments that exceed the limit. Currently a subset of the TRI procedure codes and certain hospital directed payments exceed the proposed limit. It is unclear whether the hold-harmless provision within the bill is indefinite or time-limited.
- **Medicaid Work Requirements** – Mandates every state to install a work requirement for certain beneficiaries no later than December 31, 2026, or earlier at each individual state's discretion. Able-bodied adults without any dependents would have to work at least 80 hours a month or perform other activities such as community engagement which includes school or volunteer work. It would apply to adults age 19 to 64 and exclude pregnant women. Partnership currently serves 355,000 members who are non-disabled adults between the ages of 19 to 64 who may be subject to these new requirements.
- **Changes to Medicaid Eligibility Verification –** Requires eligibility verification for the adult expansion population to occur every six months instead of annually. Implementation would be effective for Medicaid renewals scheduled on or after December 31, 2026. Nearly 30% of Partnership's current membership could be subject to these new requirements.
- **Federal Medical Assistance Percentage (FMAP) Penalty for States Who Cover UIS Members** – States who continue to cover individuals regardless of immigration status will have their federal match for the adult expansion population reduced by 10%. The FMAP penalty would be

implemented October 1, 2027. It is currently estimated California could lose over $4 billion in federal funding annually with the implementation of this policy.

The OBBBA is now in the Senate for review and amendment. It is anticipated the Senate will likely make changes to the bill before going back to the House for another vote.

Centers for Medicare and Medicaid Services (CMS) - Notice of Proposed Rulemaking

On May 12, 2025, CMS issued a Medicaid proposed rule aimed at adjusting the approval of provider tax waivers to ensure that they are broad based and generally redistributive. In short, the proposed rule would:

- Prohibit states from taxing Medicaid businesses at higher rates than non-Medicaid businesses.
- Maintain statistical testing while adding safeguards.
- Provide a transition timeline based on the age of existing waivers.

Currently, 48 states have at least one provider tax in place. Per the proposed rule, states may be provided up to 3 years to come into compliance with these new provisions based on the age of the approved waiver. However, it is unclear if California qualifies for the compliance implementation runway.

In California, the two largest provider tax programs are the MCO Tax and the Hospital Quality Assurance Fee (HQAF) program. The MCO tax proceeds fund TRI and Prop 35 directed payment investments while the HQAF funds the Private Hospital Directed Payment (PHDP) program. Currently the MCO Tax and the HQAF programs tax Medicaid provider utilization at a higher rate than non-Medicaid provider utilization. If the rule passes, we do not know how California would adjust the MCO Tax and HQAF taxing tiers. This proposal in combination with the House Budget Resolution is anticipated to have significant impacts on our providers. Ultimately this change will require the MCO Tax and the HQAF taxing tiers to be redesigned (and renegotiated with the providers that are taxed), it is anticipated tax tier changes would result in less funding for these programs.

Given the timing of finalizing the State's May Revision and the release of the House Budget Resolution and the CMS Proposed Rule, it is unclear how the State will react to the proposed federal Medicaid changes in the final enacted budget. Depending on when federal action occurs, the Governor will likely propose additional budget solutions after the FY 2025-26 State budget is enacted.

Membership

Partnership's membership increased by 319,122 in January 2024 due to our planned expansion into our 10-new counties. Partnership experienced further membership growth tied to the State's expansion of Medi-Cal coverage to adults ages 26 through 49 regardless of immigration status. As of June 1, 2025, Partnership is currently serving 910,264 members. The charts below illustrate, by county, the enrollment trends along with the various point-in-time comparisons. The trailing 10-month average (T10M) of 0.1%, trailing 6-month average (T6M) of 0.1%, and the trailing 4-month average (T4M) of 0.1% reflect relatively flat membership trends. This is further supported in the June 2025 to June 2024 membership comparison that reflects an average membership net increase of 0.8% across all counties.

We anticipate a 0.4% enrollment increase for the budget period through June 2026, resulting in 913,879 members. This projection is informed by the proposed Governor's May budget state-wide caseload projections, adjusted for emerging trends in Partnership's actual enrollment data.

Partnership Membership as of 06/01/2025

County	T4M	T6M	T10M	Jun '25 vs Jun '24	# of MM
Solano	0.3%	0.1%	0.2%	1.7%	1,688
Sonoma	-0.1%	-0.1%	0.1%	1.4%	1,593
Napa	0.6%	0.5%	0.4%	3.3%	879
Yolo	1.0%	0.7%	0.5%	2.7%	1,435
Marin	0.0%	0.1%	0.1%	0.8%	349
Humboldt	-0.4%	-0.3%	-0.1%	-1.9%	(1,112)
Shasta	-0.4%	-0.4%	-0.3%	-4.5%	(3,031)
Mendocino	0.0%	-0.1%	-0.1%	-1.3%	(556)
Lake	-0.2%	-0.2%	0.0%	-1.3%	(458)
Siskiyou	0.1%	0.0%	0.0%	-1.0%	(172)
Lassen	-0.3%	-0.1%	-0.1%	0.1%	8
Del Norte	-0.2%	-0.1%	0.0%	0.2%	21
Trinity	-0.3%	-0.4%	-0.3%	-4.9%	(269)
Modoc	-0.7%	-0.3%	-0.2%	-1.6%	(65)
Butte	-0.1%	-0.1%	0.1%	1.0%	839
Colusa	0.2%	0.1%	0.2%	0.6%	58
Glenn	-0.1%	0.0%	0.1%	0.7%	90
Nevada	0.0%	0.0%	0.2%	1.2%	352
Placer	0.6%	0.5%	0.5%	4.5%	2,674
Plumas	-0.6%	-0.4%	-0.3%	-2.4%	(143)
Sierra	-1.0%	-0.8%	-0.1%	0.7%	6
Sutter	0.5%	0.4%	0.3%	2.1%	925
Tehama	-0.1%	-0.2%	0.0%	-0.2%	(52)
Yuba	0.8%	0.6%	0.7%	6.3%	2,226
Total	**0.1%**	**0.1%**	**0.1%**	**0.8%**	**7,285**
	Trailing # Month average month-to-month increase			**Point-in-time comparison, % △ and # of members**	

Revenue

Partnership budgeted overall revenue of $7.1 billion for a year-over-year increase of $1.5 billion. The budget utilized modified CY 2025 draft rates received from DHCS for the period of July to December 2025. Given CY 2026 draft rates will not be delivered to Partnership until the last quarter of CY 2025, Partnership relied on actuarial revenue projections for the period of January to June 2026. The potential federal Medicaid changes and subsequent State Medi-Cal program changes create challenges for prospective rate

development and are expected to put downward pressures on Partnership's future revenue. Like in prior years, Partnership's final revenue is expected to be delayed. Updates are anticipated to the draft CY 2025 rates; multiple versions of CY 2026 rates are also expected.

Medi-Cal State Capitation Revenue

2025-26: $7 billion | 2024-25 Δ : $1.5 billion or 27.2%

The Medi-Cal Base Capitation includes offsetting variances driven by base revenue, membership trends, and other supplemental revenues. As noted in the previous fiscal year's budget presentation, revenues related to "at-risk" programs such as hospital directed payments and the voluntary rate range, are now recognized in top line revenue. These programs represent $1.4 billion in total revenue. The primary drivers for the year-over-year increase are the CY 2025 base rate increases and the statewide increase in hospital directed payment programs, all subject to CMS final approval. Offsetting this increase are anticipated reductions associated with Enhanced Case Management (ECM) and Prop 56 risk corridors. There are changes associated with the Quality Withhold, with further details noted below. While rates increased for the CY 2025 rating period, we anticipate a decrease in CY 2026 rates based on actuarial projections. A full year of Whole Child Model (WCM) revenue was applied to our expansion region with the program change going into effect as of January 1, 2025. Offsetting the increase in WCM revenue is the SPD revenue decrease as a result of the newly implemented DHCS Medicare Part A Buy-In Program which funds the Medicare Part A premium for eligible Medi-Cal and Medicare members who previously only had partial Medicare coverage. There are corresponding savings in expense to offset this decrease in revenue for the SPD aid category, with Medicare providing primary coverage for hospitalizations and other inpatient benefits covered through Medicare Part A.

DHCS implemented a 0.5% quality withhold on plan capitated revenue effective January 1, 2024, which increased to 1% effective January 1, 2025, for all counties. The increased withhold results in a $49.4 million decrease in base revenue. DHCS has indicated they intend to increase the quality withhold percentage and the associated quality benchmarks in each subsequent fiscal year which poses financial risk to Partnership. For budgeting purposes, we are assuming we will earn back 70% of the quality withhold based on preliminary estimates.

Lastly, as in previous years, MCO tax revenue and the offsetting expense are excluded from this presentation.

Interest & Other Income

2025-26: $83.2 million | 2024-25 Δ : $10.1 million or 13.9%

Other Revenue includes interest income and building tenant revenue. Interest income of $80.8 million is expected to be earned and is based on an assumed 3.75% annual rate of return. The increase in earnings is primarily due to an expected higher average cash balance compared to prior year. Building tenant revenue is projected at $2.4 million which is a slight increase from prior year. The increase can be attributed to the additional tenants from the new buildings that have been recently acquired. Lastly, the timing of the recognition of the DHCS incentive grant revenues (along with the corresponding offsetting expenses) varies and is not included as part of the FY 2025-26 presentation. Recognition of the incentive revenue and related expense will be recorded when and if awarded, if applicable.

Health Care Expenses

As stated in our budget assumptions last month, while there is looming uncertainty, Partnership is dedicated to continue providing care to our members based on the current set of Medi-Cal benefits and services. Partnership FY 2025-26 budget will assume costs and membership for these members and services. However, Partnership staff expect to complete an off-cycle budget to account for any Medi-Cal program changes that may occur subsequent to the finalization and approval of Partnership's budget in June of 2025.

Health care cost projections for FY 2025-26 are based on the Plan's historical claims experience for currently covered Medi-Cal members and benefits. Partnership utilized cost experience from January 2023 through December 2024 for our respective counties, serving as the base data for budget development, factoring emerging trends in more recent months. While we have reviewed a year's worth of data for the expansion counties, the data remains incomplete. Completion factors were applied where appropriate to account for incurred but not yet reported claims.

Adjustments were applied to the base period cost data for the following:

- Reasonable assumptions regarding underlying utilization trends based on internal analysis and a review of DHCS trends used in developing Plan capitation rates.
- Anticipated impacts of case management, utilization management, and specific disease management programs from year-to-year, or newly developed programs.
- Changes in provider contracting such as new payment amendments.

At this time, Partnership does not have enough information to estimate the associated revenue and costs of the new transitional rent benefit and the CY 2025 and CY 2026 Prop 35 investments for inclusion in our final June budget. We will include transitional rent along with CY 2025 and CY 2026 Prop 35 investments in our off-cycle budget review.

The health care budget assumes an overall expense of $6.8 billion, which is $1.2 billion, or 21.9%, greater than the FY 2024-25 budget. Considerations and estimates by cost category are presented in more detail, below.

Inpatient Hospital

2025-26: $1.6 billion | 2024-25 Δ : $-58.8 million or -3.5%

The Inpatient Hospital line item includes inpatient fee-for-service (FFS), hospital capitation, and stop loss expenses. The year-over-year decrease is primarily due to emerging trends from more comprehensive claims data in the expansion region. However, establishing reliable trends in this new region will take several years. With the implementation of the WCM program in our expansion region effective January 1, 2025, and the new statewide Medicare Part A Buy-In program, further adjustments were required for the final budget.

With the overall uncertainty in Medicaid and with the State's budgetary condition, Partnership must continue to be prudent in controlling health care expenses through appropriate medical management and sound contracting decisions. As contract requests are evaluated, it is imperative contract levels are appropriate for Medicaid funding levels and recognize other hospital revenue sources that are afforded to contracted providers in Medi-Cal managed care, such as the PHDP program and the District Hospital Directed Payment (DHDP) program. As of CY 2025, the PHDP and the DHDP programs grew significantly to account for the cost pressures hospitals are currently facing. Partnership is an outlier with our inpatient

contracting levels in comparison to other Medi-Cal plans across the state. The State's actuaries assess the reasonableness of Partnership's contracting levels inclusive of the hospital directed payments.

As in prior years, we expect DHCS to remain focused on cost-effective spending in managed care. Partnership has faced increased scrutiny from DHCS on contracting heath care costs levels, some of which resulted in downward inpatient rate adjustments.

Physician Services

2025-26: $1.1 billion | 2024-25 Δ : $189.9 million or 19.9%

Physician Services includes Proposition 56 payments (Prop 56), specialty capitation, primary capitation, and physician FFS expenses. FFS expenses are increasing year-over-year due to a ramp up in utilization and recent contracting increases. Additionally, annual Tribal OMB rates and utilization for Indian Health Service (IHS) reimbursement have significantly increased.

Effective January 1, 2024, the Prop 56 physician supplemental payment program transitioned into TRI. In CY 2024, TRI increased eligible contracted providers minimum reimbursement levels to at least 87.5% of the lowest Medicare locality in the state for certain Medi-Cal services. The CY 2024 TRI payment levels will continue for FY 2025-26. Details surrounding the final CY 2025 and CY 2026 provider investments through Prop 35 will not be known until the State's final budget is enacted. Adjustments will be included in the off-cycle budget.

Long-Term Care

2025-26: $740.4 million | 2024-25 Δ : $105.4 million or 16.6%

As explained in prior year budget cycles, the Long-Term Care expense category is challenging to budget due to the timing and complexity of the retroactive DHCS rate increases. The rates are often released months after their effective date, more recently with multiple versions released on a monthly basis, requiring multiple claim adjustments. This requires Partnership staff to complete an in-depth analysis to calculate and correct prior payments. Pursuant to Assembly Bill (AB) 86, DHCS has established the Workforce Standards Program. Facilities that opted-in receive an enhanced per diem. DHCS annual facility per diem rate increases, along with SB525 impacts and increased utilization, are driving the overall year-over-year increase.

Ancillary Services

2025-26: $1.2 billion | 2024-25 Δ : $261.4 million or 26.6%

Ancillary Services is comprised of FFS and capitated ancillary services, ECM, and Community Supports. High-cost drugs such as gene therapy treatments administered at approved Centers of Excellences outpatient infusion clinics are also in this category. The budget assumes increases tied to FFS utilization and unit cost increases specific to emergency department, outpatient hospital services, ECM, and Community Supports.

Other Medical

2025-26: $495.1 million | 2024-25 Δ : $60.3 million or 13.9%

The Other Medical category includes transportation, quality assurance, health care investment fund, nurse advice line, and the DHCS voluntary rate range program. As of April 2024, transportation benefits were directly coordinated by Partnership. The in-house administration of the non-medical and non-emergency medical transportation benefits continues to provide greater access and better customer service to our members and providers. Increases in transportation utilization and the rural nature of the

counties we serve are the main drivers for the year-over-year increase. The quality assurance expenses are slightly higher than the prior year due to staffing increases in the medical administration departments.

DHCS Facility Directed Payment Programs

2025-26: $1.4 billion | 2024-25 Δ : $672.9 million or 89.3%

The following facility directed payment programs are included in this category: Private Hospital Directed Payment (PHDP), District Hospital Directed Payment (DHDP), Skilled Nursing Facility Workforce and Quality Incentive Program (SNF WQIP), Designated Public Hospital Enhanced Payment (EPP), and Designated Public Hospital Quality Improvement Programs. The significant increase in statewide totals for the PHDP, EPP, and DHDP programs is the primary driver of the year-over-year increase. Statewide, the PHDP program grew from $7.2 billion in 2024 to $13.2 billion in 2025, an overall increase of 83%. The DHDP program increased by 300% from the prior year, and combined, the EPP and QIP programs increased by 62%. The CMS preprints for these programs have been approved, except for PHDP, which is pending as part of the broader hospital fee program approval. Partnership applied a proportional increase of the statewide increase based on our prior year revenue. Refined estimates on the directed payments for the expansion counties based on utilization data are also contributing to the increase.

The Children's Hospital Directed Payment and the Community Clinic Directed Payment are new programs in CY 2025 and are pending updates and formal approval. Costs related to these two new programs will be reported in the off-cycle budget once more information is available.

Quality Improvement Programs (Incentives)

2025-26: $89.2 million | 2024-25 Δ : $-10.8 million or -10.8%

The year-over-year decrease in QIP expenses is due to the conclusion of the Specialty Quality Access Incentive program on December 31, 2024. This program was sunset in conjunction with the CY 2024 TRI investments. Partnership continues to invest in quality improvement programs to enhance performance on quality metrics prioritized by the DHCS Quality Withhold Incentive program to provide quality, equitable and cost-effective care to our members. As in previous periods, incentive funding remains contingent on final revenue projections.

Off-Cycle Budget

Given the uncertainty surrounding potential changes to the federal Medicaid program and the State's budgetary response, Partnership staff expect to complete an off-cycle budget to account for material programmatic and cost changes that occur subsequent to the finalization of Partnership's budget in June.

Administrative Expense

Overall administrative spend is estimated to be $387.9 million, which is an increase to the prior year's budget of $76.4 million or 24.5%. The increase in administrative spending is mainly driven by an increase in staffing and investments in IT infrastructure. Given the significant increase in regulatory requirements, many of which are tied to the Medi-Cal contract, Partnership increased its staffing levels and IT infrastructure to comply with the new and on-going requirements. Historically, Partnership operated with one of the lowest administrative ratios in comparison to other Medi-Cal plans across the state. However, as noted in numerous prior discussions, operating at these levels is not sustainable. Partnership continues to take a measured approach in investing in the appropriate administrative needs. The increased costs associated with administrative spend are expected to be reflected in future revenue rates. This year's

budget will continue to include those costs necessary to operationalize a Medicare D-SNP program which will now be implemented on January 1, 2027.

Employee Workforce

2025-26: $247.8 million | 2024-25 Δ : $54 million or 27.9%

The workforce, as well as the accompanying employee costs, are expected to increase to meet the needs of the DHCS contract, to continue work on the new claims system implementation, and to build the D-SNP infrastructure. Partnership is expecting to make progress in hiring and in filling the positions that were open and unfilled in the prior fiscal year. The overall increase from prior year includes the addition of 319 permanent staff as well as funding for temporary staff. Given the uncertainty with the State and Federal budget and proposed Medicaid impacts, the Plan will look to utilize temporary resources that could be converted to permanent positions dependent on final need. Of the FTEs being requested, 90% are administrative related and the other 10% are health services related which is reflected in the Medical Admin section of the budget. Also contributing to the increase is a projected 3.5% merit increase, an assumed 20% increase in employee medical costs, and 8% in dental and vision costs. As noted in the previously approved budget assumptions document, the proposed merit increase would be based on the latest employment cost index as published by the U.S. Bureau of Labor Statistics (BLS) for the Western Region. The 3.5% was formally released by the BLS at the end of April.

Occupancy

2025-26: $33.4 million | 2024-25 Δ : $-6.8 million or -17%

Decreases in Occupancy costs are primarily from a decrease in expected depreciation costs. The new core claims processing system was expected to go live in the previous year and the associated depreciation costs would have accompanied it; with the delay in the implementation of the system, depreciation for this system is not anticipated during this fiscal year. This decrease is offset by the accompanying depreciation that comes along with capital purchases for the upcoming year.

Professional Services

2025-26: $39.5 million | 2024-25 Δ : $3.5 million or 9.7%

Professional Services primarily includes outside services such as consultants, contracted claims processing, and other third-party processing vendors. Claims processing and adjudication costs and costs for translation services are expected to increase based on increased membership, volume, and utilization.

Computer & Data

2025-26: $54 million | 2024-25 Δ : $25.4 million or 88.8%

Hardware, software, and data processing purchases in IT and other departments are expected to increase across all of Partnership's regions. Increased licensing costs, additional software to accommodate increased staffing, and additional and enhanced infrastructure contributes to the overall increase in computer & data. Lastly, increased transportation utilization will also contribute to the increased computer system costs.

Profit & Loss Statement

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

Annual Capital & Operating Budget

	2025-26 Budget	2024-25 Budget	$ VARIANCE	2025-26 Budget PMPM	2024-25 Budget PMPM
Membership at Fiscal Year End	**913,879**	**858,157**	**55,722**		
Total Member Months	**10,946,668**	**10,528,712**	**417,956**		
REVENUE					
State Capitation Revenue	7,046,897,376	5,538,765,135	1,508,132,241	643.75	526.06
Interest Income	80,779,000	70,743,000	10,036,000	7.38	6.72
Other Revenue	2,447,000	2,335,100	111,900	0.22	0.22
TOTAL REVENUE	**7,130,123,376**	**5,611,843,235**	**1,518,280,141**	**651.35**	**533.00**
HEALTHCARE COSTS					
Physician Services					
PCP Capitation	119,415,716	106,664,971	(12,750,745)	10.91	10.13
Specialty Capitation	2,570,827	2,628,366	57,539	0.23	0.25
Non-Capitated Physician Services	1,022,631,615	845,399,200	(177,232,415)	93.42	80.29
Total Physician Services	**1,144,618,158**	**954,692,537**	**(189,925,621)**	**104.56**	**90.68**
Inpatient Hospital					
Hospital Capitation	206,752,864	214,000,006	7,247,142	18.89	20.33
Inpatient Hospital - FFS	1,423,506,378	1,465,895,850	42,389,472	130.04	139.23
Hospital Stoploss	9,999,852	19,200,000	9,200,148	0.91	1.82
Total Inpatient Hospital	**1,640,259,094**	**1,699,095,856**	**58,836,762**	**149.84**	**161.38**
Long Term Care	740,374,189	634,948,033	(105,426,156)	67.63	60.31
Ancillary Services					
Ancillary Services - Capitated	16,574,512	14,635,449	(1,939,063)	1.51	1.39
Ancillary Services - Non-Capitated	1,228,900,510	969,400,736	(259,499,774)	112.26	92.07
Total Ancillary Services	**1,245,475,022**	**984,036,185**	**(261,438,837)**	**113.78**	**93.46**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

Annual Capital & Operating Budget

	2025-26 Budget	2024-25 Budget	$ VARIANCE	2025-26 Budget PMPM	2024-25 Budget PMPM
Other Medical					
Quality Assurance	92,329,487	87,600,012	(4,729,475)	8.43	8.32
Healthcare Investment Funds	241,427,350	210,369,671	(31,057,679)	22.05	19.98
Advice Nurse	1,729,200	1,729,200	-	0.16	0.16
Transportation	159,645,568	135,094,176	(24,551,392)	14.58	12.83
Total Other Medical	**495,131,605**	**434,793,059**	**(60,338,546)**	**45.23**	**41.30**
DHCS Facility Directed Payment Programs	1,426,371,794	753,440,101	(672,931,693)	130.30	71.56
Quality Improvement Programs	89,200,150	100,009,080	10,808,930	8.15	9.50
TOTAL HEALTHCARE COSTS	**6,781,430,012**	**5,561,014,851**	**(1,220,415,161)**	**619.50**	**528.18**
ADMINISTRATIVE COSTS					
Employee	247,828,143	193,794,546	(54,033,597)	22.64	18.41
Travel And Meals	2,294,006	1,992,350	(301,656)	0.21	0.19
Occupancy	33,393,279	40,233,429	6,840,150	3.05	3.82
Operational	10,909,163	10,865,941	(43,222)	1.00	1.03
Professional Services	39,490,454	36,009,640	(3,480,814)	3.61	3.42
Computer And Data	53,983,631	28,587,942	(25,395,689)	4.93	2.72
TOTAL ADMINISTRATIVE COSTS	**387,898,676**	**311,483,848**	**(76,414,828)**	**35.44**	**29.58**
Medi-Cal Managed Care Tax	-	-	-	-	-
Surplus / (Deficit)	**(39,205,312)**	**(260,655,464)**	**221,450,152**	**(3.58)**	**(24.76)**

Fund Balance

Total Fund Balance includes reserves for the State Financial Performance Guarantee, Capital Assets, and Strategic Use of Reserves (SUR). The State Financial Performance Guarantee allows for calculation of the reserve at two months' (2x) worth of state capitation revenue; the Guarantee also satisfies the regulatory requirements for State Tangible Net Equity (TNE) as well as Knox-Keene. Net capital assets are included as part of Fund Balance. Lastly, SURs are initiatives that were approved by the Board in previous years. The reserves for these SURs have been utilized over the years in a manner that has expanded member access, increased provider reimbursement, and improved overall operational efficiency; Partnership 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. Note also that Fund Balance includes an unrestricted amount that is projected to be negative, which represents the shortfall of funds needed to meet the reserve requirements. Like in prior county expansions, it is not uncommon to reflect a negative fund balance for the first several years of a coverage expansion. The total fund balance for the year ending June 30, 2026 is estimated at $1.3 billion.

Partnership Healthplan of California
Fiscal Year 2025/26 Fund Balance Analysis
Projected through June 2026
Fund Balance Analysis / TNE

Fund Balance at April 30, 2025		1,371,202,250
Actual Year to Date Surplus at April 30, 2025	123,599,540	
Projected Year to Date Surplus at June 30, 2025	129,894,206	
Projected Surplus for May - June 2025		6,294,666
Projected Fund Balance at June 30, 2025		**1,377,496,916**
Projected (Deficit) for Fiscal Year 2025/26		(39,205,312)
Estimated Fund Balance at June 30, 2026		**1,338,291,604**
Estimated Fund Balance Allocated at June 30, 2026		
Reserved Funds		
State Financial Performance Guarantee		1,307,646,000
Capital Assets		253,004,000
Strategic Use of Reserve-Board Approved		71,002,668
Unrestricted (Shortfall)		(293,361,064)
Estimated Fund Balance at June 30, 2026		**1,338,291,604**

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 supply chain issues and labor shortages and other unforeseen circumstances, certain projects that were approved in the 2024-25 budget were either not started or were started and not completed during the fiscal year as originally planned. These projects (**) have been included, below, for 2025-26 budget consideration.

The capital budget for Facilities includes expenditures for building improvements for maintenance of the facilities, safety, and business continuity in addition to tenant improvements for vacant spaces expected to be leased in fiscal year 2026.

The capital budget for Information Technology includes expenditures intended to increase system security, improve efficiency and data storage for general operations, and provide support for the core system implementation (Phoenix Project). Purchases for the core system implementation will be recorded as a capital project in progress until the year the system is fully implemented, in which case depreciation begins.

A summary of capital expenditures by department is listed below:

SUMMARY OF CAPITAL BUDGET					
DEPARTMENT	BUDGET ITEM DESCRIPTION	CARRY OVER	COSTS APPROVED IN PRIOR FISCAL YEARS	NEW OR CHANGE IN ESTMATED PURCHASE COSTS	TOTAL FY 25-26 ESTIMATED PURCHASE COSTS
Facilities	Infrastructure and Annual Maintenance	**	$ 10,061,899	$ 18,474,414	$ 28,536,313
	New Vehicles		$ -	$ 277,185	$ 277,185
Total Facilities Purchase Cost FY 2025-26			**$ 10,061,899**	**$ 18,751,599**	**$ 28,813,498**
Information Technology	Infrastructure and Annual Maintenance	**	$ 7,945,632	$ 41,419,836	$ 51,915,468
	Phoenix Project	**	$ 59,090,089	$ 18,697,186	$ 77,787,275
Total Information Technology Purchase Cost FY 2025-26			**$ 67,035,721**	**$ 60,117,022**	**$ 129,702,743**
Total Purchase Cost FY 2025-26			**$ 77,097,620**	**$ 78,868,621**	**$ 158,516,241**

DETAIL CAPITAL BUDGET					
DEPARTMENT	BUDGET ITEM DESCRIPTION	CARRY OVER	COSTS APPROVED IN PRIOR FISCAL YEARS	NEW OR CHANGE IN ESTMATED PURCHASE COSTS	TOTAL FY 25-26 ESTIMATED PURCHASE COSTS
Facilities	Airpark Office: Infrastructure Investments		$ -	$ 214,800	$ 214,800
	Avtech Office: Infrastructure Investments		$ -	$ 150,000	$ 150,000
	Building 4605: Infrastructure Investments	**	$ 3,220,000	$ 386,640	$ 3,606,640
	Building 4665: Infrastructure Investments	**	$ 750,000	$ 836,292	$ 1,586,292
	Building 4820: Infrastructure Investments		$ -	$ 34,200	$ 34,200
	Building 4820: Tenant Improvements	**	$ 619,718	$ 700,282	$ 1,320,000
	Eureka Office: Infrastructure Investments	**	$ 626,137	$ 445,613	$ 1,071,750
	Santa Rosa Office: Infrastructure Investments	**	$ 31,000	$ 4,000	$ 35,000
	Santa Rosa Office: Solar/EV Charging Stations & Infrastructure	**	$ 361,005	$ 90,251	$ 451,256
	281 Nevada St., Auburn: Infrastructure Investments	**	$ 609,844	$ 1,595,381	$ 2,205,225
	1950 -Napa Building-Gasser Foundation : Infrastructure Investments		$ -	$ 43,700	$ 43,700
	2175 Shasta View-Redding: Infrastructure Investments	**	$ 1,918,150	$ 11,334,875	$ 13,253,025
	351 Hartnell-Redding (the VA building): Infrastructure Investments	**	$ 1,926,045	$ 1,753,955	$ 3,680,000
	1000 Fortress-Chico: Infrastructure Investments		$ -	$ 884,425	$ 884,425
	New Vehicles		$ -	$ 277,185	$ 277,185
Total Facilities Purchase Cost FY 2025-26			**$ 10,061,899**	**$ 18,751,599**	**$ 28,813,498**
Information Technology	Annual Maintenance/renewals/upgrades	**	$ 2,970,691	$ 5,044,309	$ 8,015,000
	Citrix VDI/UX Monitoring Solution	**	$ 375,000	$ -	$ 375,000
	Infrastructure Enhancements	**	$ 1,120,444	$ 10,269,556	$ 11,390,000
	System/Software Enhancements	**	$ 3,479,497	$ 26,105,971	$ 32,135,468
	Total Infrastructure and Annual Maintenance		**$ 7,945,632**	**$ 41,419,836**	**$ 51,915,468**
	Phoenix Project	**	$ 59,090,089	$ 18,697,186	$ 77,787,275
Total Information Technology Purchase Cost FY 2025-26			**$ 67,035,721**	**$ 60,117,022**	**$ 129,702,743**
Total Purchase Cost FY 2025-26			**$ 77,097,620**	**$ 78,868,621**	**$ 158,516,241**

Version History

This table was created for Committee Members to quickly review changes between the preliminary healthcare budget presented in May 2025 and the final budget presented above.

	FY 2025-26		Final vs HCC Assumptions Version △		
Health Care Categories	**Budget - Final**	**HCC Assumptions (1st Pass)**	**$**	**%**	**Notes**
Inpatient Hospital	$1,640,259,094	$1,643,371,839	($3,112,745)	(0.2%)	Adjusted to account for refined estimates for stoploss expense
Physician Services	$1,144,618,158	$1,070,203,027	$74,415,131	7.0%	Adjusted to account for current Physician Services trends
Long Term Care	$740,374,189	$703,914,904	$36,459,285	5.2%	Adjusted to account for current LTC cost and utilization trends
Ancillary Services	$1,245,475,022	$1,105,418,263	$140,056,759	12.7%	Adjusted to account for current Ancillary Services trends
Other Medical	$495,131,605	$497,756,774	($2,625,170)	(0.5%)	
DHCS Facility Directed Payment Programs	$1,426,371,794	$1,426,708,534	($336,740)	(0.0%)	
Quality Improvement Programs	$89,200,150	$89,200,000	$150	0.0%	
Total Health Care Expense	**$6,781,430,012**	**$6,536,573,342**	**$244,856,671**	**3.7%**	

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date:
June 25, 2025

Agenda Item Number:
4.2

Resolution Sponsor:
Sonja Bjork, CEO, Partnership HealthPlan of CA

Recommendation by:
Compliance Committee and Partnership 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 Partnership's Q12025 Compliance Dashboard.

REGULAR AGENDA REQUEST
for
PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Board Meeting Date
June 25, 2025

Agenda Item Number:
4.2

Resolution Number:
25-

IN THE MATTER OF: APPROVING PARTNERSHIP HEALTHPLAN COMPLIANCE DASHBOARD FOR Q12025

Recital: Whereas,

A. Partnership 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 Partnership's Q12025 Compliance Dashboard.

PASSED, APPROVED, AND ADOPTED by the Partnership HealthPlan of California this 25th day of June 2025 by motion of Commissioner seconded by Commissioner and by the following votes:

AYES: Commissioners:

NOES: Commissioners:

ABSTAINED: Commissioners:

ABSENT: Commissioners:

EXCUSED: Commissioners:

_____
Kim Tangermann, Chair

_____

ATTEST:

BY: _____
Ashlyn Scott, Clerk

2025 Regulatory Affairs and Compliance Dashboard

Category	Description	Q1	YTD	Comments
DELEGATION OVERSIGHT	**Annual Delegate / Subcontractor Audits**	**3 / 3**	**3 / 3**	
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%**	**100%**	
	Oversight of Delegate Reporting	**12 / 12**	**12 / 12**	
	Percentage of timely submissions of regulatory reports.	**100.0%**	**100.0%**	
REGULATORY REPORTING	**DHCS Reports Submitted Timely**	**73 / 73**	**73 / 73**	
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.	**100.0%**	**100%**	
	Report Acceptance Rate	**72 / 73**	**72 / 73**	
	Percentage of standard regulatory reports submitted by RAC and not rejected by DHCS for being incomplete, on the wrong template, or for other findings.	**98.6%**	**98.6%**	Q1- 73 total reports submitted to DHCS. 72 were accecpted. One quarterly report was rejected for edits. Report was resubmitted and accepted.
HIPAA REFERRALS	**Timely DHCS Privacy Notification Filings**	**10 / 10**	**10 / 10**	
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%**	**100.0%**	Q1- 10 total reportable incidents submitted to DHCS; however, none of those incidents were deemed breaches
FWA REFERRALS	**Timely DHCS FWA Notifications**	**9 / 9**	**9 / 9**	
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.	**100.0%**	**100%**	

***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

FINANCIAL HIGHLIGHTS
Of The Partnership HealthPlan of California
For the Period Ending April 30, 2025

Financial Analysis for the Current Period

Total Surplus

For the month ending April 30, 2025, Partnership reported a net surplus of $9.4 million, increasing the year-to-date surplus to $123.6 million. Key variances are outlined below.

Revenue

Total Revenue exceeded the budget for the month by $67.9 million and $436.4 million for the year-to-date. Medi-Cal revenue is $459.5 million favorable to budget, primarily due to the recognition of $251.6 million in additional MCO tax revenue for calendar year 2024, as authorized by Assembly Bill (AB) 160. A corresponding offset was recorded in MCO tax expense. Additionally, revenue was adjusted to reflect the draft CY 2025 rates, retro to January, resulting in favorable variances of $188.6 million in base rates and $103.3 million in MCO tax and Voluntary Rate Range revenue; these adjustments also have matching offsets recorded in expenses. These positive variances were partially offset by an unbudgeted $84.0 million related to the UIS risk corridor for calendar years 2024 and 2025. Directed Payments were $108.2 million below budget due to lower-than-expected rates with a corresponding offset recorded in Healthcare Investment Funds (HCIF). Supplemental revenues exceeded the budget by $55.4 million, largely driven by the timing of DHCS submissions—particularly in the expansion counties for American Indian Health Services (AIHS)—and higher-than-anticipated volumes of Maternity Kick payments. Interest income is $28.2 million favorable due to higher than anticipated interest rates accompanied with higher than budgeted cash balances. The remaining favorable variance is attributed to other revenues.

Healthcare Costs

Total healthcare costs are unfavorable to budget for the month by $10.9 million and favorable by $131.8 million for year-to-date. Non-Capitated Physician and Ancillary expenses were $123.8 million unfavorable to budget due to the accrual of Targeted Rate Increases (TRI) and updates to Incurred But Not Reported (IBNR) reserves based on current utilization and cost trends. Capitation expenses were $32.5 million favorable due to changes in the funding methodology for certain healthcare providers. Long-term care costs exceeded the budget by $19.3 million, primarily due to anticipated rate increases retroactive to January 2024. Inpatient Hospital Fee-For-Service (FFS) expenses were $160.0 million favorable, driven by downward adjustments to prior fiscal year IBNR reserves which reflected lower-than-expected utilization in the new expansion region and seasonal trends. HCIF expenses were $74.6 million favorable due to lower than anticipated directed payment rates, partially offset by the timing of IPP CalAIM incentive payments. Transportation costs were $12.7 million unfavorable, attributed to increased utilization. Quality Assurance expenses were $25.4 million favorable due to the timing of medical administrative costs. Conversely, Quality Improvement Program expenses were $5.2 million unfavorable due to the timing of incentive grant disbursements.

Administrative Costs

Administrative costs have an overall positive variance of $0.9 million for the month and $39.4 million year-to-date. The primary variance is in Employee costs due to the timing of the filling of open positions geared

towards the expansion counties and the fulfilling of the 2024 DHCS Contract requirements. An additional variance is in Occupancy due to the timing of building related costs including repairs and maintenance, as well as the depreciation of capitalizable items, most notably the new claims system. The increase in professional services fees due to prior period invoices paid in the current month. The increased negative variance in Computer and Data is primarily due to the timing of licensing cost payments and computer stock equipment purchases. Most non-Employee and non-Occupancy costs are prorated relatively evenly throughout the year; as the year progresses, the variances between actual and budget in these categories are expected to narrow.

Balance Sheet / Cash Flow

Total Cash & Cash Equivalents decreased by $140.7 million for the month. Inflows include $657.7 million in State Capitation payments, $2.8 million in Drug Medi-Cal payments, and $9.3 million in interest earnings. These inflows were offset by outflows of $572.1 million in healthcare cost payments, $5.7 million in Drug Medi-Cal payments, $225.3 million in administrative and capital cost payments, and the recording of $7.6 million in board designated reserve transfers. The remaining difference can be attributed to other revenues.

General Statistics

Membership

Membership had a total net decrease of 1,804 members for the month.

Utilization Metrics and High Dollar Case

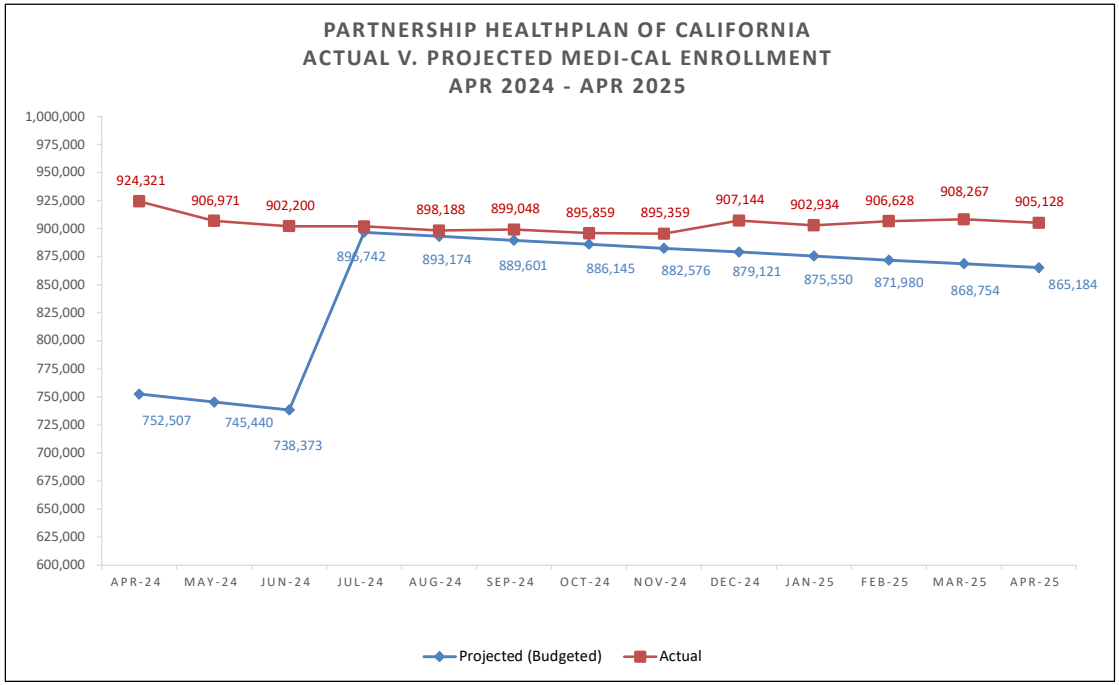
For the fiscal year 2024/25 through April 2025, 698 members reached the $250,000 threshold with an average cost of $505,277. For fiscal year 2023/24, 890 members reached the $250,000 threshold with an average cost per case of $511,851. For fiscal year 2022/23, 694 members reached the $250,000 threshold with an average claims cost of $519,608.

Current Ratio/Reserved Funds

Current Ratio Including Required Reserves:	**1.45**
Current Ratio Excluding Required Reserves:	**1.00**
Required Reserves:	**$1,354,227,618**
Total Fund Balance:	**$1,371,202,250**

Days of Cash on Hand

Including Required Reserves:	**119.98**
Excluding Required Reserves:	**57.50**



Member Months by County:

County	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25
Solano	105,274	102,979	102,062	101,490	101,565	102,138	101,685	101,430	103,225	102,170	102,511	102,443	102,189
Napa	27,891	27,017	27,071	26,878	26,697	26,466	26,242	26,374	26,961	26,991	27,197	27,289	27,339
Yolo	55,592	54,076	53,489	53,332	52,195	52,185	51,806	51,458	53,062	52,646	52,963	53,239	53,213
Sonoma	112,999	110,510	110,327	110,662	110,074	110,141	109,880	110,115	112,185	110,844	112,863	112,617	112,643
Marin	48,257	46,564	46,520	46,274	46,147	46,484	46,059	46,033	46,460	46,616	46,859	47,015	46,629
Mendocino	42,150	41,381	41,239	41,408	41,314	41,195	40,901	41,046	40,947	40,708	40,899	41,086	40,682
Lake	35,494	34,624	34,390	34,422	34,207	34,227	34,122	34,257	34,495	34,338	34,229	34,164	34,124
Del Norte	12,675	12,401	12,214	12,252	12,327	12,382	12,404	12,387	12,420	12,466	12,513	12,468	12,246
Humboldt	60,273	58,758	58,876	58,607	58,434	58,422	58,495	58,614	58,593	58,332	58,577	58,588	58,149
Lassen	8,793	8,668	8,714	8,765	8,802	8,753	8,814	8,754	8,756	8,761	8,825	8,821	8,767
Modoc	4,051	3,944	3,933	3,958	3,941	3,983	3,933	3,925	3,939	3,943	3,990	4,011	4,013
Shasta	70,514	68,436	67,907	67,685	67,173	67,073	66,723	66,780	66,863	66,195	65,800	66,052	65,219
Siskiyou	18,653	18,137	18,131	18,088	17,918	17,839	17,972	18,041	17,945	17,902	17,706	17,777	17,605
Trinity	5,704	5,607	5,540	5,540	5,464	5,437	5,422	5,380	5,419	5,286	5,348	5,345	5,321
Butte	85,581	84,795	84,347	84,598	84,856	85,378	85,666	85,502	85,772	85,639	85,539	86,256	85,897
Colusa	10,392	10,270	10,239	10,208	10,148	10,152	10,097	10,038	10,215	10,219	10,232	10,288	10,340
Glenn	13,772	13,618	13,583	13,501	13,491	13,595	13,543	13,596	13,664	13,594	13,623	13,786	13,690
Nevada	28,519	28,420	28,313	28,407	28,226	28,261	28,434	28,721	28,515	28,748	28,736	28,570	28,579
Placer	59,915	60,009	59,226	59,648	59,419	59,331	58,737	58,334	60,679	60,497	60,860	61,013	61,260
Plumas	5,942	5,925	5,903	5,938	5,924	5,857	5,820	5,870	5,866	5,792	5,858	5,925	5,886
Sierra	869	865	850	839	852	871	866	892	887	874	888	868	862
Sutter	43,816	43,711	43,619	43,542	43,122	43,076	42,418	42,244	43,425	43,430	43,691	43,601	43,739
Tehama	30,932	30,323	29,996	30,297	30,365	30,492	30,542	30,456	30,426	30,321	30,240	30,059	30,011
Yuba	36,263	35,933	35,711	35,569	35,527	35,310	35,278	35,112	36,425	36,622	36,681	36,986	36,725
All Counties Total	**924,321**	**906,971**	**902,200**	**901,908**	**898,188**	**899,048**	**895,859**	**895,359**	**907,144**	**902,934**	**906,628**	**908,267**	**905,128**

Medi-Cal Region 1: Sonoma, Solano, Napa, Yolo & Marin; Medi-Cal Region 2: Mendocino & Rural 8 Counties; Medi-Cal Region 3: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama & Yuba

Partnership HealthPlan of California
Comparative Financial Indicators Monthly Report
Fiscal Year 2024 - 2025 & Fiscal Year 2023 - 2024

FINANCIAL INDICATORS	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25	Feb-25	Mar-25	Apr-25			YTD	Avg / Month As of Apr-25
Total Enrollment	898,490	898,153	897,450	895,408	895,235	905,698	901,907	904,947	906,317	904,513			9,008,118	900,812
Total Revenue	516,467,263	505,732,274	517,421,674	517,491,108	507,895,691	520,768,067	518,706,967	759,253,557	692,900,747	592,855,121			5,649,492,468	564,949,247
Total Healthcare Costs	455,570,291	455,587,935	449,203,390	445,671,531	422,571,150	440,227,707	443,280,032	430,197,038	480,694,520	490,255,409			4,513,258,999	451,325,900
Total Administrative Costs	17,164,116	20,965,109	20,303,694	22,663,983	19,787,655	21,565,508	23,537,967	22,873,201	21,628,246	26,832,114			217,321,594	21,732,159
Medi-Cal Hospital & Managed Care Taxes	46,566,563	46,437,851	46,436,856	46,083,262	46,460,193	46,509,845	46,696,106	298,302,026	105,449,368	66,370,265			795,312,335	79,531,234
Total Current Year Surplus (Deficit)	(2,833,707)	(17,258,621)	1,477,734	3,072,332	19,076,693	12,465,007	5,192,862	7,881,292	85,128,613	9,397,333			123,599,540	12,359,954
Total Claims Payable	884,509,979	911,448,691	890,651,592	852,864,933	830,533,762	775,002,932	770,859,204	759,273,827	639,166,969	601,722,478			601,722,478	791,603,437
Total Fund Balance	1,244,769,003	1,227,510,382	1,228,988,116	1,232,060,447	1,251,137,140	1,263,602,149	1,268,795,012	1,276,676,303	1,361,804,917	1,371,202,250			1,371,202,250	1,272,654,572
Reserved Funds														
State Financial Performance Guarantee	1,092,899,000	1,093,798,000	1,096,923,000	1,100,211,000	1,102,840,000	1,046,032,000	1,049,745,000	1,091,605,000	1,119,293,000	1,130,765,000			1,130,765,000	1,092,411,100
Board Approved Capital and Infrastructure Purchases	79,941,518	79,360,193	77,250,794	76,202,434	75,447,816	73,742,888	72,667,651	71,478,836	70,124,244	66,296,695			66,296,695	74,251,307
Capital Assets	134,500,819	148,731,129	150,227,245	152,420,562	152,556,243	152,888,655	154,088,260	154,631,556	155,340,379	157,165,923			157,165,923	151,255,077
Strategic Use of Reserve-Board Approved	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668	71,002,668			71,002,668	71,002,668
Unrestricted Fund Balance	(133,575,002)	(165,381,608)	(166,415,591)	(167,776,217)	(150,709,587)	(80,064,063)	(78,708,568)	(112,041,757)	(53,955,374)	(54,028,036)			(54,028,036)	(116,265,580)
Fund Balance as % of Reserved Funds	90.31%	88.13%	88.07%	88.01%	89.25%	94.04%	94.16%	91.93%	96.19%	96.21%			96.21%	91.63%
Current Ratio (including Required Reserves)	1.45:1	1.41:1	1.40:1	1.40:1	1.40:1	1.39:1	1.41:1	1.37:1	1.44:1	1.45:1			1.45:1	1.41:1
Medical Loss Ratio w/o Tax	96.95%	99.19%	95.38%	94.54%	91.58%	92.82%	93.91%	93.33%	81.83%	93.12%			92.98%	92.98%
Admin Ratio w/o Tax	3.65%	4.56%	4.31%	4.81%	4.29%	4.55%	4.99%	4.96%	3.68%	5.10%			4.48%	4.48%
Profit Margin Ratio	-0.60%	-3.76%	0.31%	0.65%	4.13%	2.63%	1.10%	1.71%	14.49%	1.78%			2.55%	2.55%

FINANCIAL INDICATORS	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	YTD	Avg / Month As of Jun-24
Total Enrollment	697,169	694,364	689,096	674,680	670,710	660,101	918,590	916,349	921,546	912,331	906,971	900,691	9,562,598	796,883
Total Revenue	346,807,441	341,606,254	341,452,348	336,820,011	333,606,699	704,499,918	494,922,661	507,388,749	527,490,882	524,377,176	544,442,127	729,388,400	5,732,802,666	477,733,555
Total Healthcare Costs	327,163,476	330,010,604	317,050,232	309,178,329	314,689,553	312,699,931	427,212,628	429,268,912	475,024,262	449,448,163	476,657,036	383,635,425	4,552,038,550	379,336,546
Total Administrative Costs	11,697,451	12,604,507	11,948,835	13,398,097	13,672,021	13,241,394	16,243,013	17,074,221	15,790,362	16,678,381	18,392,413	19,471,144	180,211,837	15,017,653
Medi-Cal Hospital & Managed Care Taxes	-	-	-	-	-	376,406,250	46,790,714	48,056,922	47,537,225	47,123,221	46,858,980	46,582,645	659,355,957	54,946,330
Total Current Year Surplus (Deficit)	7,946,514	(1,008,857)	12,453,281	14,243,584	5,245,126	2,152,343	4,676,307	12,988,694	(10,860,967)	11,127,412	2,533,699	279,699,187	341,196,322	28,433,027
Total Claims Payable	422,844,079	452,077,175	486,822,447	455,222,013	481,847,695	499,411,492	589,212,971	701,582,898	808,535,908	829,697,152	838,350,235	886,017,427	886,017,427	620,968,458
Total Fund Balance	914,352,902	913,344,045	925,797,326	940,040,910	945,286,036	947,438,379	952,114,686	965,103,380	954,242,413	965,369,824	967,903,523	1,247,602,710	1,247,602,710	969,883,011
Reserved Funds														
State Financial Performance Guarantee	946,269,906	964,438,886	980,910,354	994,265,111	1,009,422,758	1,026,741,282	1,074,004,763	1,076,192,481	1,092,267,035	1,098,614,311	1,102,328,343	1,135,207,631	1,135,207,631	1,041,721,905
Board Approved Capital and Infrastructure Purchases	47,177,080	46,374,091	45,797,964	41,394,205	40,388,299	39,549,920	37,862,493	36,225,975	35,770,696	28,270,742	27,812,009	26,342,225	26,342,225	37,747,142
Capital Assets	118,991,470	119,235,734	119,254,457	123,078,590	126,154,438	126,341,441	127,443,936	128,495,663	128,366,608	135,257,004	135,105,115	133,498,833	133,498,833	126,768,607
Strategic Use of Reserve-Board Approved	70,659,883	70,318,568	70,455,056	71,514,836	72,116,668	72,116,668	72,116,668	72,116,668	72,116,668	72,116,668	71,786,668	71,002,668	71,002,668	71,536,474
Unrestricted Fund Balance	(268,745,437)	(287,023,235)	(290,620,505)	(290,211,832)	(302,796,127)	(317,310,932)	(359,313,174)	(347,927,407)	(374,278,595)	(368,888,901)	(369,128,612)	(118,448,647)	(118,448,647)	(307,891,117)
Fund Balance as % of Reserved Funds	77.28%	76.09%	76.11%	76.41%	75.74%	74.91%	72.60%	73.50%	71.83%	72.35%	72.39%	91.33%	91.33%	75.90%
Current Ratio (including Required Reserves)	1.69:1	1.63:1	1.49:1	1.59:1	1.56:1	1.43:1	1.38:1	1.34:1	1.33:1	1.33:1	1.35:1	1.45:1	1.45:1	1.43:1
Medical Loss Ratio w/o Tax	94.34%	96.61%	92.85%	91.79%	94.33%	95.31%	95.33%	93.46%	98.97%	94.17%	95.79%	56.19%	89.72%	89.72%
Admin Ratio w/o Tax	3.37%	3.69%	3.50%	3.98%	4.10%	4.04%	3.62%	3.72%	3.29%	3.49%	3.70%	2.85%	3.55%	3.55%
Profit Margin Ratio	2.29%	-0.30%	3.65%	4.23%	1.57%	0.66%	1.04%	2.83%	-2.26%	2.33%	0.51%	40.96%	6.73%	6.73%

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Membership and Financial Summary
For The Period Ending April 30, 2025

CURRENT MONTH	PRIOR MONTH	INC / DEC	MEMBERSHIP SUMMARY	CURRENT YTD AVG	PRIOR YTD AVG	VARIANCE
904,513	906,317	(1,804)	**Total Membership**	900,812	775,494	125,318

ACTUAL MONTH	BUDGET MONTH	$ VARIANCE MONTH	FINANCIAL SUMMARY	ACTUAL YTD	BUDGET YTD	$ VARIANCE YTD
592,855,121	524,938,753	67,916,368	**Total Revenue**	5,649,492,468	5,213,058,410	436,434,058
490,255,409	479,366,656	(10,888,753)	**Total Healthcare Costs**	4,513,258,999	4,645,094,241	131,835,242
26,832,114	27,770,890	938,776	**Total Administrative Costs**	217,321,594	256,748,685	39,427,091
66,370,265	44,458,650	(21,911,615)	**Medi-Cal Managed Care Tax**	795,312,335	454,223,945	(341,088,390)
9,397,333	**(26,657,443)**	**36,054,776**	**Total Current Year Surplus (Deficit)**	**123,599,540**	**(143,008,461)**	**266,608,001**
93.12%	99.77%		**Medical Loss Ratio (HC Costs as a % of Rev, excluding Managed Care Tax)**	92.98%	97.61%	
5.10%	5.78%		**Admin Ratio (Admin Costs as a % of Rev, excluding Managed Care Tax)**	4.48%	5.40%	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of April 30, 2025

	April 2025	March 2025
A S S E T S		
Current Assets		
Cash & Cash Equivalents	**1,101,586,630**	**1,242,331,978**
Receivables		
Accrued Interest	428,800	1,293,600
State DHS - Cap Rec	1,496,622,441	1,429,409,288
Other Healthcare Receivable	57,665,115	54,144,470
Miscellaneous Receivable	7,520,009	7,681,035
Total Receivables	**1,562,236,365**	**1,492,528,393**
Other Current Assets		
Payroll Clearing	21,515	20,731
Prepaid Expenses	12,525,863	13,614,116
Total Other Current Assets	**12,547,378**	**13,634,847**
Total Current Assets	**2,676,370,373**	**2,748,495,218**
Non-Current Assets		
Fixed Assets		
Motor Vehicles	515,462	515,462
Furniture & Fixtures	7,028,251	7,028,251
Computer Equipment	19,798,738	19,772,918
Computer Software	9,031,896	8,997,689
Leasehold Improvements	124,288	124,288
Land	7,619,204	7,619,204
Building	83,185,784	83,185,784
Building Improvements	39,688,760	39,688,760
Accum Depr - Motor Vehicles	(319,104)	(308,341)
Accum Depr - Furniture	(6,630,794)	(6,622,704)
Accum Depr - Comp Equipment	(17,098,520)	(16,899,673)
Accum Depr - Comp Software	(8,795,966)	(8,748,392)
Accum Depr - Leasehold Improvements	(124,288)	(124,288)
Accum Depr - Building	(13,941,883)	(13,764,140)
Accum Depr - Bldg Improvements	(15,846,137)	(15,641,741)
Construction Work-In-Progress	52,930,232	50,517,302
Total Fixed Assets	**157,165,923**	**155,340,379**
Other Non-Current Assets		
Deposits	134,604	88,468
Board-Designated Reserves	1,196,761,695	1,189,117,244
Knox-Keene Reserves	300,000	300,000
Prepaid - Other Non-Current	11,456,275	11,288,636
Net Pension Asset	4,919,453	4,919,453
Deferred Outflows Of Resources	1,620,052	1,620,052
Net Subscription Asset	2,790,269	2,790,269
Total Other Non-Current Assets	**1,217,982,348**	**1,210,124,122**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Balance Sheet
As Of April 30, 2025

	April 2025	March 2025
Total Non-Current Assets	**1,375,148,271**	**1,365,464,501**
Total Assets	**4,051,518,644**	**4,113,959,719**
L I A B I L I T I E S & F U N D B A L A N C E		
Liabilities		
Current Liabilities		
Accounts Payable	205,269,693	330,292,676
Unearned Income	109,464,493	109,464,493
Suspense Account	17,876,507	16,801,088
Capitation Payable	40,296,544	40,296,544
State DHS - Cap Payable	32,633,113	32,633,113
Accrued Healthcare Costs	1,513,631,945	1,431,822,654
Claims Payable	224,137,731	232,630,987
Incurred But Not Reported-IBNR	377,584,747	406,535,982
Quality Improvement Programs	149,455,633	141,711,277
Total Current Liabilities	**2,670,350,406**	**2,742,188,814**
Non-Current Liabilities		
Deferred Inflows Of Resources	7,617,910	7,617,910
Net Subscription Liability	2,348,078	2,348,078
Total Non-Current Liabilities	**9,965,988**	**9,965,988**
Total Liabilities	**2,680,316,394**	**2,752,154,802**
Fund Balance		
Unrestricted Fund Balance	**(54,028,036)**	**(53,955,374)**
Reserved Funds		
State Financial Performance Guarantee	1,130,765,000	1,119,293,000
Board Approved Capital and Infrastructure Purchases	66,296,695	70,124,244
Capital Assets	157,165,923	155,340,379
Strategic Use of Reserve-Board Approved	71,002,668	71,002,668
Total Reserved Funds	**1,425,230,286**	**1,415,760,291**
Total Fund Balance	**1,371,202,250**	**1,361,804,917**
Total Liabilities And Fund Balance	**4,051,518,644**	**4,113,959,719**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Statement of Cash Flow
For The Period Ending April 30, 2025

	Current Month Activity	Year-To-Date Activity
CASH FLOWS FROM OPERATING ACTIVITIES:		
Cash Received From:		
Capitation from California Department of Health Care Services	657,724,778	5,572,296,032
Other Revenues	340,801	36,123,215
Cash Payments to Providers for Medi-Cal Members		
Capitation Payments	(18,728,770)	(230,928,591)
Medical Claims Payments	(553,393,457)	(4,301,742,781)
Drug Medi-Cal		
DMC Receipts from Counties	2,752,177	37,386,575
DMC Payments to Providers	(5,718,849)	(53,573,931)
Cash Payments to Vendors	(198,434,488)	(943,089,874)
Cash Payments to Employees	(24,348,984)	(173,530,747)
Net Cash (Used) by Operating Activities	**(139,806,792)**	**(57,060,102)**
CASH FLOWS FROM CAPITAL FINANCING & RELATED ACTIVITIES:		
Purchases of Capital Assets	(2,562,867)	(27,140,906)
Net Cash (Used) by Capital Financial & Related Activities	**(2,562,867)**	**(27,140,906)**
CASH FLOWS FROM INVESTING ACTIVITIES:		
Board-Designated Reserve Transfers	(7,644,451)	(35,511,839)
Interest and Dividends on Investments	9,268,762	87,408,386
Net Cash Provided by Investing Activities	**1,624,311**	**51,896,547**
NET (DECREASE) IN CASH & CASH EQUIVALENTS	**(140,745,348)**	**(32,304,461)**
CASH & CASH EQUIVALENTS, BEGINNING	**1,242,331,978**	**1,133,891,091**
CASH & CASH EQUIVALENTS, ENDING	**1,101,586,630**	**1,101,586,630**
RECONCILIATION OF TOTAL OPERATING INCOMETO NET CASH (USED) BY OPERATING ACTIVITIES		
TOTAL OPERATING INCOME	**993,371**	**36,625,048**
DEPRECIATION	**647,412**	**6,305,991**
CHANGES IN ASSETS AND LIABILITIES:		
Other Receivables	(3,359,619)	(25,133,727)
California Department of Health Services Receivable	(67,213,153)	(304,468,344)
Other Assets	963,605	(1,946,404)
Accounts Payable and Accrued Expenses	(42,138,274)	455,646,729
Accrued Claims Payable	(37,444,491)	(284,294,949)
Quality Improvement Programs	7,744,357	60,205,554
Net Cash (Used) by Operating Activities	**(139,806,792)**	**(57,060,102)**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Statement of Revenues and Expenses

For The Period Ending April 30, 2025

****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
904,513	**904,513**	**-**			**TOTAL MEMBERSHIP**	**9,008,118**	**9,008,118**	**-**		
					REVENUE					
584,271,383	518,633,953	65,637,430	645.95	573.38	State Capitation Revenue	5,558,969,289	5,152,303,410	406,665,879	617.11	571.96
8,403,962	6,103,300	2,300,662	9.29	6.75	Interest Income	86,974,493	58,813,700	28,160,793	9.66	6.53
179,776	201,500	(21,724)	0.20	0.22	Other Revenue	3,548,686	1,941,300	1,607,386	0.39	0.22
592,855,121	**524,938,753**	**67,916,368**	**655.44**	**580.35**	**TOTAL REVENUE**	**5,649,492,468**	**5,213,058,410**	**436,434,058**	**627.16**	**578.70**
					HEALTHCARE COSTS					
					Physician Services					
7,854,509	9,202,007	1,347,498	8.68	10.17	Pcp Capitation	75,396,659	90,271,611	14,874,952	8.37	10.02
214,451	230,328	15,877	0.24	0.25	Specialty Capitation	2,137,489	2,240,336	102,847	0.24	0.25
88,356,624	77,375,616	(10,981,008)	97.68	85.54	Non-Capitated Physician Services	798,015,399	727,075,132	(70,940,267)	88.59	80.71
96,425,584	**86,807,951**	**(9,617,633)**	**106.60**	**95.96**	**Total Physician Services**	**875,549,547**	**819,587,079**	**(55,962,468)**	**97.20**	**90.98**
					Inpatient Hospital					
16,672,579	18,164,415	1,491,836	18.43	20.08	Hospital Capitation	163,263,707	180,041,018	16,777,311	18.12	19.99
118,830,413	125,260,183	6,429,770	131.38	138.48	Inpatient Hospital - Ffs	1,052,941,460	1,213,005,411	160,063,951	116.89	134.66
1,583,472	1,583,472	-	1.75	1.75	Hospital Stoploss	15,888,007	15,888,006	(1)	1.76	1.76
137,086,464	**145,008,070**	**7,921,606**	**151.56**	**160.31**	**Total Inpatient Hospital**	**1,232,093,174**	**1,408,934,435**	**176,841,261**	**136.77**	**156.41**
66,798,349	54,285,250	(12,513,099)	73.85	60.02	Long Term Care	555,797,379	536,479,555	(19,317,824)	61.70	59.56
					Ancillary Services					
1,183,434	1,280,416	96,982	1.31	1.42	Ancillary Services - Capitated	11,742,771	12,471,659	728,888	1.30	1.38
81,074,434	83,056,628	1,982,194	89.63	91.82	Ancillary Services - Non-Capitated	835,121,404	782,307,275	(52,814,129)	92.71	86.84
82,257,868	**84,337,044**	**2,079,176**	**90.94**	**93.24**	**Total Ancillary Services**	**846,864,175**	**794,778,934**	**(52,085,241)**	**94.01**	**88.22**
					Other Medical					
5,708,138	7,603,125	1,894,987	6.31	8.41	Quality Assurance	47,346,904	72,722,060	25,375,156	5.26	8.07
78,914,309	81,521,615	2,607,306	87.25	90.13	Healthcare Investment Funds	737,354,247	811,958,271	74,604,024	81.85	90.14
128,900	149,200	20,300	0.14	0.16	Advice Nurse	1,248,200	1,437,600	189,400	0.14	0.16
646	7,800	7,154	-	0.01	Hipp Payments	6,709	75,000	68,291	-	0.01
13,396,689	11,902,245	(1,494,444)	14.81	13.16	Transportation	124,797,209	112,099,015	(12,698,194)	13.85	12.44
98,148,682	**101,183,985**	**3,035,303**	**108.51**	**111.87**	**Total Other Medical**	**910,753,269**	**998,291,946**	**87,538,677**	**101.10**	**110.82**
9,538,462	7,744,356	(1,794,106)	10.55	8.56	Quality Improvement Programs	92,201,455	87,022,292	(5,179,163)	10.24	9.66
490,255,409	**479,366,656**	**(10,888,753)**	**542.01**	**529.96**	**TOTAL HEALTHCARE COSTS**	**4,513,258,999**	**4,645,094,241**	**131,835,242**	**501.02**	**515.65**
					ADMINISTRATIVE COSTS					
15,615,159	17,057,726	1,442,567	17.26	18.86	Employee	136,383,787	160,242,174	23,858,387	15.14	17.79
112,492	171,903	59,411	0.12	0.19	Travel And Meals	825,628	1,656,600	830,972	0.09	0.18
1,390,065	4,151,877	2,761,812	1.54	4.59	Occupancy	13,141,715	29,526,922	16,385,207	1.46	3.28
908,645	896,192	(12,453)	1.00	0.99	Operational	5,847,956	8,927,105	3,079,149	0.65	0.99
4,423,407	3,026,793	(1,396,614)	4.89	3.35	Professional Services	28,602,504	29,916,259	1,313,755	3.18	3.32
4,382,346	2,466,399	(1,915,947)	4.84	2.73	Computer And Data	32,520,004	26,479,625	(6,040,379)	3.61	2.94
26,832,114	**27,770,890**	**938,776**	**29.65**	**30.71**	**TOTAL ADMINISTRATIVE COSTS**	**217,321,594**	**256,748,685**	**39,427,091**	**24.13**	**28.50**
66,370,265	44,458,650	(21,911,615)	73.38	49.15	**Medi-Cal Managed Care Tax**	795,312,335	454,223,945	(341,088,390)	88.29	50.42
9,397,333	**(26,657,443)**	**36,054,776**	**10.40**	**(29.47)**	**TOTAL CURRENT YEAR SURPLUS (DEFICIT)**	**123,599,540**	**(143,008,461)**	**266,608,001**	**13.72**	**(15.87)**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
April 30, 2025

1. ORGANIZATION

The Partnership HealthPlan of California (the HealthPlan) 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. The HealthPlan has quasi-independent political jurisdiction to contract with the State for managing Medi-Cal beneficiaries who reside in various Northern California counties. The HealthPlan is a combined public and private effort engaged principally in providing a more cost-effective method of healthcare. The HealthPlan began serving Medi-Cal eligible persons in Solano County in May 1994. That was followed by additional Northern California counties in March 1998, March 2001, October 2009, two counties in July 2011, and eight counties in September 2013. Beginning July 2018 and in accordance with direction from the Department of Health Care Services (DHCS), the HealthPlan consolidated its reporting from these fourteen counties into two regions, which are in alignment with the two DHCS rating regions. Beginning January 2024, the HealthPlan expanded into ten additional counties, which comprise a third region.

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 the HealthPlan 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:
The HealthPlan 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.

RESERVED FUNDS:
As of April 2025, the HealthPlan has Total Reserved Funds of $1.4 billion. This includes $71.0 million of funds set aside for Board approved Strategic Use of Reserve (SUR) initiatives; this also includes funding for the Wellness & Recovery program. The total SUR amount represents the net amount remaining for all SUR projects that have been approved to date and is periodically adjusted as projects are completed. Reserved Funds also includes $0.3 million of Knox-Keene Reserves.

RECLASSIFICATIONS:
Certain reclassifications of prior period balances have been made to conform with the current period presentations. Such reclassifications do not affect the total increase in net position or total current or noncurrent assets or liabilities.

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

The HealthPlan 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 becomes available. Budgeted capitation revenues and healthcare costs are adjusted each month to reflect changes in enrollee counts.

5. QUALITY IMPROVEMENT PROGRAM

The HealthPlan maintains quality improvement contracts with acute care hospitals and primary care physicians. As of April 2025, the HealthPlan has accrued a Quality Improvement Program payout of $149.5 million.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
NOTES TO FINANCIAL STATEMENTS
April 30, 2025

6. ESTIMATES

Due to the nature of the operations of the 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 Reported
- 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, the HealthPlan's Management is of the opinion that any liability which 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

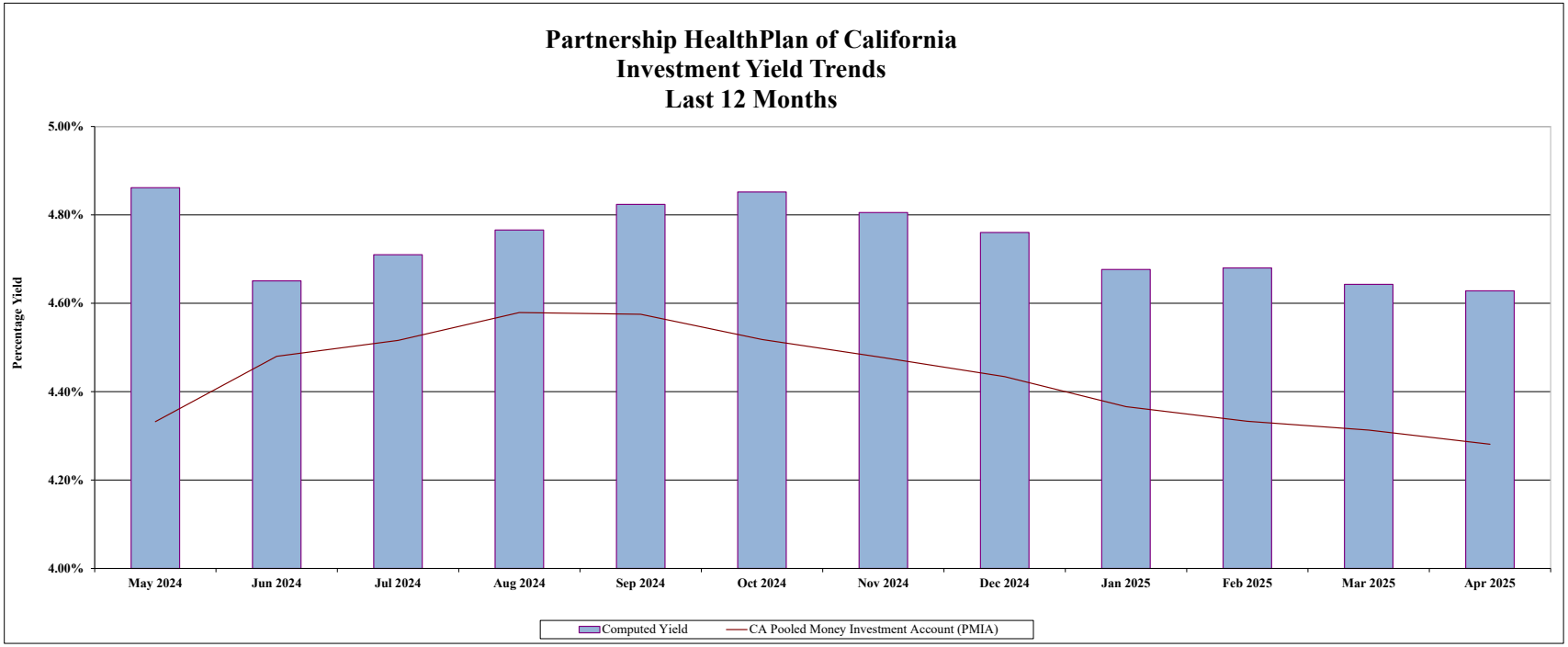
None noted.

Partnership HealthPlan of California
Investment Schedule
April 30, 2025

Name of Investment	Investment Type	Yield to Maturity	Trade Date	Maturity Date	Call Date	Face Value	Purchase Price	Market Value	Credit Rating Agency	Credit Rating
FUNDS HELD FOR INVESTMENT:										
Highmark Money Market	Cash & Cash Equiv	NA	Various	NA	NA	NA	$ 1,746,283	$ 1,746,283	NA	NR
Certificate of Deposit for Knox Keene	Cash & Cash Equiv	0.0405	1/31/2025	1/30/2030	NA	$ 300,000	$ 300,000	$ 300,000	NA	NR
FUNDS HELD FOR OPERATIONS:										
Merrill Lynch Institutional	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 75,187,778		
Merrill Lynch MMA - Checking	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 2,735,267		
US Bank - General, MMA, and Sweeps	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 2,098,776,825		
Government Investment Pools (LAIF)	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 75,000,000		
Government Investment Pools (County)	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 44,750,343		
West America Payroll	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 148,529		
Petty Cash	Cash for Operations	NA	NA	NA	NA	NA	NA	$ 3,300		
GRAND TOTAL:								$ 2,298,648,325		

Partnership HealthPlan of California
Investment Yield Trends

PERIOD		May 2024	Jun 2024	Jul 2024	Aug 2024	Sep 2024	Oct 2024	Nov 2024	Dec 2024	Jan 2025	Feb 2025	Mar 2025	Apr 2025
Interest Income		9,436,106	9,367,229	9,655,722	9,298,928	9,343,307	10,427,933	7,842,623	8,546,229	7,610,667	7,079,412	8,765,710	8,403,962
Cash & Investments at Historical Cost	(1)	2,186,519,113	2,295,440,947	2,234,052,950	2,273,253,498	2,415,112,928	2,185,207,714	2,223,891,960	2,419,126,236	2,214,161,851	2,249,046,624	2,431,749,222	2,298,648,325
Computed Yield	(2)	4.86%	4.65%	4.71%	4.77%	4.82%	4.85%	4.81%	4.76%	4.68%	4.68%	4.64%	4.63%
CA Pooled Money Investment Account (PMIA)	(3)	4.33%	4.48%	4.52%	4.58%	4.58%	4.52%	4.48%	4.43%	4.37%	4.33%	4.31%	4.28%



NOTES:

(1) Investment balances include Restricted Cash and Board Designated Reserves

(2) Computed yield is calculated by dividing the past 12 months of interest by the average cash balance for the past 12 months.

(3) LAIF limits the amount a single government entity can deposit into LAIF; currently that amount is set at $75 million.

Transportation

As part of our ongoing commitment to improving access to care and enhancing the member experience, the Transportation Services team has made significant strides in developing a digital solution for scheduling rides.

The Transportation App allows Partnership members to request transportation, monitor real-time trip updates, track their driver's location, and directly contact drivers—all from their mobile device. This innovation enables members to manage their transportation needs more independently and with greater convenience, virtually eliminating the need to call in for trip coordination. By shifting toward a digital-first approach, we are also strategically positioned to reduce inbound call volume and significantly shorten wait times for those who still rely on phone-based assistance.

In its initial phase, we launched a focused pilot program involving 39 active Partnership members. These individuals were selected to evaluate the app's ease of use, reliability, and functional value. The group's usage data, combined with their feedback, provided the foundation for assessing the platform's effectiveness and identifying areas for enhancement. Since the start of the pilot, members have successfully booked over 900 individual trip legs via the app, indicating strong interest and demand for a digital self-service transportation tool.

Building on the momentum of the initial pilot, we are now launching a one-county pilot in Solano County. This next phase will expand app access to a broader but controlled population, allowing us to validate the enhanced app in a more complex, real-world environment. Solano County members who call the Transportation Call Center will be offered access to the app as part of this expanded test. This will also help us evaluate any county-specific barriers to adoption, such as regional connectivity issues or member demographic factors.

To support members during this transition, our Transportation team has established a dedicated support line for app-related issues. Members who experience login difficulties, request challenges, or technical glitches can be transferred directly to our Transportation team, for expedited support.

As we prepare for broader implementation across all 24 counties, we are coordinating communications through various member touchpoints. Automated messaging in our call center will encourage callers to inquire about the app, and promotional content will be included in the Member Newsletter and other outreach efforts. These strategies are designed to ensure smooth onboarding and consistent member engagement. We are targeting mid-July for a full roll out to all counties.

Claims

The Claims Department continues to meet and exceed timeliness and quality standard, while simultaneously dedicating time and effort on the Claims system implementation project. The team is processing claims and provider dispute resolutions (PDRs) with precision and efficiency. At the end of May, 95% of clean claims are being paid or denied within 45 business days, while 99% of all claims are addressed within 90 calendar days, as federally mandated by DHCS and the Department of Managed Care.

Claims Call Center achieved a service level of 98.82% in May, demonstrating our continued commitment to timely and responsive provider support and maintaining an average wait time of under 4 minutes.

Provider Relations

In an effort to increase the quality of provider education and communication the structure of provider visits has been updated and implemented. Provider visits are now scheduled rather than drop-in and includes higher level provider leadership as well as front line staff. PR has also significantly increased the number of educational events offered, including both in person and virtual. In the previous quarter 16 trainings were offered and providers responded with high numbers of attendance and positive feedback on post-training surveys.

A special focus has also been made through this increased communication to obtain and verify valuable individual contact information to enable information to reach critical stakeholders and hands on providers rather than just forwarding updates to general facility contacts. This has resulted in a positive increase in participation and very positive feedback from our providers.

Partnership Board: Legislative Update
June 2025

Bills of Interest

SB 669 (McGuire) **Rural hospitals: standby perinatal medical services.**
06/09 In Assembly Health: From committee with author's amendments. Read second time and amended. Re-referred to Com. on Health.
This bill will increase access to community based, culturally centered care for pregnant people within their communities – improving the likelihood that they continue to access care throughout their pregnancy and postpartum. This bill seeks to establish a narrowly tailored pilot program for rural and critical access hospitals, that do not currently have labor and delivery units, or that are affiliated with an alternative birthing center to offer care through a standby perinatal unit – improving access to full scope labor and delivery services for low-risk pregnancies.

SB 32 (Weber) **Public health: maternity ward closures**
06/09 In Assembly: referred to Health.
This bill would express the intent of the Legislature to enact legislation to address maternity ward closures.

SB 250 (Ochoa Bogh) **Medi-Cal: provider directory: skilled nursing facilities.**
06/05 In Assembly: referred to Health.
This bill would require, as part of the health care options information posted by the department, in the provider directory that lists accepted Medi-Cal managed care plans, through the Medi-Cal Managed Care Health Care Options internet website and any other applicable mechanisms, that the directory include skilled nursing facilities as one of the available searchable provider types.

SB 306 (Becker) **Health care coverage: prior authorizations.**
06/05 In Assembly: Referred to Health.
Requires a covered health care service that has been approved 90% or more times in the prior calendar year to be exempt from health plan or health insurer imposed prior authorization for one year.

SB 324 (Menjivar) **Medi-Cal: enhanced care management and community supports**
06/05 In Assembly: Referred to Health.
This bill would require a Medi-Cal managed care plan, for purposes of covering the ECM benefit, or if it elects to cover a community support, to give preference to contracting with community providers, as defined, whenever those providers are available in the respective county and have experience in providing the applicable ECM or community support.

AB 29 (Arambula) **Medi-Cal: Adverse Childhood Experiences trauma screenings: providers.**
06/05 In Assembly: Read 1st time. Held at Desk.
This bill would require the department to include (1) community-based organizations and local health jurisdictions that provide health services through community health workers and (2) doulas, that are enrolled Medi-Cal providers, as providers qualified to provide, and eligible to receive payments for, ACEs trauma screenings pursuant to the provisions described above.

AB 55 (Bonta) **Alternative birth centers: licensing and Medi-Cal reimbursement**
05/27 In Senate: From committee chair, with author's amendments: Amend, and re-refer to committee. Read 2nd time, amended. Re-referred to Health.
Under existing law, as a criterion under both the licensing provisions and the Medi-Cal reimbursement, the facility is required to be a provider of comprehensive perinatal services as defined in the Medi-Cal provisions. This bill would remove, under both sets of criteria, the certification condition of being a provider of comprehensive perinatal services as defined in the Medi-Cal provisions.

AB 220 (Jackson) **Medi-Cal: subacute care services.**
05/29 In Senate. Read 1st time. To RLS. for assignment.
This bill would require a health facility that provides pediatric subacute or adult subacute care services pursuant to these provisions to submit with a treatment authorization request, including an electronic treatment authorization request, a specified form when requesting authorization for subacute care services. The bill would prohibit a Medi-Cal managed care plan from developing or using its own criteria to substantiate medical necessity for pediatric subacute or adult subacute care services with a condition or standard not enumerated in those forms.

AB 257 (Flora) **Specialty care network: telehealth and other virtual services.**
05/23 In Assembly: Referred to APPR Suspense File. Held under submission.
This bill would, subject to an appropriation, require the California Health and Human Services Agency, in collaboration with the Department of Health Care Access and Information and the State Department of Health Care Services, to establish a demonstration project for a telehealth and other virtual services specialty care network that is designed to serve patients of safety-net providers consisting of qualifying providers, defined to include, among others, rural health clinics and community health centers. The bill would authorize the focus of the project to include increasing access to behavioral and maternal health services and additional specialties prioritized by the agency

AB 315 (Bonta) **Medi-Cal: Home and Community-Based Alternatives Waiver.**
05/23 In Assembly: Referred to APPR Suspense File. Held under submission.
The bill would delete a provision authorizing the expansion of the number of waiver slots up to 5,000 additional slots, and would instead require the enrollment of all eligible individuals who apply for the HCBA Waiver. The bill would require the department, by March 1, 2026, to seek any necessary amendments to the waiver to ensure that there is sufficient capacity to enroll all eligible individuals who are currently on a waiting list for the waiver, as specified. The bill would require the department, by March 1, 2026, to submit a rate study to the appropriate fiscal and policy committees of the Legislature addressing the sustainability, quality, and transparency of rates for the HCBA Waiver. The bill would require that the study include an assessment of the effectiveness of the methods used to pay for services under the waiver, with consideration of certain factors.

AB 350 (Bonta) **Health care coverage: fluoride treatments.**
06/03 In Senate. Read 1st time. To RLS. for assignment.
This bill would make the application of fluoride or other appropriate fluoride treatment, including fluoride varnish, a covered benefit under the Medi-Cal program for children under 21 years of age. The bill would require the State Department of Health Care Services to establish and promulgate a policy governing billing and reimbursement for the application of fluoride varnish, as specified.

AB 403 (Ortega) **Medi-Cal: community health worker services.**
05/23 In Assembly: Referred to APPR Suspense File. Held under submission.
The bill would require the department to annually conduct an analysis of the CHW services benefit, submit each analysis to the Legislature, and publish each analysis on the department's internet website, with the first analysis due July 1, 2027.

AB 510 (Addis) **Health care coverage: utilization review: appeals and grievances.**
05/23 In Assembly: Referred to APPR Suspense File. Held under submission.
This bill would, upon request, require that an appeal or grievance regarding a decision by a health care service plan or disability insurer delaying, denying, or modifying a health care service based in whole or in part on medical necessity, be reviewed by a licensed physician who is competent to evaluate the specific clinical issues involved in the health care service being requested, and of the same or similar specialty as the requesting provider. The bill, notwithstanding the above-described timelines, would require these reviews to occur within 2 business days, or if an enrollee or insured faces an imminent and serious threat to their health, within a timely fashion appropriate for the nature of the enrollee's or insured's condition, as specified. If a health care service plan or disability insurer fails to meet those timelines, the bill would deem the prior authorization request as approved and supersede any prior delay, denial, or modification.

AB 512 (Harabedian) **Health care coverage: prior authorization.**
06/03 In Senate. Read 1st time. To RLS. for assignment.
This bill would shorten the timeline for prior authorization requests to no more than 48 hours for standard requests or 24 hours for urgent requests from the plan's or insurer's receipt of the information reasonably necessary and requested by the plan or insurer to make the determination.

AB 517 (Krell) **Medi-Cal: complex rehabilitation technology: wheelchairs.**
05/23 In Assembly: Referred to APPR Suspense File. Held under submission.
This bill would prohibit the department from requiring prior authorization for the repair of a CRT-powered wheelchair if the cost of the repair does not exceed $1,250.

AB 539 (Schiavo) **Health care coverage: prior authorizations.**
06/03 In Senate. Read 1st time. Referred to Health.
This bill would require a prior authorization for a health care service by a health care service plan or a health insurer to remain valid for a period of at least one year from the date of approval.

AB 543 (Gonzalez) **Medi-Cal: street medicine.**
06/03 In Senate. Read 1st time. To RLS. for assignment.
This bill would set forth provisions regarding street medicine, as defined, under the Medi-Cal program for persons experiencing homelessness. The bill would state the intent of the Legislature that the street medicine-related provisions coexist with, and not duplicate, other Medi-Cal provisions, including, but not limited to, those regarding community health worker services, enhanced care management, and community supports. The bill would require the department to implement a program of presumptive eligibility for persons experiencing homelessness for purposes of full-scope Medi-Cal benefits without a share of cost. The bill would authorize an enrolled Medi-Cal provider to make a presumptive eligibility determination for those persons.

News Updates
June 2025

Partnership Press Releases:

Partnership CEO Sonja Bjork continues working with MACPAC
Partnership HealthPlan of California
May 6, 2025
FAIRFIELD – Partnership HealthPlan of California's CEO Sonja Bjork was reappointed on May 5, 2025, to the Medicaid and CHIP Payment and Access Commission (MACPAC).

Your Partner in Health: Let's Talk About STI Screening
Partnership HealthPlan of California – Colleen Townsend, M.D.
March 28, 2025
Despite the sensitivity of the topic, it is critical to highlight the importance of screening for sexually transmitted infections (STIs).

Partnership Statement on U.S. House of Representatives Budget Resolution
Partnership HealthPlan of California – Sonja Bjork, Chief Executive Officer
February 27, 2025
It is not only critical to protect Medicaid funding, but it is fiscally prudent.

Partnership Mentioned:

Solano Supervisor John Vasquez announces cancer diagnosis
Vallejo Times Herald
June 3, 2025
Debbie Vaughn, assistant county administrator, presented options for appointments to the Partnership HealthPlan of California Commission.

EPHC team receives inaugural award from Partnership
The Plumas Sun
May 27, 2025
Eastern Plumas Health Care reports that its California Advancing and Innovating Medi-Cal team was recently selected by Partnership HealthPlan of California to receive an inaugural CalAIM Make a Difference Award.

Third primary care OLE clinic opens in Fairfield
Fairfield Daily Republic
May 20, 2025
Partnership HealthPlan of California, a nonprofit community-based health care organization that helps administer Medi-Cal benefits in the region, provided $300,000 in funding to help CommuniCare+OLE open the site.

CommuniCare+OLE opens third primary care location

Vacaville Reporter

May 19, 2025

"Access to primary care in Fairfield is a challenge, so the creation of new facilities, like this one from CommuniCare+OLE, makes a tremendous difference in ensuring our members can get access to the medical services they need," said Sonja Bjork, CEO of Partnership.

Eastern Plumas Health Care's CalAIM Team Recipient of Partnership's Inaugural CalAIM Make a Difference Award

Sierra Booster

May 15, 2025

PORTOLA, California— on April 30th, Eastern Plumas Health Care's CalAIM Team was selected by Partnership HealthPlan of California for an inaugural CalAIM Make a Difference Award.

Eastern Plumas Health Care's CalAIM Team Recipient of Partnership's Inaugural CalAIM Make a Difference Award

Sierra Daily News

May 15, 2025

Eastern Plumas Health Care's CalAIM Team was selected by Partnership HealthPlan of California for an inaugural CalAIM Make a Difference Award.

Partnership CEO brings rural perspective to MACPAC

The Plumas Sun

May 9, 2025

Partnership HealthPlan of California reports that its CEO, Sonja Bjork, was reappointed May 5 to the Medicaid and CHIP Payment and Access Commission.

74 organizations at United Way community resource fair

The Appeal-Democrat

May 8, 2025

The Yuba Sutter Colusa United Way's annual Community Resource Fair Saturday, May 17, will feature 74 participating non-profit, governmental, and sponsor booths.

Partnership HealthPlan exec stays on Medicaid panel

Daily Republic

May 8, 2025

FAIRFIELD — Partnership HealthPlan of California Chief Executive Officer Sonja Bjork has been reappointed to the Medicaid and CHIP Payment and Access Commission.

Partnership CEO Sonja Bjork continues working with MACPAC

Lake County News

May 7, 2025

Partnership HealthPlan of California's CEO Sonja Bjork was reappointed on May 5, 2025, to the Medicaid and CHIP Payment and Access Commission, or MACPAC.

Weds 9AM | What's the impact of proposed federal Medicaid cuts in Shasta County?
Jefferson Public Radio
May 6, 2025
In Shasta County, approximately 66,000 individuals rely on Partnership HealthPlan of California for their health care needs, according to Brandon Thornock, CEO of Shasta Community Health Center.

Redding Farmers Market gets schooled after opening year round. Now what?
Redding Record Searchlight
May 3, 2025
A health fair backed by Partnership HealthPlan of California is scheduled to happen at the Redding Farmer's Market on Aug. 9, complete with a mobile mammogram booth.

Federal Medicaid Cuts Would Devastate Health Care Systems in California's Vast Rural North
California Health Care Foundation Blog
May 1, 2025
"We are very worried about the long-term impact of these cuts," said Sonja Bjork, JD, the CEO of Partnership HealthPlan.

From the Sierra Nevada to Death Valley, Rural Californians Fear Medi-Cal Cuts
California Health Care Foundation
April 29, 2025
Sonja Bjork, CEO of Partnership HealthPlan, said the organization has invested significant resources into attracting providers to the region and retaining them through incentive programs.

Opinion: Stand up for Medi-Cal and Medicare
Chico Enterprise Record
April 23, 2025
And in 24 northern counties served by Partnership HealthPlan of California, an estimated 28 percent of people -- totaling nearly 900,000 – depend on affordable health care options available through community-based providers that are funded in part my Medi-Cal.

Empire Recovery Center in Redding sees revenue fall, has laid off staff. What's next?
Redding Record Searchlight
April 2, 2025
Since its modest beginning as an ad hoc effort to help alcoholics that was established in the former Old Crow Bar in south Redding, Empire has grown into a respected and well-known treatment program that largely services people covered by Partnership HealthPlan of California.

Chief Medical Officer Quality Report

June 25, 2025

Robert Moore, MD MPH

1. Primary Care Provider Quality Incentive Program (PCP QIP) performance

The measurement year 2024 PCP QIP results have been processed and payments sent out. Here are some highlights of the results.

With the 10-county geographic expansion in 2024, the number of sites participating in the PCP QIP increased from 252 to 390 providers by the end of the year. The Adjusted average score dropped from 68% in 2023 to 59% in 2024, largely due to lower scores in PCPs in the 10 expansion counties, compared to the legacy counties, even though the these new PCP sites had lower thresholds for their first year.

Approximately $52.2 million was earned by all sites, including just over $1 million in Unit of Service incentives.

Among sites with at least 50 members assigned, here are the ones scoring over 90%:

Private Practices:

West Marin Medical Center:	100%
Shasta Family Care:	91%

Medical Groups:

Sutter Medical Group, Yolo, Suite 200:	95%
Center for Primary Care (Northbay Hospital), Hillborn Rd.:	93%
Queen of the Valley Medical Associates, Trancas	92%

Federally Qualified Health Center Sites

Marin Community Clinics:	
Larkspur	98%
Greenbrae	97%
San Rafael 3260 Kerner Blvd.	94%

Novato	92%
South Novato	92%
San Rafael 3110 Kerner Blvd:	92%
Communicare+Ole	
St. Helena	98%
Calistoga	98%
South Napa Campus	90%
Santa Rosa Community Health Centers	
Lombardi	93%
Petaluma Health Center	
Petaluma	93%
Pt. Reyes	92%
Mendocino Coast Clinics	
Pediatric Group	92%
Open Door CHC	
Ferndale	90%

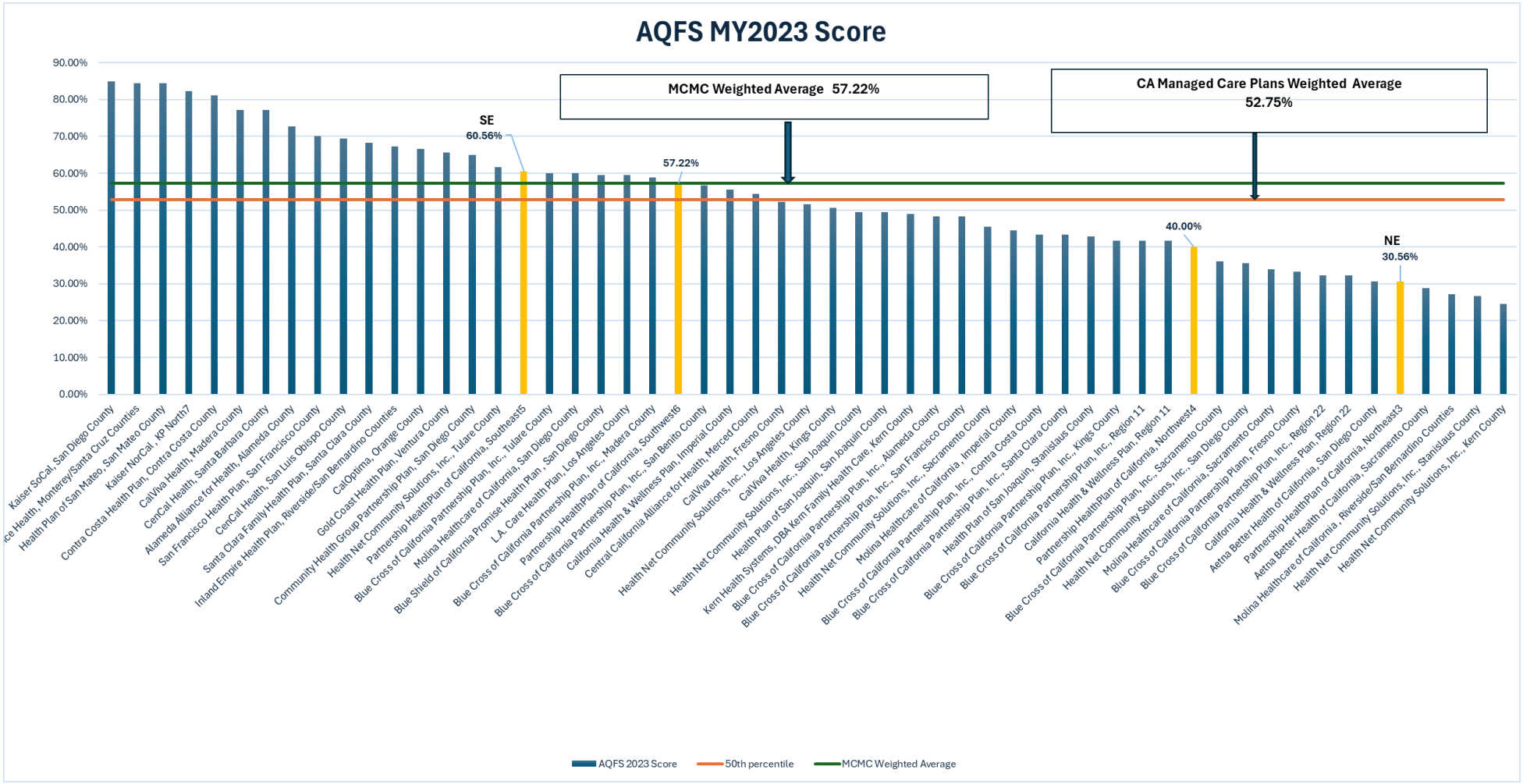
Among tribal health centers, **Lake County Tribal Health** sites had their best year ever, with scores between 80-89%. Small sites **Round Valley Tribal Health** and **K'ima:w Medical Center** both scored 75%, a dramatic improvement from last year.

In the expansion counties, in the first year participating in the PCP QIP, eight of **Ampla Health** sites scored above the overall weighted average (Yuba City Pediatrics scored highest with 78%), as did two of **Northern Valley Indian Health** sites (Willows site scored highest at 77%).

2. **Quality Factor scores for Health Plans in California 2023**

DHCS finally released the comparative results of HEDIS MY 2023, as summarized below with Partnership's 4 regions noted in Yellow. The top performance (which had been 100% in most years) was down to 84% and the California Managed Care Plan weighted average was 5% below the national MediCal Managed Care average for the first time ever. This is attributable to the addition of several new MCAS measures with data reporting issues, as noted later.

The spread of performance in partnership regions is typical of past years, reflecting the strong influence of rural health inequities due to several underlying sociodemographic factors.


AQFS MY2023 Score
MCMC Weighted Average 57.22%
CA Managed Care Plans Weighted Average 52.75%
SE
60.56%
57.22%
40.00%
NE
30.56%
90.00%
80.00%
70.00%
60.00%
50.00%
40.00%
30.00%
20.00%
10.00%
0.00%
AQFS 2023 Score
50th percentile
MCMC Weighted Average

3. DHCS Quality Sanction Update

Measurement Year 2023. In October, DHCS announced an intent to sanction Partnership HealthPlan $475,000 for performance the four 2023 HEDIS reporting regions on the 16 measures in the Managed Care Accountability Set that were below the national NCQA median.

Of this amount, $362,752.20 was for low performance on Topical Fluoride Vanish in children. Since topic fluoride varnish is predominantly done by dental care providers, we rely on DHCS to send us this data to use for the HEDIS project. However, DHCS have never sent Dental Fluoride data for dental providers that are FQHCs, RHCs, and Tribal health centers. When we analyzed the data we did have, we back-engineered the dental visit data for children and were able to show DHCS that the services provided were above the national median, so dental access for children appears to be above average.

On November 4, the Partnership leadership team met with DHCS to argue that the topical fluoride varnish measure, as well as two others with major data issues related to actions of DHCS should be excluded from the sanctions calculation. Removal of these three measures would result in a lower sanction of $87,753.88.

In December, DHCS publicly published the sanctioned amounts which were unchanged after our meeting with them. The Partnership Executive team has appealed this sanction, based on the same arguments we submitted in November. Our hearing date has been set for October 28-30, 2025. DHCS and Partnership are in conversations about a settlement conference.

Measurement Year 2024. In January, DHCS walked back its plan to assign sanctions at the county level, deferring the decision on how to group small counties for sanctions until after the year's data is collected.

As a review, here are the issues with county level sanctions.

1. The variation of performance in our small counties is a reflection of social determinants of health and small area variation within the health care delivery system, which are not within the ability of the Health Plan to resolve.
2. DHCS has not tested or piloted the concept of county level sanctions for validity, fairness, or operationalization before implementing this policy. In fact, they did not review any county level data nor run county level scenario testing before establishing this policy.

Partnership's actuaries have prepared an independent analysis of the statistical validity of county-level sanctions. We will continue to vigorously contest county level sanctions. We are happy to meet with any Commissioner who has questions to discuss this further.

Health Services Board Update

Name: Katherine Barresi, RN, BSN, PHN, NE-BC, CCM

Chief Health Services Officer

The Health Services departments have been working steadily and heavily in implementing the many new programs, initiatives, and requirements under the new 2024 Medi-Cal contract, DHCS APLs and/or strategic organizational goals. Significant progress has been made, positioning Partnership well for sustained impact while delivering value and reinforcing our commitment to our mission. Key milestones, ongoing challenges, and outlined priorities are noted below. Through continued collaboration, innovation, and a focus on operational excellence, the Health Services departments remain committed to supporting the organization's strategic goals and delivering impactful results for our members and communities.

Dept. Updates for Board

<table>
<tr><th>Update Topic</th><th>Notes</th></tr>
<tr><td>Care Coordination</td><td>
Care Coordination Productivity and Key Performance Indicators (KPIs)
For measurement period: 1/1/2025 – 5/31/2025
• Referrals – across all regions: 29,978
<table>
<tr><th></th><th>EA</th><th>NR</th><th>SR</th><th>Grand Total</th></tr>
<tr><td>Jan</td><td>4495</td><td>1438</td><td>2048</td><td>7981</td></tr>
<tr><td>Feb</td><td>2228</td><td>1060</td><td>1867</td><td>5155</td></tr>
<tr><td>Mar</td><td>2317</td><td>1284</td><td>1965</td><td>5566</td></tr>
<tr><td>Apr</td><td>2427</td><td>1391</td><td>2373</td><td>6191</td></tr>
<tr><td>May</td><td>1992</td><td>1387</td><td>1706</td><td>5085</td></tr>
<tr><td>Grand Total</td><td>13459</td><td>6560</td><td>9959</td><td>29978</td></tr>
</table>
</td></tr>
</table>

- **Cases (Members Served): 34,194**

Row Labels	EASTERN	NORTHERN	SOUTHERN	Grand Total
2025	14734	7538	11922	34194
January	4363	1664	2483	8510
February	2857	1317	2310	6484
March	2729	1480	2330	6539
April	2627	1557	2707	6891
May	2158	1520	2092	5770
Grand Total	14734	7538	11922	34194

- **Volume of Calls: 30,768**
  This volume of calls represents calls presented to the department's 800#
  - Eastern Region Members: 5,640
  - Northern Region Members: 7,176
  - Southern Region Members: 17,952

Transitional Care Services: Since the recent reporting period, the department has been laser focused on fully implementing the required Transition Care Services activities as outlined and described in DHCS' Population Health Management Policy Guide. The department has achieved 100% implementation with adjustments made to daily TCS reports and assessments being made while the department stabilizes operations for the volume and requirements of the work. Anecdotally, some providers have reported to the department an inconvenience to the increased call volume from Partnership staff, however department leadership is discussing and evaluating opportunities to address the issue. For the Pregnant and/or Post-partum population that is eligible for TCS, Care Coordination has worked closely with the Population Health Management dept. to transition their TCS services to that team for a holistic approach that aligns with Healthy Moms and Health Baby campaigns and gift card incentives.

Partnership Advantage (DSNP): In anticipation of the go-live date of 1/1/2026 the department had made considerable progress in developing policies, procedures and

	workflows related to DSNP. Time and attention was dedicated to the mapping reporting requirements with JIVA, Project presented to PRB for the Annual Wellness Vendor selection process, and inter-department collaboration and alignment for monitoring of stars, outcomes and compliance. With the announcement of the DSNP launch delay, the department is revisiting their project plan to align with the new go-live date and will continue to pursue AWV selection.

Utilization Management	**Utilization Management (UM) Productivity and Key Performance Indicators (KPIs)**
	
	Treatment Authorization Request Volume (1/1/2025 – 5/31/2025):
	
	• 139,464 Total TARs
	  ○ Approved: 105,181
	  ○ Denied due to Medical Necessity and Appeal Upheld: 5,655 (3.9%)
	  ▪ Industry Benchmarks: July 2023 report from the Office of Inspector General (OIG) noted:
	  • California: Medicaid Managed Care denial rate, per plan averaged: 13%
	  • National average per Medicaid plan in 2023: 15-25%
	
	TAR Timeliness (1/1/2025 – 5/31/2025): 86.93% - GOAL PARTIALLY MET
	
	○ Outpatient Timeliness = 85.8%
	○ Inpatient Timeliness = 90.43%
	▪ NCQA timeliness thresholds are set at 90%. During the reporting period the inpatient reviews met this requirement, but the request for outpatient services fell behind the goal.
	▪ Department leadership is closely monitoring and is making operational and staffing changes to address and assure compliance.
	
	Inter-Rater Reliability (IRR) – Q1 2025 – GOALS MET (90%)
	
	• Inpatient – 375 reviews – 90.93%
	• Outpatient – 705 reviews – 98.30%
	• Long Term Care – 150 reviews – 98.00%
	
	Faxing Volumes: The UM department continues to work closely with Provider Relations, key provider partners and IT to remedy and address the growing number of faxes coming to the department each month. During Q1 of 2025, the department saw a monthly average of

	over 15,000 faxes per month: with each fax representing more than one document and more than one member. High volumes of faxes have the potential to delay the review process for partnership and more importantly delay care to members. Opportunities for efficiency gains were made by working with IT to optimize the Provider Online Services portal which now allows providers to resubmit attachments to their TAR requests. Other strategies such as identifying providers with high fax volumes and partnering with Provider Relations to provide targeted education on the use and efficiency of Partnership's Provider Portal have proven to be the most effective method in addressing the volume challenges. **Operational System Transformation (JIVA)** – over the previous reporting period the department as remained committed and proactive in finalizing new workflows in the UM module of Partnership's new authorization platform, JIVA. The department also completed a universal inventory of all reporting needs for both Medicare (DSNP) and Medi-Cal lines of business to ensure that any customized reporting needs for JIVA were captured.

Enhanced Health Services	The Enhanced Health Services Dept. continues to focus on working with many providers and external partners to provide services and coordination of care to members under CalAIM. As of June 10, 2025, Partnership has over 20,000 members enrolled in Enhanced Care Management (ECM) and 13,683 members receiving one or more Community Support (CS). The provider support and training continue to grow in breadth, scale and depth. Additionally, the department has excelled in meeting meet regulatory, operational and production timelines as it relates to authorizations.
	
	Treatment Authorization Request Volume (1/1/2025 – 5/31/2025):
	
	• 34,432 Total TARs:
	  ○ Community Supports: 21,686 TARs
	  ▪ 88.4% approved
	  ○ Enhanced Care Management: 12,746 TARs
	  ▪ 89.6% approved
	• Top 3 reasons for authorization denials: Duplicate request to one that was already approved in the system, voided, or medical necessity (there was no evidence the member met criteria or no documentation that accompanied the request).
	
	Provider Network Support and Expansion: The department continues to actively support the on-boarding, training, and support of existing and new ECM and CS providers to Partnership's growing CalAIM network. During 1/1/2025 – 5/31/2025 the department has

	on-boarded 40 ECM providers (20% growth) and 35 Community Supports providers (25% growth). The department continues to facility provider roundtables that allow our contracted providers and their teams to meet directly with Enhanced Health Services staff and leaders to have tailored support, and their questions answered. As of June 2025, Partnership has 184 total ECM providers, and 139 Community Supports providers. **ECM and CS Monitoring and Oversight:** the Enhanced Health Services department continues to prioritize activities that strengthen the care and quality of services for members as well as support the expansive CalAIM provider community. In response, clinical members of the team continue to perform quarterly audits of ECM and CS providers. In Q1, 15 providers and 250 member records were audited and reviewed. Providers that did not pass were placed on Performance Improvement Plans (PIP) with Partnership and received additional training and monitoring from the Enhanced Health Services teams. The Q2 audits have been scheduled, and the Enhanced Health Services staff will be conducting provider site visits to some of the locations as part of the auditing and monitoring activities. **New CalAIM Policies & Implementation: –** In response to new state and federal health policy directives, the department quickly undertook several key actions to prioritize and implement necessary operational changes, including: • Beginning 7/1/2025 Closed Loop Referrals are a requirement for all health plans for ECM and CS. The department has identified and created a meaningful workflow to meet this new notification requirement for members and referring entities. • Global Capitation Limits effective 1/1/2025: a dedicated task force of internal stakeholders interpreted this new, retroactive guidance, to assess operational implications and impacts to providers and members. Activities are under weigh to realign our policies to reflect this new state and federal guidance. An assessment has been carried out to understand member impact and member notices have been sent to DHCS and are with them for review. • Community Supports Criteria changes: DHCS has updated and refined criteria and services for some of the optional Community Supports under CalAIM in their revised, re-released Community Supports Policy Guides in April 2025. While some of these changes are small, others necessitate changes in Partnership's policies, TAR review processes, provider education materials, systems and staffing. • HCBS Waiver Referrals: In May, DHCS informed the Partnership of 257 members who were currently on the Home and Community Based Waiver (HCBS) wait-list. The HCBS Waiver is a program operated directly by DHCS outside of Managed

	Care Plans under a separate five (5) year waiver to CMS and it includes the approval of 15 counties statewide to participate. Currently, Partnership only has one (1) county approved for the waiver: Sonoma County. The 257 Partnership members identified by DHCS, likely qualify for ECM and/or may benefit from one or more Community Support. The Enhanced Health Services team have identified, tracked, and referred all members to an available ECM and/or CS provider in their community for further care and support.
Behavioral Health	Over the past reporting period, the Behavioral Health Department has advanced several key initiatives to strengthen services, deepen community engagement, and align with evolving health policies for Medi-Cal's delivery system. Through strategic collaboration and a commitment to integrated care, the Behavioral Health Department and leadership have made significant strides toward building a more accessible, coordinated, and responsive behavioral health system. The efforts and accomplishments further strengthen and support Partnership's strategic goals and quality care for our members. Key accomplishments include: **CYBHI – Child and Youth Behavioral Health Initiative:** the Children and Youth Behavioral Health Initiative was first launched by DHCS in 2022 and contains a portfolio of activities and services. The behavioral health teams have been at the forefront of implementing, partnering, supporting and meeting with stakeholders to advance this initiative with services such as: Dyadic Benefit, Soluna/Bright Life for Kids app, All-Payor-Fee-Schedule for school-based behavioral health services, etc. They have also been meeting with schools and partners over the SBHIP funds to help collaborate, understand and help to align the grant-based investment dollars awarded in our local communities. **BH-Connect and Transitional Rent –** In close coordination with the county behavioral health departments, association groups, providers and internal Partnership teams (e.g. Enhanced Health Services, Health Service, Executive Team, etc.) the department has meeting and planning for the new Transitional Rent benefit. This benefit is scheduled to start 1/1/2026 and is connected to the recently approved CMS 1115 waiver. A webinar was held on June 11, 2025, for all county Behavioral Health Directors and Partnership to discuss joint planning efforts; especially as it relates to timing, Flex Pools, and workflows. As DHCS continues to evolve policy guidance, the department leadership continues to provide feedback to DHCS and stakeholders to meet this joint, state-wide effort.

Health Equity	**NCQA Health Equity Accreditation:** Partnership HealthPlan of California remains committed and on-track to submit our first-ever, initial submission to NCQA for Health Equity Accreditation June 17, 2025. The Health Equity and Quality teams have been busy collecting, compiling, organizing and preparing the necessary policies, reports, documents and files for the organization. Partnership should be in receipt of initial feedback from NCQA about three weeks after the initial submission with formal notification coming to the health plan in mid-September. The department and teams remain committed to supporting Partnership in achieving this milestone and stand ready to engage with NCQA and the quality dept. for any back-and-forth questions and concerns while the health plan undergoes the audit and review process. **Diversity, Equity and Inclusion Provider Training:** Pursuant to APL 23-025, and with organizational leadership from Partnership's Chief Health Equity Officer, Partnership has launched and completed a handful of required activities in the first half of this calendar year. In collaboration with Human Resources, Provider Relations and other key departments, the Health Equity team has successfully worked to complete Phase 1 of the implementation which included key milestones such as: Securing a vendor, Rival, to support software, content and reporting needs, assess and develop training materials, and pilot initial training with provider site. CommuniCare+Ole has supported this work by volunteering for this pilot with over 64 clinicians participating in pilot training and providing survey feedback to Health Equity team. For the remainder of the calendar year, the team will be focused on the other requirements such as ensuring all new Partnership staff and launching the phased approach to ensure that all providers in Partnership's network are trained. **Community Reinvestments:** During this reporting period, with Executive Sponsorship from the Chief Health Services Officer, the department has launched Partnership's operationalization of DHCS' APL 25-004 Community Reinvestments. This multi-year, multi-stakeholder initiative focuses on Partnership's requirements in the MCP Medi-Cal Contract with DHCS as well as alignment with other CalHHS departments and local agencies with Partnership's Chief Heath Equity Officer facilitating a key role. The department is at the beginning stages to work and develop Partnership's workflows, methodologies, reports, policies, training, communication support Partnership Community Reinvestment program and compliance with the Medi-Cal contract. Partnership must submit its Community Reinvestment Plan to DHCS in early Q3 2026.

Federal and State Policy Update

As of June 20, 2025

Federal Update

- On May 22, the House passed H.R. 1, also known as the "One Big Beautiful Bill Act."
- H.R. 1 contains significant health care provisions, primarily focused on Medicaid and the Affordable Care Act (ACA) marketplaces. Key changes:
    - Seeks to reduce and limit Medicaid enrollment particularly under the ACA optional expansion through increased cost sharing for expansion members, mandatory work requirements, and increased scrutiny and tightening of eligibility.
    - Cuts in federal funding for states that choose to cover undocumented individuals
    - Cuts and limits the use of certain Medicaid financing arrangements used by states to fund their Medicaid programs with harsher requirements for states that exercised the optional expansion.
    - Prohibits the use of federal funds to reimburse certain providers and types of services.
- If this bill is passed, CBO estimates this bill would increase the number of people without health insurance by 10.9 million.[i] In CA, this number is estimated to be 1.7 million. Furthermore, the financial provisions of this bill could result in the loss of billions of dollars in federal funding for California.
- On June 16, the Senate Finance Committee released its reconciliation legislative text which mostly preserve the House proposed changes and in some cases exacerbate the coverage and financial losses CA could experience.
- Kaiser Family Foundation has a great resource tracking the different changes to health care policy proposals from the House and Senate, which can be found **here.**
- Although the bill has already passed the House, changes to the bill in the Senate will require a reconciliation vote in the House. There will still be a lot of debate in Congress before a final bill reaches the president's desk.

State Update:

- Governor released his May Revise last month, projecting a $12 billion deficit.
- The Budget Summary specifically calls out Medi-Cal as the key source of expenditure growth.
- May Revision Budget total projected enrollment: Estimated average monthly Medi-Cal caseload projections for 2025-2026 is 14.8 million.
- May Revise eligibility changes include:
    - Enrollment Freeze for Full-Scope (State-Only) adults 19+ with Unsatisfactory Immigration Status (UIS) (starting January 1, 2026)
    - Medi-Cal Premiums (State-Only) for UIS Adults 19+ (starting January 1, 2027)

  - Elimination of (State-Only) PPS Rates to FQHCs and Rural Health Clinics for UIS Individuals
  - Elimination of LTC and Dental services for UIS 19+
- May Revise CalAIM changes include:
  - Transitional Rent is included in the May Revision and does not reflect increased cost estimates from the governor's January Budget.
  - There is $200 million of Proposition 35 funds to support Flexible Housing Pool rental assistance and housing supports over two years.
- In order to help address the deficit, the governor proposed to sweep approximately $1.2 billion in Managed Care Organization tax revenue that was to be used primarily for Medi-Cal provider rate increases that were authorized under Proposition 35 approved by the voters in November 2024.
- The May Revise also proposed to eliminate Proposition 56 supplemental payments for dental, family planning, and women's health and also sunset the Skilled Nursing Workforce Quality and Incentive Program (WQIP).

- On June 13, the Legislature passed its budget. Key different from the governor's May Revise include:
  - Restores the Medi-Cal Asset Limit at $130,000, rather than the governor's $2,000 proposal.
  - Modifies the governor's Medi-Cal enrollment freeze proposal, applying it to those with unsatisfactory immigration status (UIS) 19 years of age and older beginning January 1, 2026, specifying that there is no "age out", and establishing a 6 month re-enrollment grace period for those that fall off the rolls and delays the elimination of dental services for this population
  - Modifies the governor's proposal to establish Medi-Cal premiums for UIS by lowering the governor's proposal from $100 per month to $30 per month, limiting the age range from 19-59, and starting January 1, 2027.
  - Approves the governor's proposal to increase General Fund offsets from the MCO Tax implemented by Proposition 35 resulting in $1.2 billion of savings in 2025-26 and $236.7 million in 2026-27.
  - Delays the governor's proposal to cut $1.1 billion ongoing from Health Centers and Rural Health Clinics until July 1, 2027 as a result of not paying PPS for state-only funded services provided to UIS members.
  - Rejects the governor's proposal to eliminate $172 million Proposition 56 supplemental payments for family planning and women's health services.

  - Rejects the governor's proposal to eliminate long-term care and in-home supportive services for adults with unsatisfactory immigration status.

- The governor and Legislature must now negotiate a compromise in the coming weeks, with July 1 approaching.

[i] https://www.cbo.gov/system/files/2025-06/Wyden-Pallone-Neal_Letter_6-4-25.pdf