PARTNERSHIP HEALTHPLAN OF CALIFORNIA
QUALITY/UTILIZATION ADVISORY COMMITTEE MEETING NOTICE

FROM: Leslie Erickson, Program Coordinator II, Quality Improvement
DATE: Oct. 10, 2024
SUBJECT: Quality/Utilization Advisory Committee (Q/UAC) Meeting

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

Meeting Time/Date: 7:30 – 8:55 a.m., Wednesday, Oct. 16, 2024
Meeting Locations:

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

Other Locations:
Open Door Community Health Center, 3770 Janes Road, Arcata
Kaiser Permanente, 5820 Owens Drive, Pleasanton, CA 94588
Chapa-de Indian Health: 11670 Atwood Road, Auburn, 95603

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

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

PHC Staff (Ex-Officio) Members:
Barresi, Katherine, RN, BSN, PHN, NE-BC, Chief Health Equity Officer
Bides, Robert, RN, BSN, Mgr, Member Safety-Quality Investigations, QI
Bontrager, Mark, Sr. Director of Behavioral Health, Health Services
Cotter, James, MD, Associate Medical Director
Cox, Bradley, DO, Regional Medical Director, Northeast
Devido, Jeffrey, MD, Behavioral Health Clinical Director
Esget, Heather, BSN, ACM-RN, Director of Utilization Management
Frankovich, Terry, MD, Associate Medical Director
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director of Care Management
Glickstein, Mark, MD, Associate Medical Director
Guevarra, Angela, RN, Associate Director, Care Coordination (SR)
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Katz, Dave, MD, Associate Medical Director
Kubota, Marshall, MD, Regional Medical Director, Southwest
Leung, Stan, PharmD., Director of Pharmacy Services
Matthews, R. Douglas, MD, Regional Medical Director, Chico
Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Newman, Rachel, RN, BSN, Manager, Clinical Compliance - Inspections
O'Connell, Lisa, MHA, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, MPH, FAAP, Regional Medical Director, Northwest
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Spiller, Bettina, MD, Associate Medical Director
Steffen, Nancy, Senior Dir. of Quality and Performance Improvement
Thornton, Aaron, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director, Southeast
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

cc:
Andrews, Leigha, Regional Director, Southwest
Beltran-Nampraseut, Athena, Program Manager II, PCP/QIP
Bjork, Sonja, JD, Chief Executive Officer
Blake, Jill, Regional Director, Auburn
Booth, Garnet, Manager of PR Representatives (NR)
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MHA/MBA,Director of Quality Management, QI
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Davis, Wendi, Chief Operations Officer
Devan, James, Manager of Performance Improvement, QI (NR)
Escobar, Nicole, Senior Manager of Behavioral Health
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Gual, Kristine, Manager of Performance Improvement, QI (SR)
Harrell, Bria, Configuration Specialist, Configuration
Harris, Vander, Senior Health Data Analyst, Finance
Innes, Latrice, Manager of Grievance & Appeals Compliance
Lopez, Eva, CPhT, Program Manager I, Palliative QIP
Jarrett-Lee, Kevin, RN, Associate Director, UM
Kerlin, Mary, Senior Director of Provider Relations
Klakken, Vicki, Regional Director, Northwest
McCune, Amy, MPH, MS, Manager of Quality Incentive Programs, QI
Nakatani, Stephanie, Manager of Provider Relations Representatives
Ocampo, Andrea, Pharm.D, Clinical Pharmacist, Pharmacy
O'Leary, Hannah, Manager of Population Health, Population Health
Power, Kathryn, Regional Director, Southeast
Quichocho, Sue, Manager of Quality Improvement, QI
Sharp, Tim, Regional Director, Northeast
Stark, Rebecca, Regional Director, Chico

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

Date: Oct. 16, 2024 **Time: 7:30 – 8:55 a.m.**

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle Room

Other Locations:

Chapa-de Indian Health: 11670 Atwood Road, Auburn, 95603

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

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

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

Welcome / Introductions / Public welcome at cited locations

	Item	Lead	Time	Page #
I.	**Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes**			
1	Welcome Phuong Luu, MD, QUAC's newest member	Robert Moore, MD	7:30	--
2	*Approval of* • Sept. 18 Quality/Utilization Advisory Committee (Q/UAC) Minutes			5 -14
3	*Acknowledgment and acceptance* of • Sept. 10 Internal Quality Improvement (IQI) Committee Meeting Minutes • July 25 Substance Use Internal Quality Improvement (SUIQI) *draft* Meeting Minutes			15 - 26
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Nancy Steffen	7:37	27 - 40
2	HealthPlan Update *Q/UAC voters are asked to help with NCQA Health Equity Accreditation efforts by completing this survey:* https://www.surveymonkey.com/r/QUACDEI	Robert Moore, MD	7:42	--
III.	**Old Business –** None			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:50	41
	Proposed 2025 PCP QIP Measures Summary – *refer questions to Athena Beltran-Nampraseut*			43 - 48
	Proposed 2025 Palliative QIP Measures Summary – *refer questions to Eva Lopez, CPhT*			49
	Quality Improvement Policy			
	MPQP1008 – Conflict of Interest Policy for QI Activities			51 - 53
	Utilization Management Policies			
	MCUG3032 – Orthotic and Prosthetic Appliances Guidelines			55 - 57
	MCUP3020 – Hospice Services Guidelines			58 – 62
	MPUP3116 – Positron Emission Tomography (PET Scans)			63 - 65

	Item	Lead	Time	Page #
	Grievance & Appeals Policy			
	CGA022 – Member Discrimination Grievance Procedure			67 - 72
V.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	73 - 78
	Care Coordination			
	MCCP2032 – CalAIM Enhanced Care Management (ECM)	Lisa O'Connell, MHA	7:55	79 - 109
	Population Health			
	MCND9002 – Cultural & Linguistic Program Description – *CLEAN policy copy begins on p. 165; C&L/QIHETP Work Plan follows at packet's end*	Hannah O'Leary, MHA	8:00	111 - 187
	Health Equity			
	MCED6001 – Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description – *CLEAN copy begins on p. 211; C&L/QIHETP Work Plan follows at packet's end*	Mohamed Jalloh, Pharm.D	8:05	189 - 228
	Utilization Management			
	MCUG3038 – Review Guidelines for Member Placement in Long Term Care (LTC) Facilities	Tony Hightower, CPhT	8:10	229 - 238
	MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities		8:15	239 - 243
	MCUP3049 – Pain Management Specialty Services		8:20	245 - 266
VI.	**Presentations**			
1	Grand Analysis: Health Equity – *Health Equity Standards – HE 6: Reducing Healthcare Disparities begins on p. 297*	Moe Jalloh, Pharm.D Dorian Roberts	8:25	267 - 381
2	2025 C&L/QIHETP Work Plan – *Excel file*	Moe Jalloh, Pharm.D		383 - 385
	Adjournment scheduled for 8:55 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Nov. 20, 2024			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, Sept. 18, 2024 / 7:30 a.m. – 9:05 a.m. Napa/Solano Room, 1st Floor

Q/UAC has now returned to in-person meetings governed by Brown Act requirements following the Feb. 28, 2023 lifting of California's Public Health Emergency.

Voting Members Present		
Sara Choudhry, MD	Meagan Mulligan, FNP-BC	Randolph Thomas, MD
Emma Hackett, MD, FACOG	John Murphy, MD	Jennifer Wilson, MD
Brian Montenegro, MD	Robert Quon, MD, FACP	
	Michael Strain, PHC Consumer Member	
Voting Members Absent: Brandy Lane, PHC Consumer Member; Steven Gwiazdowski, MD, FAAP; Chris Swales, MD		
Partnership *Ex-Officio* Members Present:		
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI	Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair	
Cox, Bradley, DO, Regional Medical Director (Northeast)	Netherda, Mark, MD, Medical Director for Quality – Vice Chair	
Devido, Jeff, MD, Behavioral Health Clinical Director	Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections	
Frankovich, Terry, MD, Associate Medical Director	O'Connell, Lisa, Director, Enhanced Health Services	
Glickstein, Mark, MD, Associate Medical Director	Ribordy, Jeff, MD, Regional Medical Director (Northwest)	
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)	Spiller, Bettina, MD, Associate Medical Director	
Katz, Dave, MD, Associate Medical Director	Thornton, Aaron, MD, Associate Medical Director	
Kubota, Marshall, MD, Regional Medical Director (Southwest)	Townsend, Colleen, MD, Regional Medical Director (Southeast)	
Leung, Stan, Pharm.D, Director of Pharmacy Services	Watkins, Kory, MBA-HM, Director, Grievance and Appeals	
Partnership *Ex-Officio* Members Absent:		
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Guevarra, Angela, RN, Associate Director, Care Coordination (SR)	
Bontrager, Mark, Sr. Director of Behavioral Health, Administration	Hartigan, Nicole, RN, Associate Director, Care Coordination (NR)	
Cotter, James, MD, Associate Medical Director	Hightower, Tony, CPhT, Associate Director, UM Regulations	
Esget, Heather, RN, BSN, ACM, Director of Utilization Management	Jones, Kermit, MD, JD, Medical Director for Medicare Services	
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	Kerlin, Mary, Senior Director of Provider Relations	
Guillory, Ledra, Senior Manager of Provider Relations Representatives	Randhawa, Manleen, Senior Health Educator, Population Health	
	Ruffin, DeLorean, DrPH, Director of Population Health	
	Steffen, Nancy, Senior Director of Quality and Performance Improvement	
Guests:		
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance	Morris, Matthew, MD, CMO, Western Sierra Medical	
Brown, Isaac, Director of Quality Management, QI	Nakatani-Phipps, Stephanie, Manager of Provider Relations Representatives	
Campbell, Anna, Health Policy Analyst, Utilization Management	Quichocho, Sue, Manager of Quality Measurement, QI	
Chishty, Shahrukh, Sr. Mgr of Foster Care Programs, Behavioral Health	Sackett, Anthony, Program Manager II, QI (CAHPS)	
Erickson, Leslie, Program Coordinator I, QI (scribe)	Vo, Kathleen, Pharm.D, Clinical Pharmacist, Pharmacy	
Harris, Vander, Sr. Health Data Analyst, Finance	Watson, Deanna, Program Manager I, QI (ECM QIP)	
Matthews, Richard "Doug," MD, Regional Medical Director (Chico)		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *None made* Approval of Minutes Introductions	Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:33 a.m. The Aug. 21, 2024 Q/UAC Minutes were approved as presented without comment. *Acknowledgment and acceptance of draft meeting minutes of the* • Aug. 13 Internal Quality Improvement (IQI) Committee • Aug. 20 Quality Improvement Health Equity Committee (QIHEC) • Aug. 1 Population Needs Assessment Committee (PNA) • Aug. 6 Over/Under Utilization Workgroup Regional Medical Director Doug Matthews, MD introduced Matthew T. Morris, MD, observing Q/UAC today from Dr. Matthews' Chico office. Dr. Morris is a board-certified family medicine practitioner who serves on Partnership's Board of Commissioners. He is also the Chief Medical Officer at Western Sierra in Grass Valley. Vander Harris introduced himself, saying he would be speaking later on the 2024 3rd Next Available and Next Available Survey in his first address ever to Q/UAC.	Unanimous Approval of Q/UAC Minutes as presented: Brian Montenegro, MD Second: Randy Thomas, MD Unanimous Acceptance of other Minutes: John Murphy, MD Second: Randy Thomas, MD
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Isaac Brown, Director of Quality Management*	• We recently finalized the specifications for our Electronic Clinical Data Systems (ECDS) unit of service measure for 2024 and held a webinar, sharing that the specs are being updated. Part of this is contracting as many provider organizations as possible with a data aggregator called DataLink by the end of September. • In our Department of Health Care Services (DHCS)-mandated Performance Improvement Project (PIP) on well-child visits in the first 15 months of life, we have found that many of our African-American babies in Solano County are not being connected early on with their mothers in our system: enrollment is not being done in a timely manner. We are piloting having "navigators" at Northbay help connect (i.e., link) the care of mothers and babies within the electronic data systems so that all the great work that our primary care providers and pediatricians do is being captured. • A second PIP is improving percentage of provider notifications for members with serious mental health diagnoses within seven days of an emergency room visit. Cycle 1, wherein we are piloting sending daily ADT notifications to providers, starts this month to try to increase our rates there. • Our National Committee on Quality Assurance (NCQA) Health Equity Accreditation (HEA) team has been working with Director of Health Equity Moe Jalloh, Pharm.D, on a Grand Analysis that should identify significant disparities in our Health Effectiveness Data and Information Set (HEDIS®) measures. The data is coming from different areas and is being filtered through our Quality Measure Score Improvement (QMSI) workgroups, cross-functional teams charged with identifying and implementing interventions. • Our NCQA consultant awarded us 85% of available points on our recent NCQA HEA Mock Survey. (A minimum of 80% is required to become accredited.) We are working on corrective	For information only: no formal action required.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	action plans to gain points in areas where we can before the actual survey in June 2025. (Dr. Moore said he believes we will capture 90% or better on the actual Survey.)	
2. HealthPlan Update *Robert Moore, MD Chief Medical Officer*	• This committee will recall that we have had a few policies going through this committee that will be easing the Treatment Authorization Referral requirements in quite a number of ways. The first one is the removal of TARs for many CT scans and MRIs. That is actually configured already but we have to roll it out and educate the network about it. We do not have an easy way to let all hospitals' radiology personnel know no TAR is required for adults having CTs or MRIs on anything but the abdomen, chest and pelvis. (A CT angiogram does not require a TAR; a MRI angiogram does.) A TAR is not required for any spine or extremity CT or MRI on an adult. Our Provider Relations team will be doing some education. o Anthony Sackett asked through the chat function whether this will improve the member experience. Dr, Moore replied that it should improve both member and provider experiences. o Q/UAC voter Randy Thomas, MD, asked if there any changes for pediatric CTs and MRIs? Dr. Moore replied that CTs and MRIs on pediatric patients still require a TAR because they are not common and many of them involve a radiation concern. Medical Director for Quality Mark Netherda, MD, added there is also concern about the risks of anesthesia involved. • We are resurrecting the long-retired "Partnership Advantage" name to describe our mandated Medicare Dual Special Needs Plan (D-SNP) slated to go live Jan. 1, 2026. We have received the State's permission to do a "regional implementation," that is, basically our coastal counties and those who may be considered San Francisco Bay: Del Norte, Humboldt, Mendocino, Lake, Sonoma, Marin, Napa and Solano counties. The other 16 Partnership counties will not have this option for perhaps two years or so, according to current plans. Partnership is beginning to offer contracts to the big "chains" that have a whole provider network – Sutter, Adventist, Providence-St. Joseph's, and Northbay-Marin – and also a smaller group of practices associated with smaller independent hospitals – Mad River, southern Humboldt, and Sonoma Valley among them. We anticipate the initial enrollment to be 3,000 – 5,000. o Those Medicare-eligible members choosing to become Partnership Advantage members will carry less federal money with them, so providers are encouraged to improve and refine their coding practices in 2025. Doing this should ensure more revenue in 2026. Partnership will be conducting trainings on this. • This committee will recall that the State is employing a number of ways to incentivize managed care plans to work on quality. The biggest is the financial withhold. Next year, 1% of all health plan revenue will be withheld and Partnership will have to "earn" it back. The State specifically wants to close equity gaps on the well-child measures, and has told Partnership on what groups to focus. The State put all race groups together and then chose the two lowest across four of our regions; so, two of the eight are white groups. This may be at odds with Partnership's prior foci; however, all well-child visits are important. The State is putting many millions at stake for that one measure. Partnership will share with this committee in the very near future what our priorities are for the rest of this year and all of next. • We will convey at a future Q/UAC meeting the findings and details of both the regulated Consumer	*Meeting postscript:* Dr. Moore's September Medical Directors Newsletter was emailed Sept. 20 to Q/UAC providers. It includes a short news article on the easing of TAR requirements for adults needing CT scans and MRIs. Q/UAC members are encouraged to share this information with hospital radiology personnel with whom they have a relationship.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Assessment of Health Providers and Systems (CAHPS) survey and the drill-down survey we put in the field. Partnership has work to do, as do our providers, who earned below national average scores on communication. ("Access to appointments" also did not score well.) o Dr. Netherda stated the specific survey question "my doctor listens carefully to me" is subjective. John Murphy, MD, commented that if patients are broadly satisfied with services and appointment access, they might be more likely to say everything is going well. He wondered whether the term "physician" could not be modified to "provider" in the next survey. Dr. Netherda noted that CAHPS terminology is set across the country. It only allows for two genders too.	
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Consent Calendar	PULSE Report, Issue 14 – *direct any questions to Latrice Innes* Proposed 2025 ECM Measure Summary – *direct any questions to Deanna Watson* 1st/2nd Qtr Pharmacy/UM IRR/Timeliness Report – *direct any questions to Andrea Ocampo, Pharm.D and Anna Campbell* ***Health Services Policies*** <u>Utilization Management</u> MCUG3022 – Incontinence Guidelines MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities MCUP3003 – Rehabilitation Guidelines for Acute Skilled Nursing Inpatient Services MCUP3015 – Family Planning By-Pass Services MCUP3050 – Medication Abortion in the First Trimester MCUP3115 – Community Based Adult Services MCUP3128 – Cardiac Rehabilitation MPUP3035 – Preoperative Day Review <u>Care Coordination</u> [1] MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services MCCP2023 – New Member Needs Assessment	Nothing was pulled from the Consent Calendar. Motion to approve as presented: Brian Montenegro, MD Second: Randy Thomas, MD *Approved unanimously* <u>Next Steps</u>: Oct. 9 Physician Advisory Committee (PAC)
V. New Business – Discussion Policies		
Policy Owner: Care Coordination – *Presenter: Lisa O'Connell, Director, Enhanced Health Services*		

[1] Edits are mainly to the attachments in both CC policies

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MCCP2033 – Community Health Worker (CHW) Health Services Benefit	**Policy edits due to All Plan Letter (APL) 24-006** **Definitions added:** Closed loop referral Managed Care Plan (MCP) **VI.B.3 revised** to state Supervising Providers will maintain evidence of CHWs completing a minimum of six hours of additional relevant training annually, which can be in core competencies or a specialty area. **VI.C.2 added** The Supervising Provider does not need to have a licensed provider on staff in order to contract with Partnership to provide CHW services **VI.G.1 replaced** require a referral with require a written recommendation per APL **V1.G.1.b added** to indicate for CHW services rendered in the ED **VI.G.1.c added** the required recommendation can be provided by a written recommendation placed in the Member's record **V1.H.1 added** data on health risks and clinical core gaps as data sources to identify member needs for CHW services **VI.J.1 added** Partnership does not require prior authorization for CHW services as preventive care for the first 12 units **with a limit of four (4) units a day**. **VI.J.2.a added** Documentation to be provided **with the TAR** includes **the original written recommendation**, **(with the exception of services provided in the ED)** **VI.L.2 added** If the parent or legal guardian of the Member is not enrolled in Medi-Cal, the Member must be present during the session. **VI.M.1.l replaced** Coordinating and assisting with transportation to **Transporting members** **VI.O.2 added** Claims processes must adhere to contractual requirements related to claims processing and encounter data submission including use of approved codes pursuant to the Med-Cal Provider Manual for CHW Preventative Services **VI.O.6 revised** to state Providers must not double bill, as applicable, for CHW services that are duplicative to services that are reimbursed through other benefits such as ECM, which is inclusive of the services within the CHW benefit. **VI.O.8 section added** in Pursuant to Welfare and Institutions Code (WIC) 14087.325 (d) **References updated:** Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006 Community Health Worker Services Benefit (05/13/2024) *supersedes APL 22-016* DHCS APL 24-001 Street Medicine Provider: Definitions and Participation in Managed Care (01/12/2024) *supersedes APL 22-023* **References added:** Welfare and Institutions Code (WIC) 14087.325(d) Lisa reported that DHCS finalized APL 24-006 in May, allowing Partnership to finalize policy language in just the last few weeks. It is now easier for Emergency Department providers to refer patients to CHW services. Lisa reiterated that Partnership does not require prior authorization for CHW services as preventive	Motion to approve as presented: Randy Thomas, MD Second: Jennifer Wilson, MD *Approved unanimously* Next Steps: Oct. 9 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	care for the first 12 units with a limit of four (4) units a day. One unit is 30 minutes, Lisa replied to Dr Netherda's question. Members cannot receive CHW services if they are enrolled in Enhanced Care Management (ECM) because it is largely duplicative. Partnership contracts with the supervising provider, not any CHW as an individual. Dr. Montenegro pointed out a typo on p. 9 of the policy. It and another typo were corrected before the policy was forwarded for Oct. 9 PAC consideration.	
VI. Presentations		
2024 3rd Next Available & Next Available Survey *Vander Harris*	The 3rd Next Available & Next Available Survey is a point-in-time largely telephonic survey to monitor appointment availability, telephone access, and appointment wait time among primary care providers and high-volume specialists. In March 2024, Provider Relations staff employed extensive outreach to 925 sites, in comparison to 687 sites in the same survey in March 2023, the difference being those providers reached in our new East Region added effective Jan. 1, 2024. In total, 357 primary care sites, 428 specialty providers, and 140 prenatal providers were surveyed. The applicable DHCS standards are: <u>Primary Care Providers</u> <= 10 business days to 3NA Adult Appointments and to 3NA Pediatric Appointment <= 48 hours (two business days) to next available newborn appointment and time to next available urgent appointment <u>High-volume Specialists</u> <= 15 business days to 3NA specialty appointments <= 48 hours (two business days) to next available urgent appointment <u>Prenatal Care</u> <= 10 business days to 3NA prenatal care (PCPs and specialists) Dr. Moore prefaced Vander's remarks by providing context: Partnership contacts those providers who do not meet the standards, reminds them of these standards and then re-surveys them at a later date. Although this is a point-in-time survey, it has some predictive value as to their overall yearly access but because we put together so many practices, the actual trend region-wide or plan-wide becomes more valid. Vander went through the results by region within each category. Overall, there was a downward trend across adult, pediatric, and newborn PCP appointments when compared to 2023 survey results. However, the North experienced a 3.1% increase for next available for newborns and a 2.6% increase in distribution of clinics by days to next available urgent appointments. The East Region was monitored for the first time in 2024, and scored >90% across all categories, "a good place to start," Vander commented. The majority of southern counties have a low share of clinics meeting adult and pedi targets. Sutter and Yuba counties have low share meeting newborn and urgent targets. The East had the highest rates for 100% of clinics by county meeting targets. Generally, North and South counties had the same or lower share of clinics making targets compared to 2023. Napa County, however, improved by 29% to score 86% for pediatric appointments. In 2024, 58% of clinics missed at least one PCP next appointment target. The maximum wait times for next appointment are exceedingly long. The specialty clinics improved by 15.5% to 94.3% in the North 3NA compared to 2023 survey but the South fell 18% to just 70%. Similarly specialty urgent appointments improved by 6% to 98.9% in the North but fell 4% to 91.8% in the South. The North has lowest rates for	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	endocrinology, gastroenterology and ophthalmology. The South had lowest rates of clinics meeting targets for neurology, dermatology, and gastroenterology. Taken all together, 22% of surveyed clinics did not meet the 3NA specialist appointment target. Days to next prenatal appointment in the North rose 9.8% to 96.9% meeting target while the South fell 19.5% to just 73.7% of clinics hitting targets. (The East registered 91% target acquisition.) Long wait times at Marin and Solano county clinics heavily contributed to the South's decline. Southwest Regional Medical Director Colleen Townsend, MD, commented that progress has been made in Solano County: when staffing is well managed, the wait times to next available appointment are shorter. We must remember, however, that many prenatal practices work a five-, not a seven-, day week. She said that since this March survey there has been a narrowing of the gap: many practices are trying to add more clinical care or perinatal services within a three- to seven-day window. The situation is still fully dependent on labor and delivery staffing at the Center for Women's Health at Northbay. Southeast Regional Medical Director Marshall Kubota, MD, asked whether the wait in a small clinic counts the same as a wait in a large one. Dr. Moore said yes; these survey results are not weighted by the size of the practice, nor are they viewed by whether the member is a new or existing patient, he added in response to a question from Dr. Netherda. Manager of Provider Relations Stephanie Nakatani-Phipps confirmed that it is not broken down by new appointment or established care. Associate Medical Director Dave Katz, MD, suggested the in-person visits should be compared with telehealth visits, else some specialties may never see their overall performance improve. Dr. Moore agreed this would be an interesting comparison, adding he senses specialty telehealth services are used more widely in the North than they are in the South. Paradoxically, access is generally worse in the North but telehealth may be one reason why some northern areas have better access than does the South. Q/UAC voter Brian Montenegro, MD, noting that access to appointments is one of the big areas of member grievances, said of the South, "it's concerning that this is such a great decline." Dr. Moore said we can speculate about any number of reasons why: • We have a global shortage of primary care and specialty providers. • Medicare reimbursement rates have been stagnant for 25 years. • The number of Accreditation Council for Graduate Medical Education (ACGME) spots for most specialties apart from primary care specialties has not changed in 25 years. (The number of new endocrinologists, nephrologists, and rheumatologists coming out of school is the same today as it was in 1998, Dr. Moore said.) Specialists make their rates on Medicare, and when they don't go up, income drops, Dr. Moore noted. The last nephrologist willing to see Partnership members in hospital in Humboldt closed his practice in August because he had been taking money out of his own retirement to pay his office staff. After a short discussion among the physicians to Dr. Townsend's remark that the overall FTEs of providers has not recovered to pre-pandemic rates, Dr. Montenegro commented that we may have an issue with recruiting providers to live and work in relatively high-cost areas. Dr. Moore said it is a rural/urban issue: the larger urban groups (e.g., Kaiser, Sutter) have robust networks and hire away specialists. The Providence network has some specialties but not all: they do not have a multi-specialty group in Humboldt. Further, Dr. Montenegro said he sees new housing going up and assumes the population is growing. Dr. Netherda did a Google search and learned that Yolo and Sutter populations declined last year. Yes, there would seem to be more housing starts; however, we do not know how many might be low income units that could be occupied by our member demographic.	

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	Dr. Netherda shared a remote participant's question: is this survey a "secret shopper"? Stephanie replied no; the Provider Relations' callers identified themselves and said why they were calling before they started asking questions.	
Summation of MY 2023/HEDIS® v. PCP QIP Performance *Robert Moore, MD*	Dr. Moore presented a side-by-side comparison of where providers scored relative to national benchmarks for both methodologies: the MY 2023 HEDIS® and the weighted average for parent organization for 2023 QIP clinical measure points. Partnership's weighted average on the 15 clinical measures was 87; so counties above that are raising the numbers, and counties below that mark are pulling it down. Looking at a maximum of 150 points (10 for each of the 15 clinical measures), Napa County moved up to 115 points, edging out Marin with 114. Sonoma and Yolo dropped a bit. The other county that made it above the weighted line was Mendocino. Humboldt had a big improvement, almost making it to the average. Siskiyou also improved. Lassen scored the lowest among the counties. The larger providers pulling up the clinical QIP scores include La Clinica, Winters Health Care Foundation (Yolo County),Santa Rosa, Petaluma, Marin, OLE CommuniCare, Sonoma Valley, West County and Community Medical Centers as an organization. Rising but still under the average are Open Door, Mendocino Community Health Clinic and Shasta. Fairchild, Adventist, Mountain Valley, Solano County are down toward the bottom of the larger providers. Dr. Moore congratulated La Clinica on scoring 95% of the available 150 clinical points. Dr. Montenegro asked why Kaiser is always on top? Dr. Netherda noted Kaiser pay well. Dr. Kubota noted Kaiser does not have the shortage of providers that many other networks do. Dr. Moore concluded that a closed system has its advantages. Others who open up to new patients even if it stresses the healthcare delivery system may be doing the right thing by our communities but QIP and HEDIS® scores will be impacted. Dr. Netherda asked where the "somewhat closed system" of Northbay – missing from the matrix – placed. Northbay was near the top, Dr. Moore said.	
Undercounting of American Indian Race Category *Robert Moore, MD*	Dr. Moore prefaced his remarks by saying he would appreciate any feedback so that he might fine tune this presentation before delivering it at a Tribal Health Convening Oct. 7, at which will be present the single DHCS person who could most effect change. Dr. Moore began by defining and exemplifying "indigenous erasure" in sociological and governmental terms before implying that how we define "race" is key to address inequities and disparities in both resource allocations and healthcare outcomes. Presently, DHCS is undercounting the American Indian/Alaskan Native population likely receiving Medi-Cal benefits, perhaps by as much as 1200% when looked at through the lens of both state and federal census data. The 2020 Census data puts AI/AN population at 1.6% with an additional 2% identified as AI/AN in combination with some other race, for a total of 3.6%. Meanwhile, DHCS puts the AI/AN Medi-Cal population at just .3% (approximately 51,000) of the nearly one-third of all Californians on Medi-Cal. If the census data were to be extrapolated, the true figure could approximate 600,000 persons identifying in some part as AI/AN, Dr. Moore said. Why is the DHCS number so low? The Medi-Cal application form itself – designed without tribal consultation as mandated by both state and federal law – offers these race options: White, Black or African American, AI/AN, and a variety of Asian/Pacific Islanders. The ethnicity question follows: are you of Hispanic, Latino or Spanish origin? Those who answer yes can further define themselves by country of origin. The AI/AN can say yes or no to "is this person a member of a federally recognized American Indian or Alaska Native tribe?" This is important because one can be 100% Native American and not identify with a federally recognized tribe. The 834 (membership) file that DHCS sends to health plans utilizes an algorithm that chooses a single race. The algorithm is not transparent but some things may be inferred, Dr. Moore noted. Hispanics are overcounted in Medi-Cal because if the member has	

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indicated they are both Hispanic and Black, they are counted as Hispanic. If identifying as Hispanic and Native American, Hispanic takes precedence. Members who indicate they are multi-racial get put in the "other" category. The 2020 Census offers more ways to self identify; however, the recent option additions of "Mayan" and "Aztec" makes it clear that any indigenous person from the Americas, not just the United States, is to be categorized as AI/AN. Below are three examples of how the same person could be accounted for in three different ways.

Medi-Cal Application	Census	DHCS Membership File
Race: AI/AN Ethnicity: non-Hispanic Enrolled in federally recognized tribe: Yurok	Race: AI/AN and lists Yurok, Karuk, and Hupa tribes Ethnicity: non-Hispanic	Single Race: AI/AN Principle: non-Hispanic ethnicity with only one race chosen
Race: Other: Mexican Ethnicity: Hispanic: Mexican	Race: AI/AN: Aztec tribe Ethnicity: Hispanic: Mexican	Single Race: Hispanic Principle: Hispanic status trumps any race choice
Race: White and AI/AN selected Ethnicity: non-Hispanic Enrolled in federally recognized Tribe: Round Valley	Race: White: German and AI/AN: Concow, Pomo (runs out of characters so cannot include others) Ethnicity: non-Hispanic	Single Race: Other/Missing Principle: non-Hispanic ethnicity with more than one race

Although some categorized in the Census as AI/AN identify with recognized Canadian or Latin American Indian tribes, this cannot fully explain the approximate 12-fold undercounting in DHCS, Dr. Moore said. Undercounting has many adverse impacts:

- Erroneous framing of Native and non-Native populations
- Insufficient prioritization of policies coming out of Sacramento
- Inequitable resource allocation
- Incorrect conclusions are drawn from invalid data (All of the ethnicity data Partnership has done on our HEDIS® analysis is based on invalid data we received from DHCS.)

The federal Office of Management and Budget (OMB)'s 2024 standard for categorizing race/ethnicity must be implemented by 2029 at the latest, Dr. Moore noted. Big changes include:

- Removing Middle Eastern/North African out of "White," thereby creating a new race category
- Moving Latino/Hispanic to be a co-equal race/ethnicity category (which DHCS is doing anyway)

The changes will partly resolve Hispanic over counting, and more persons will appear in other categories, including "other." OMB has given the states three options for categorizing individuals who select more than one race:

1. "Alone or in combination" would add to more than 100% and add statistical complexities.
2. "Most frequent multiple responses" would enable answering questions such as "is Native American plus Hispanic different from the Native American plus White in terms of analyzing healthcare outcomes?
3. "Multiracial" or "mixed" may be what DHCS is leaning towards. It's the simplest methodology but the least useful for analysis.

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	Dr. Moore added that although DHCS has tentatively chosen #3, there is a movement within its Population Health division to go for #1. Partnership recommends that DHCS adopt #1 and share the detailed ethnicity data with us at least monthly in a file supplemental to the 834. Partnership would then need to figure how to ingest the data and develop a framework for analyzing disparities using more inclusive racial categories that add to more than 100%. In summary, undercounting any racial or ethnic group is a form of structural racism and presents a health equity issue. New federal standards offer opportunities to change how racial and ethnic data is captured. Tribal consultation should be done early in the decision-making process, especially if there is significant controversy and major policy implications. Associate Medical Director Dave Katz, MD, asked "if I am a farmworker in Fresno, and I come from Mexico but I have Aztec blood and there is no tribe around, how will I be affected?" Dr. Moore said the Census category of AI is not related to your legal rights as an American Indian. Dr. Katz reframed his question: "if you are not in a place where you can get benefits from the tribe you say you belong to, isn't it better that more money goes to Latinos, rather than to the tribe?" Dr. Moore said this is a judgment call. Q/UAC voter Dr. Montenegro suggested a shuffling of the slide deck: show it is undercounted, show the implications and then go into the why of it. Q/UAC voter John Murphy, MD, agreed.	
VIII. **Adjournment** – Q/UAC adjourned at 9:05 a.m. Q/UAC next meets at 7:30 a.m. Wednesday, Oct. 16, 2024.		

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

Signature of Approval: _____ Date: _____

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Sept. 10, 2024 / 1:30 – 2:38 PM

Members Present:

Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI
Boyle, Shannon, RN, Manager of Care Coordination Regulatory Performance
Brown, Isaac, MHA, MBA, Director of Quality Management, Quality Improvement
Brundage O'Connell, Lisa, MHA, Director of Enhanced Health Services
Brunkal, Monika, RPh, Assoc. Dir., Population Health
Campbell, Anna, Policy Analyst, Utilization Management
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Garcia-Hernandez, Margarita, PhD, Director of Health Analytics
Innes, Latrice, Manager of Grievance & Appeals Compliance
Klakken, Vicki, Regional Director – Northwest
Kubota, Marshall, MD, Regional Medical Director – Southwest
Leung, Stan, Pharm.D, Director of Pharmacy Services
Matthews, Richard "Doug," MD, Regional Medical Director – Chico
Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Randhawa, Manleen, Senior Health Educator, Population Health
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Sharp, Tim, Regional Director – Northeast
Steffen, Nancy, Senior Director of Quality and Performance Improvement
Villasenor, Edna, Senior Director, Member Services and G&A

Members Absent:

Ayala, Priscila, Associate Director of Provider Relations
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bjork, Sonja, JD, Chief Executive Officer
Davis, Wendi, Chief Operating Officer
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director, Care Management
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer
Kerlin, Mary, Senior Director, Provider Relations
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Turnipseed, Amy, Senior Director of External and Regulatory Affairs

Guests:

Arrazola, Kelcie, Education Specialist, provider Relations
Bikila, Dejene, Manager of Data Science, Finance
Clark, Kristen, Manager of Quality & Training, Member Services
Devan, James, Manager of Performance Improvement (NR), QI
Devido, Jeff, MD, Behavioral Health Clinical Director
Erickson, Leslie, Program Coordinator I, QI (scribe)
Gual, Kristine, Manager of Performance Improvement, (SR) QI
Harris, Vander, Senior Health Data Analyst I, Finance
Jarrett-Lee, Kevin, RN, Associate Director of UM
Lee, Donna, Manager of Claims, Claims
Moore, Jordan, Education Specialist, Provider Relations
McCune, Amy, Manager of Quality Incentive Programs, QI
Ocampo, Andrea, Pharm.D, Clinical Pharmacist, Pharmacy
Power, Kathryn, Regional Director, Southeast
Rathnayake, Russ, Senior Health Data Analyst I, Finance
Roberts, Dorian, Improvement Advisor, QI
Rodekohr, Dianna, Project Manager I, Configuration
Sivasankar, Shivani, Senior Data Scientist, Finance
Salehi, Tiphanie, Sr. Health Data Analyst, Finance
Thomas, Penny, Sr. Health Data Analyst, Finance
Vaisenberg, Liat, Associate Director of Health Analytics, Finance
Watson, Deanna, Program Manager, QI

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Introductions – None Approval of Minutes	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA called the meeting to order at 1:32 p.m. Approval of Aug. 13, 2024 IQI Minutes *Acknowledgement and Acceptance of draft meeting minutes of the* • Aug. 1 Population Needs Assessment (PNA) Committee • Aug. 6 Over/Under Utilization Workgroup	Motion to approve IQI Minutes: Isaac Brown Second: Mark Netherda, MD Motion to accept other minutes: Stan Leung, Pharm.D Second: Mark Netherda, MD
II. Old Business – None		
III. New Business (Committee Members as applicable) – Consent Calendar		
PULSE Report, Issue 14 – *direct questions on this and the internal NCQA ME:7 Member Experience Threshold Report on FYI to Latrice Innes* ***Health Services Policies*** <u>Utilization Management</u> MCUG3022 – Incontinence Guidelines MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities MCUP3003 – Rehabilitation Guidelines for Acute Skilled Nursing Inpatient Services MCUP3015 – Family Planning By-Pass Services MCUP3050 – Medication Abortion in the First Trimester MCUP3115 – Community Based Adult Services MCUP3128 – Cardiac Rehabilitation – ***pulled by Anna Campbell*** MPUP3035 – Preoperative Day Review <u>Care Coordination</u> [1] MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services MCCP2023 – New Member Needs Assessment <u>Pharmacy</u> MCRP4066 – AB1114 Benefit Implementation and Oversight MPRP4062 – Drug Wastage Payments ***Member Services*** MC305A – Distribution of Member Rights and Responsibilities – Wellness and Recovery Program ***Provider Relations / Credentialing Policies*** MPCR13D – Registered Pharmacists for AB1114 Credentialing MPPR209 – Provider Network/Subcontractor Contract Terminations and Facility De-certifications and Suspensions Anna Campbell **pulled MCUP3128 to audible two changes** Associate Medical Director Mark Glickstein, MD suggested after the packet was published: • Amend VI.B.5.d. as follows: Program Description for Intermediate-Risk Members:	The Consent Calendar but for MCUP3128 was **approved as presented:** Marshal Kubota, MD Second: Isaac Brown Motion to approve MCUP3128 **as amended:** Marshall Kubota, MD Second: Mark Netherda <u>Next Steps:</u> • UM and Care Coordination policies will go to Sept. 18 Quality/Utilization Advisory Committee (Q/UAC) and the Oct. 9 Physician Advisory Committee (PAC) • Pharmacy policies next go to Oct. 10 Pharmacy & Therapeutics (P&T) Committee and then Nov. 13 PAC • Member Services' MC305A goes to department approval • Provider Relations' MPPR209 goes to the CEO for approval

[1] Edits are mainly to the attachments in both CC policies

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	1) 24 one-hour sessions or less of exercise training ***with or*** without continuous ECG monitoring • Add as hyperlinked Reference B: Up-To-Date: Lynne T. Braun, PhD, RN, CNP; Nanette K. Wenger, MD; Robert S. Rosenson, MD, "Cardiac Rehabilitation Programs," updated May 15, 2024 The IQI Committee had no objections.	• MPCR13D passed the Credentials Committee on Sept. 11.
IV. New Business – Discussion Policies		
Care Coordination: *Presenter: Lisa Brundage O'Connell, MHA, Director, Enhanced Health Services*		
MCCP2003 – Community Health Worker (CHW) Services Benefit	**Policy edits due to APL 24-006** **Definitions added:** <u>Closed loop referral</u> <u>Managed Care Plan (MCP)</u> **VI.B.3 revised** to state Supervising Providers will maintain evidence of CHWs completing a minimum of six hours of additional relevant training annually, which can be in core competencies or a specialty area. **VI.C.2 added** The Supervising Provider does not need to have a licensed provider on staff in order to contract with Partnership to provide CHW services **VI.G.1 replaced** require a referral with require a written recommendation per APL **V1.G.1.b added** to indicate for CHW services rendered in the ED **VI.G.1.c added** the required recommendation can be provided by a written recommendation placed in the Member's record **V1.H.1 added** data on health risks and clinical core gaps as data sources to identify member needs for CHW services **VI.J.1 added** Partnership does not require prior authorization for CHW services as preventive care for the first 12 units **with a limit of four (4) units a day**. **VI.J.2.a added** Documentation to be provided **with the TAR** includes **the original written recommendation**, **(with the exception of services provided in the ED)** **VI.L.2 added** If the parent or legal guardian of the Member is not enrolled in Medi-Cal, the Member must be present during the session. **VI.M.1.l replaced** Coordinating and assisting with transportation to **Transporting members** **VI.O.2 added** Claims processes must adhere to contractual requirements related to claims processing and encounter data submission including use of approved codes pursuant to the Med-Cal Provider Manual for CHW Preventative Services **VI.O.6 revised** to state Providers must not double bill, as applicable, for CHW services that are duplicative to services that are reimbursed through other benefits such as ECM, which is inclusive of the services within the CHW benefit. **VI.O.8 section added** in Pursuant to Welfare and Institutions Code (WIC) 14087.325 (d) **References updated:** Department of Health Care Services (DHCS) All Plan Letter (APL) 24-006 Community Health Worker Services Benefit (05/13/2024) *supersedes APL 22-016* DHCS APL 24-001 Street Medicine Provider: Definitions and Participation in Managed Care (01/12/2024) *supersedes APL 22-023* As Lisa was remoting into the meeting, Shannon Boyle, RN noted that the Department of Health Care Services (DHCS) has approved the updated policy as presented here. Anna commented that DHCS is concerned with double billing, adding that Lisa has worked with Configuration to accomplish the changes set forth in Section VI.J. Dr. Moore observed that many of the DHCS-driven language edits are self-evident and as such might be applied to many Partnership policies.	There were no questions. Motion to **approve as presented**: Mark Netherda, MD Second: Colleen Townsend, MD <u>Next Steps</u>: Sept. 18 Q/UAC Oct. 9 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
V. Presentations		
1. Quality and Performance Improvement Update *Nancy Steffen, Senior Director of Quality and Performance Improvement*	• The 2024 Electronic Clinical Data Systems (ECDS) Unit of Service measure specification as announced via webinar Sept. 4 will help us with Health Effectiveness and Data Information Set (HEDIS®) efforts and gathering additional chart-based data to give us insight into depression screening and other such services. • Provider public comment is open through Sept. 13 on proposed PCP QIP measure set changes for 2025 that will reflect our HEDIS® priorities. The changes to be presented to PAC Oct. 9 include o Adding both Chlamydia Screening in Women (CHL) and Well-Child Visits for 15-30 months old (W30+2 as monitoring measures for Family Practice and core measures for Pediatrics; and o Adding monitoring measures Breast Cancer Screening (BCS) for those age 40-49 and Topical Fluoride in Children (TFL-CH). • How Quality's performance improvement (PI) efforts intersect with both Population Health's and Health Equity's efforts to mitigate disparities is being folded into various work groups as Partnership moves toward earning National Committee on Quality Assurance (NCQA) Health Equity Accreditation (HEA) mid 2025. Director of Health Equity Moe Jalloh, Pharm.D, will present his Grand Analysis: Health Equity to IQI and Q/UAC in October. • We did well in our HEA "mock survey" conducted with our NCQA consultant in mid-August, scoring an overall HEA compliance of 85.19% (23 out of 27 total applicable points). Business owners who were asked to address improvement recommendations must submit their Corrective Action Plans by Sept. 20. • New 2025 NCQA Health Plan Accreditation (HPA) Standards and Guidelines came out at the end of August. Business owners at Partnership and other managed care plans are now reviewing and commenting. Although Partnership will follow the 2026 HPA Standards for the Renewal Survey, it is critical to align our practices with the 2025 updates and changes. The NCQA Program Management team has presented business owners with a crosswalk summary of changes from 2024 to 2025: business owners have until Oct. 4 to ask for clarification where necessary and to attest they understand any changes that may affect the survey elements for which they are responsible. The 24-month "lookback period" began Sept. 1, 2024. • We are now looking at the regulated Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Adult Survey to better understand the drivers behind some low performances in Measurement Year 2023/Reporting Year 2024. The additional "drill down" survey results will drive our work to achieve our access of care goals. These surveys play into our Member Experience Grand Analysis (MEGA) that Anthony Sackett will present to IQI and Q/UAC in November.	*For information only.* There were no questions. Dr. Moore stated that the State has now drafted a methodology for closing some disparities on Well-Child measures and that there will be a number of "withholds" in the coming budget cycle. Our goal is to have our provider network see as many of our pediatric members as they can. Focusing too on our under-represented groups will have a ripple effect both on our Managed Care Accountability Set (MCAS) measures and our ability to "earn back" monies, Dr. Moore said. Nancy added that we should know our next steps in the next few days.
2. Proposed 4th Qtr 2024 / 2025 Enhanced Care Management (ECM) QIP Measures *Deanna Watson, Program Manager, ECM QIP*	The proposed 2025 ECM QIP Measurement Set is identical to the current 2024 set but for the addition of a fourth measure: "Timely Review of EDI Admissions Notification Alerts in PointClickCare." (The addition means that the incentive pool allotment percentages will change for the existing measures.) Existing ECM providers in 4th Qtr 2024 need only set up the notification alerts function in PointClickCare. No reporting is actually required as Partnership will monitor PointClickCare to confirm the alert function is working properly. New ECM providers are eligible to participate in the ECM QIP throughout the measurement year, and will be required to complete the alert set-up during their first quarter in the program. In MY 2025 (Jan. 1 – Dec. 31), providers will receive notification alerts in PointClickCare when an ECM member visits an emergency department and/or is admitted to hospital. Providers are required to review the notification alerts within 72 hours of receiving the alert. Again, no reporting will be required as Partnership will audit provider	IQI posed no questions. The Physician Advisory Committee on Sept. 11 approved the ECM QIP measures as proposed.

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	performance based on ED/Admissions report results to be obtained from PointClickCare. Full credit will be awarded if 80% or more notification alerts are reviewed within 72 hours; partial credit will be awarded to providers with 50% - 79.9% timely reviews. Total dollars available are $100 per member per month. The Timely Reporting gateway measure determines the number of dollars placed in an incentive pool. Providers can earn up to 100% of incentive pool by meeting the other four measures, which include depression and blood pressure screenings. Incentive pool allotment or targets are subject to change for providers with five or fewer members.	
3. 1st / 2nd Qtrs 2024 UM / Pharmacy Inter-Rater Reliability / Timeliness *Andrea Ocampo, Pharm.D, Clinical Pharmacist, Pharmacy* and *Heather Esget, RN, Director of Utilization Management*	Pharmacy reviewed 5,528 Treatment Authorization Requests (TARs) during the first half of 2024, compared to 3,886 during the same 2023 period. Jan. 1 – June 30, 2024, Pharmacy exceeded its 95% timeliness goals for TARs for physician administered drugs (PAD) in both non-urgent/preservice and post service categories. Timeliness was 100% for each in both first and second quarters. (The report includes only Adverse Benefit Decision (ABD) determinations resulting from medical necessity review.) Pharmacy did not meet the same 95% compliance goal for urgent preservice TARs. The NCQA standard here is notification within 72 hours of the request: in first quarter, timeliness was only 89.71% but rose to 93.91% by the end of the second quarter. Andrea attributed the failure to hit our 95% compliance goal both to training of new staff and the 10-county expansion. Both pharmacists and pharmacy technicians exceeded 90% inter-rater reliability (IRR) concurrence goals, averaging 98% and 96%, respectively, across the first six months of 2024. UM nurse coordinators exceeded 90% concurrent IRR goals across each category for non-Behavioral Health decisions: inpatient (95.86%), outpatient (95.90%) and long-term care (LTC at 96.40%). Physician UM IRR resulted in a 98.48% concurrence rate. (No pharmacy TARs were included here.) UM TAR timeliness, however, failed to meet the 90% goal standard in any category of service, in part because the "expansion assumptions were inadequate," Heather said. "Even waiving approvals January through April didn't help." One of the biggest issues was finding double and triple requests coming in across both the LMS platform and by fax too. UM has since implemented many tactics to mitigate these issues. As of Aug. 15, thanks to IT, providers can now upload supporting documentation, Heather said. As a result, fax requests have dropped from thousands to no more than 500. Heather also thanked Provider Relations for its work in educating network providers. UM coordinators too have been outreaching our provider network to submit requests via LMS. UM is also teaching its nurse coordinators to be more proficient in our system. Heather said that it is worth noting that inpatient TAR volume the first half of 2024 was already 82% of that logged for all of 2023, adding that outpatient and LTC also experienced similar volume increases. IQI posed no questions.	
4. 2024 3rd Next Available & Next Available Survey *Vander Harris, Senior Health Data Analyst, Finance*	The 3rd Next Available & Next Available Survey is a point-in-time largely telephonic survey to monitor appointment availability, telephone access, and appointment wait time among primary care providers and high-volume specialists. In March 2024, Provider Relations staff outreached a total of 357 primary care sites (94 in the North, 153 in the South and 110 in our new East Region); 428 specialty providers (88 in the North, 223 in the South and 117 in the East), and 140 prenatal providers (37 in the North, 71 in the South, and 32 in the East). The DHCS standards are: <u>Primary Care Providers</u> • Days to 3NA Adult Appointments and to 3NA Pediatric Appointment <= 10 business days • Time to next available newborn appointment and time to next available urgent appointment <= 48 hours	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	High-volume Specialists • Days to 3NA specialty appointments <= 15 business days • Time to next available urgent appointment <= 48 hours Prenatal Care • Days to 3NA prenatal care (PCPs and specialists) <= 10 business days Vander went through the results by region within each category. Overall, there was a downward trend across adult, pediatric, and newborn PCP appointments when compared to 2023 survey results. However, the North experienced a 3.1% increase for next available for newborns and a 2.6% increase in distribution of clinics by days to next available urgent appointments. The East Region was monitored for the first time in 2024, and scored >90% across all categories. In summary of PCP targets, the majority of southern counties have a low share of clinics meeting adult and pedi targets. Sutter and Yuba counties have low share meeting newborn and urgent targets. The East had the highest rates for 100% of clinics by county meeting targets. Generally, North and South counties had the same or lower share of clinics making targets compared to 2023. Napa County, however, improved by 29% to score 86% for pediatric appointments. In 2024, 58% of clinics missed at least one PCP next appointment target. The maximum wait times for next appointment are exceedingly long. The specialty clinics improved by 15.5% to 94.3% in the North 3NA compared to 2023 survey but the South fell 18% to just 70%. Similarly specialty urgent appointments improved by 6% to 98.9% in the North but fell 4% to 91.8% in the South. The North has lowest rates for endocrinology, gastroenterology and ophthalmology. The South had lowest rates of clinics meeting targets for neurology, dermatology, and gastroenterology. Taken all together, 22% of surveyed clinics did not meet the 3NA specialist appointment target. Days to next prenatal appointment in the North rose 9.8% to 96.9% meeting target while the South fell 19.5% to just 73.7% of clinics hitting targets. (The East registered 91% target acquisition.) Long wait times at Marin and Solano county clinics heavily contributed to the South's decline. Isaac Brown asked if 3NA was calculated across all providers at a surveyed site. Vander said yes it was. A conversation ensued between Isaac, Vander and Dr. Kubota whether a prenatal appointment could be done in any "routine" primary care site's open slots. Dr. Netherda said he was impressed by the gains in the North, although he noted that they do not appear to align with our measure results there. He suggested some study be done on these disparities. Dr. Moore said we will be looking at why one specific provider's grievances are up, as noted in the PULSE report on the today's consent calendar.	
VI. FYI and Adjournment		
FYI: The Tactical Plan Update for 5-Star Quality Strategy document was included at the end of the packet – *direct any questions to Nancy Steffen*		
Dr. Moore adjourned the meeting at 2:38 p.m. IQI will next meet Tuesday, Oct. 8, 2024.		
Respectfully Submitted by Leslie Erickson, Program Coordinator I, Quality Improvement *Approval Signature:* *Date:* *Robert Moore, MD* *Chief Medical Officer and Committee Chair*		

MEETING AGENDA / MINUTES

Meeting/Project Name:	**Substance Use Internal Quality Improvement Committee Meeting (SUIQI)**		
Date of Meeting:	**July 25, 2024**	**Time:**	**10:00 AM**
Meeting Facilitator:	**Stephanie Wilson**	**Location:**	**WebEx**

Meeting Objective/s

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

Meeting Agenda

Topic	Person(s) Responsible	Time Allotted
Welcome and Introductions	Stephanie Wilson	5 Minutes
Review & Approve Minutes	Stephanie Wilson	5 Minutes
Wellness and Recovery Program Updates, Enhancements and Highlights	Nicole Escobar & Stephanie Wilson	20 Minutes
Monitoring and Oversight – Providers	Wendy Millis & Josette McKrola	10 Minutes
Monitoring and Oversight – Utilization Management	Stephanie Wilson	10 Minutes
Monitoring and Oversight – Claims Processing	Wendy Millis	5 Minutes
Monitoring and Oversight – Quality Improvement Program Activities	Alicia Kay	5 Minutes
Monitoring and Oversight – Grievances & Appeals	Latrice Innes	5 Minutes
Monitoring and Oversight – Member Services	Wendy Millis	10 Minutes
Monitoring and Oversight – Compliance	Josette McKrola	5 Minutes
Walk on Items	Stephanie Wilson	
Wrap up and Closing	Stephanie Wilson	

Attendees

Name	County	Attended
Ashley Bray		X
Deanna Bay	Humboldt	X
Dolores Navarro Turner	Modoc	X
Jill Ales	Mendocino	X
Judeth Greco Gregory	Solano	X
Loraine Wisler		X
Michelle Thomas	Humboldt	X

Nancy Starck	Humboldt	X
Ruth Leonard	Solano	X
Sarah Collard	Siskiyou	X
Tiffany Armstrong	Lassen	X
	PHC	
Alicia Kay	Quality Improvement - Redding	X
Becky Miller	Quality Improvement - Redding	X
Doreen Crume	HS Care Coordination - Redding	X
Garnet Booth	Provider Relations - Redding	X
Jackie Krznarich	Supervisor of Clinical Compliance - Redding	X
Jeff DeVido	Behavioral Health Clinical Director	X
Jennifer Cockerham	Behavioral Health Administrative Assistant	X
Joanie Williams	Manager of UM - Redding	X
Josette McKrola	Behavioral Health Quality & Compliance Specialist - Redding	X
Latrice Innes	Manager of Grievance & Appeals - Redding	X
Nicole Escobar	Sr. Manager of Behavioral Health	X
Ryan Ciulla	Supervisor of Member Services - Redding	X
Stephanie Wilson	Program Manager (FTW) - Redding	X
Vicky Klakken	Regional Director - Eureka	X
Vivian Agudelo	Behavioral Health Quality & Compliance Specialist	X
Wendy Millis	Program Manager (PTW)	X

Notes, Decisions, Issues

1. Welcome and Introductions
   - Stephanie welcomed everyone in attendance. There were no new attendees added.
2. Review & Approve Minutes from May 9, 2024
   - Stephanie Wilson asked for approval of the last SUIQI minutes. Deanna Bay approved and Nancy Starck provided a second.
3. Wellness and Recovery Program Updates, Enhancements and Highlights
   - NACT/274: Nicole Escobar shared the 274 file is in full production, having passed all testing with DHCS. The NACT will be completed this week and will be sent to the State, having been linked directly with the 274 as requested by DHCS.
   - County monitoring: Nicole shared the intent is to work with counties to ensure the boxes are checked accordingly for State audits. In order to ensure we are using your time effectively during SUIQI we would like to calendar monitoring activities to meet the need. Deanna shared the 2 ideas shared are the inclusion of specific agenda items with sections included and including the monitoring area number in the data provided. Nicole agreed to include in next SUIQI. Jill Ales added there is still work within the County workgroup which may require a session outside of SUIQI. All agreed to keep PHC updated.
   - Stephanie provided a presentation on the annual TPS. Nancy asked about the survey and whether the questions are prescribed. Stephanie responded the questions are included in the package provided by UCLA. She further asked what is considered statistically significant. Nicole added that due to the analysis being conducted at State wide level, UCLA has not provided insight into what they believe is significant. They also have not included how they review rural vs. large counties. Nancy added the inclusion of access to physical health services is important as it drives the importance of model and why it was approved.
   - Stephanie went over the provider changes related to BHIN 24-023 and DRAFT hardship fee waiver for licensing and certification costs.

4. Monitoring and Oversight
   - a) Wendy Millis went over the 7 provider agreements currently with PHC's contracting team (yet to be executed). Scope of services include outpatient and residential. Newly credentialed providers are included in the packet.
   - c) i.) Josette McKrola: The compliance numbers are still being heavily affected by the Annual Admit system issues. Due to this no CAPs were issued since the last meeting. Due to significant efforts by our team we anticipate this number improving at the next meeting.
     c) ii.) No CAPs have been issued providers for operational reporting in the last quarter.
   - c) iii.) Josette McKrola: The new process of due date of the 5th has resulted on 100% compliance for all of the counties over the last 3 months. PHC Counties being 100% with DATAR was acknowledged by DHCS Auditors. No CAPs were necessary.

5. Monitoring and Oversight
   - a) Utilization Management
   - i. SABIRT to be distributed for the next call during quarterly
   - ii. No TAR denials. Josette McKrola: There is a 28% reduction in the number of approved TARs when comparing the count of TARs approved in June 2024 to July 2023. The average number of TARs approved per month remains 131 (SW)
   - Stephanie provided an overview of authorizations for FY 23/24. There was a dip in authorizations in Q4 by 28% which is on trend with previous years. Timely access was reviewed and indicated 1881 treatment episodes from 1/1/2024 – 6/30/2024 with an average of 2.6 days for standard services and 1.9 for urgent. Transitions of care was provided.

- Call Log: the number of incoming SUD calls are initial screened calls remains 41%. The highest number of SUD calls received during this fiscal year is remains August at 351 calls and lowest is still December with 252 calls. However, lowest number of those calls resulting in an initial screening fell to 98 during May 2024 (WM)
-

6. Monitoring and Oversight
   - a) Claims Processing
   - Wendy provided an updated on claims submission. Solano County Short Doyle report does not reflect numbers for the month of June due to the halting of claims processing by the State. DHCS has reported that all issues have been resolved and claims denied can be resubmitted.
7. Monitoring and Oversight
   - a) Quality Improvement Program Activities
   - Alicia Kay presented on site reviews for the quarter recognizing there was a MRR CAP was provided in Q4 due to lack of training in personnel files, specifically C&L training and ASAM.

8. Monitoring and Oversight
   - a) Grievances & Appeals
   - Latrice Innes reported there was 1 grievance in Q4, specific to needed medical care. The member completed their 60-day treatment plan and was transitioned to a more appropriate facility for services.

9. Monitoring and Oversight
   - a) Member Services
   - i. Wendy provided an overview of beneficiary access line trends. Nancy asked what should we expect as far as callers screened. Wendy said Carelon has not provided sufficient data related to the callers that are not screened. There has been some feedback on duplicate calls, eligibility inquiries, and service questions.
   - ii. Wendy reviewed the CalOMS dashboard indicating self-referrals remain primary source of entry and opioids remain at the top of drug of choice. Standard discharges remain at 65% of total. Clients are reporting a large proportion remain unemployed at discharge, however more than two-thirds are reporting housed. 116 perinatal clients were seen in FY 23/24. Co-occurring beneficiaries remain consistent with previous months.
   - Deanna asked whether the view of the CalOMS dashboard can improve when the pdf is presented. PHC will address.

10. Monitoring and Oversight
    - a) Compliance
    - i. BHINs & Policy Updates: Josette provided an overview of the BHINs for the quarterly, highlighting the NACT will be completed by end of week. Licensing cost waiver and provider changes are in draft form.
    - 24-020 NACT we are working on it and see no issues with the 8/1 deadline. We anticipate the NACT being completed by end of day tomorrow 7/27. 274 up and running (NE)
    - 24-022 License Fee Increase it shows the 20% increase in dollars and provides instructions on how to pay them or how to apply for a hardship waiver. It also gives instructions and timelines for those licenses renewed but at the previous rate. An invoice will go out with the difference. The difference must be submitted within 60 days of the invoice date (SW)
    - 24-023 Mental Health Provider Integration to DMC/DMC-ODS. The BHIN lists the various mental health professionals that can now provide services with SUD treatment. The BHIN also describes the scope of practice for each of provider type (SW)

- 24-026 TPS survey is coming up again. The Treatment Perception Survey (TPS) period will be October 21st – 25th, so keep an eye on your emails for further instructions. The BHIN is attached giving instructions from EQRO/UCLA how and when to administer the survey. There is a link to the TPS website for detailed instructions. (SW)

11. Walk On Items
    - Nicole informed the group that Wendy Millis will no longer be at PHC and Friday, 7/27/24 would be her last day.

12. Wrap up and Closing
    - Stephanie closed the meeting.

Action Items

Action	Owner	Due Date
1.		
2.		
3.		

QI DEPARTMENT UPDATE
OCTOBER 2024
PREPARED BY NANCY STEFFEN
SENIOR DIRECTOR, QUALITY AND PERFORMANCE IMPROVEMENT

QUALITY IMPROVEMENT PROGRAMS (QIPS)

PROGRAM	UPDATE
PRIMARY CARE PROVIDER QUALITY IMPROVEMENT PROGRAM (PCP QIP)	• Proposed measurement set changes for Measurement Year (MY) 2025 will be presented to the Physician Advisory Committee (PAC) this month. • CG-CAHPS results from Press Ganey are expected in October to the PCP QIP team. Survey reports will be shared with providers at that time. • The 2023 PCP QIP Evaluation will be presented in committee meetings in the month of November.
LONG TERM CARE QUALITY IMPROVEMENT PROGRAM (LTC QIP)	• Partnership is seeking attestations from all contracted LTC and Skilled Nursing Facilities (SNFs) to confirm a proper Quality Assurance Performance Improvement (QAPI) program, per CMS requirements, is in place at their facility. These requests are being made via Partnership's cross-functional SNF Quality workgroup. This workgroup includes representatives from Provider Relations, Utilization Management, Office of the CMO, QI, and Health Analytics. This team is meeting monthly to leverage and enhance existing data, reporting, and processes to fulfill DHCS quality monitoring requirements
PALLIATIVE CARE QUALITY IMPROVEMENT PROGRAM (PALLIATIVE CARE QIP)	• January – June 2024 payment will be distributed at the end of October.
PERINATAL QUALITY IMPROVEMENT PROGRAM (PQIP)	• FY 2023-2024 incentive payments are scheduled for distribution by 10/31/2024 • Supplemental incentive payments based on the PQIP Supplemental Incentive plan for providers with assigned Dignity members are scheduled for distribution by 10/31/2024. This payment will be separate from the standard program payment. • PQIP participants interested in Datalink implementation are working directly with DataLink to complete requirements.
ENHANCED CARE MANAGEMENT QUALITY IMPROVEMENT PROGRAM (ECM QIP)	• 2nd quarter 2024 incentive payments were distributed on 10/10/2024. • The program's new Timely Review of ED/Admission Notifications measure in PointClickCare became effective 10/01/2024. This measure is included in the remainder of MY2024 and in the MY2025 measurement set. • The ECM QIP kick-off webinar was hosted on 09/30/2024.
HOSPITAL QUALITY IMPROVEMENT PROGRAM (HQIP)	• The final 2023-24 HQIP submissions from participating hospitals were reviewed during September. Partnership Medical Directors, Dr. Cotter and Dr. Spiller, reviewed the Palliative Care submissions. Dr. Cotter suggested reworking the Palliative Care attestation and requirements for training. His ideas were presented in September's HQIP Tech Workgroup and were approved. The additional language will be added to the measurement set as a revision. Dr. Jalloh, Partnership's Director of Health Equity, reviewed Health Equity Submissions and gave feedback to hospitals to help them rework their reports to better align with the requirements of the program. • Preliminary Scoring for payment is underway and the Preliminary Period along with payment will be completed in October.

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	• N/A
EREPORTS	• MY2025 eReports scoping is in progress and development meetings and deliverables will begin after October PAC.

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE

STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	*Institute for Healthcare Improvement (IHI) / DHCS Medi-Cal Child Health Equity Collaborative*
	• This collaborative is focused on improving child health equity, specifically for pediatric well-care visits.
	• Partnership and Stallant Health and Wellness in Del Norte County are collaborating in a project. The populations of focus are Native American / Alaskan Native and Hispanic populations. Defined Aims for targeted populations are as follows:
	  ○ Partnership in collaboration with Stallant Health & Wellness will increase the annual well-care visit completion rates for the Native American/Alaskan Native population who are 3-17 years of age from 8% to 25% by March 2025.
	  ○ Partnership in collaboration with Stallant Health & Wellness will increase their annual well-care visit completion rates for the Hispanic population who are 3-17 years of age from 20% to 40% by March 2025.
	• The 3rd phase of this collaborative began on 08/22/2024 and focuses on conducting a Plan-Do-Study-Act (PDSA) cycle.
	
	IHI / DHCS Medi-Cal Behavioral Health Demonstration Collaborative
	• DHCS and IHI have also launched a Behavioral Health Demonstration Collaborative to continue the work already started by the California Advancing and Innovating Medi-Cal (CalAIM) initiative. Partnership, along with the Nevada County Behavioral Health Department, were selected by DHCS to participate in this collaborative.
	• The Partnership/Nevada County DBP team is currently selecting an initial intervention to pilot in fall 2024.
	• This collaborative will run April 2024 through June 2025. It has three (3) Action Periods where quick interventions will be implemented within Nevada County and evaluated to impact the following measures:
	  ○ % of Medi-Cal members with 30-day follow up after Emergency Department visit for mental illness (FUM)

- % of Medi-Cal members with 30-day follow-up after Emergency Department visit for substance abuse (FUA)

Performance Improvement Projects (PIPs) Update
As a contracted managed care plan (MCP), DHCS assigned two (2) PIPs to Partnership that will be completed over 2023–2026. Annual submissions for both PIPs were submitted to DHCS on 09/11/2024.

- Improving Well Child Visits in the First 15 Months of Life (W30-6) Equity PIP, focused on the Black/African-American Population in Solano County:
  - Partnership will pilot an intervention with newborns born at Northbay Medical Center, the only hospital in Solano County that is open to Medi-Cal members. The intervention will pilot the use of navigators. The pilot focuses on assisting these families in enrolling in the Growing Together Program, completing the Newborn PCP Selection Form, and ensuring that they have begun the Medi-Cal enrollment process for their newborns.
  - Cycle 1 of the pilot began on 08/17/2024 and relies on Population Health Department Wellness Navigators for member outreach. Cycle 1 will continue until at least 09/30/2024. Below are preliminary outcomes for the pilot as of 09/18/2024:

Grand Total of Unique Members	**67**
Row Labels	**Count of Outcome**
Agreed To Participation	39
Declined Participation	5
Left Message	37
Participation pending	12
Unable To Reach	17
(blank)	
Grand Total of Outreach Attempts	**110**

Row Labels	**Count of Member Ethnicity**
ASIAN INDIAN	1
ASIAN/PACIFIC ISLANDER	1
BLACK	3
FILIPINO	3
HISPANIC	37
NO VALID DATA REPORTED(MEDS GENERATED)	2
OTHER	7
WHITE	13
Grand Total	**67**

- Improving the Percentage of Provider Notifications for members with Serious Mental Health (SMH) Diagnosis within 7 Days of Emergency Department (ED) Visit
  - Partnership will pilot an intervention with a provider organization (PO) to increase rates for follow-up visits for members with a recent ED visit with a mental health diagnosis.

	○ Partnership and the Provider Organization had a kick-off meeting for the intervention and began work on Cycle 1 in September 2024. *DHCS Comprehensive Quality Improvement (QI) & Health Equity (HE) Process* • Based on MY2022 HEDIS performance, DHCS has assigned Partnership additional accountability work around the Behavioral Health, Children's Health, and Reproductive Health and Cancer Prevention measure domains. This work, called the Comprehensive Quality Improvement and Health Equity Process, will require Partnership to complete strategies and action plans for 2024 activities meant to improve HEDIS rates in the included domains. • Partnership received feedback on the July 2024 submission of strategies and action plans to impact measure domains. The strategies and action plans will begin implementation in 2024, with a progress report due to DHCS in October 2024. • An overview of strategies planned to improve performance on each measure domain include: Children's Health: ○ Development of data reporting that will be reviewed with providers highlighting missed opportunities (i.e. episodes where patients were seen via an office visit, but preventative services were not completed) to capture pediatric services such as well child visits. ○ Analysis of the issue of delayed newborn Medi-Cal enrollment's impact on claims capture for the Well Child Visit Birth – 15 Months measure and design of interventions to expedite newborn Medi-Cal enrollment. Behavioral Health Domain: ○ Collection of County Department of Public Health data around Follow-Up Visits for ED Visits with a Mental Health Diagnosis using the Sacramento Valley MedShare Health Information exchange to improve real-time visibility of ED visits, specialty mental health encounters, and outpatient visits. ○ Piloting the use of embedded Community Health Workers in several EDs within Partnership's network to complete referrals for Partnership members presenting with a mental health or substance use diagnosis. Reproductive Health and Cancer Prevention Domain: ○ Improving breast cancer screening rates in imaging center deserts, using mobile mammography events and interventions with imaging centers with significant access challenges. ○ Piloting the use of chlamydia home screening kits with a partner provider(s).

QUALITY MEASURE SCORE IMPROVEMENT	• Partnership has completed two (2) rounds of Blood Lead testing grants for point-of-care (POC) devices for primary care providers and has closed its 3rd grant offering.
	  ○ The first round resulted in ten (10) POC device awardees along with two (2) reimbursements for recently purchased POC devices.
	  ○ The second round has recently finalized with eleven (11) POC device awardees along with fifteen (15) reimbursements for recently purchased POC devices. Second round devices were recently delivered to sites.
	  ○ A third round launched 09/03/2024 and closed on 09/30/2024. Applications are currently under review with up to 30 devices available for distribution.
	• Practice Facilitation coaching continues with nine (9) provider organizations throughout the provider network. At present, most practices are focusing on implementing interventions to impact SMART Aims. Expansion (i.e. Chico and Auburn) Region practices are engaged in optimizing the data tier for their QIP measures and planning a strategy for meeting benchmarks during their first year with Partnership. The following practices will be participating in Practice Facilitation in 2024:
	  ○ Solano County Family Health Services (Fairfield Region)
	  ○ Community Medical Center (Fairfield Region)
	  ○ Consolidated Tribal Health Project (Eureka Region)
	  ○ Adventist Health Clearlake – Lake, Butte, and Tehama Counties (Eureka, Redding, and Chico Regions)
	  ○ Adventist Health Ukiah Valley – Mendocino County (Eureka Region)
	  ○ Ampla Health (Chico Region)
	  ○ Northern Valley Indian Health (Chico and Fairfield Region)
	  ○ Wellspace Health (Auburn Region)
	  ○ Western Sierra Medical Clinic (Auburn Region)

IMPROVEMENT ACADEMY	• As a new offering, development of two microlearnings focused on ePrompts and Human Papillomavirus (Parent-Provider Conversations) is underway. Microlearnings offer short bursts of content in three to five minute sessions which enhance knowledge retention and the ability for learners to receive just-in-time content when needed.
	• For Fiscal Year 2024-25, the Improvement Academy will host three (3) ABCs of QI in- person trainings.
	  ○ 11/07/2024 – Fairfield
	  ○ 01/30/2025 – Ukiah
	  ○ Spring 2025 – Redding
	• Promotion for the 11/07/2024 ABCs of Quality Improvement training held in Fairfield is underway.

JOINT LEADERSHIP INITIATIVE (JLI)	• Fall JLIs are currently in the planning phase and will include Ampla as a new Parent Organization. There are a total of 9 participating organizations representing all regions. • October JLI meetings include:

	○ Ampla Health: 10/14/2024
Regional Improvement Meetings	• Scheduling for the Northern Region quarterly regional meetings is currently underway for the 4th quarter in November. • The Solano QIP Improvement (SQIP-I) Regional Bi-Monthly meeting is scheduled for 10/03/2024.

Note: Detailed information and recordings of Performance Improvement related webinars are posted to the PHC Website: http://www.partnershiphp.org/Providers/Quality/Pages/PIATopicWebinarsToolkits.aspx

QI Program & Project Management

ACTIVITY	UPDATE
State Mandated Work: Equity and Practice transformation (EPT) Program	• The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative with the goal of advancing health equity while reducing COVID-19 driven care disparities. The funding is divided between three (3) programs; the Initial Planning Incentives Payments (IPIP), the Provider Directed Payment Program (PDPP), and the Statewide Learning Collaborative (SLC). • Partnership received $1,526,085.49 in Initial Planning Incentives Payments (IPIP) funding. ○ $10,000 was awarded to twenty-three (23) qualifying provider organizations through the IPIP program. The IPIP is geared toward small and medium-sized independent practices to support their planning and application process for the Provider Directed Payment Program (PDPP). ○ The EPT strategy team continues to explore utilization for the remaining IPIP funds. A subset of funds will be allocated to tribal health organizations to support improvement efforts. More information will follow as plans for the allocation of funds continue to develop. • All twenty-seven (27) provider organizations, who were invited by DHCS to participate in the PDPP, sent acceptance responses to DHCS by their 01/26/2024 deadline. Partnership had the third most accepted applications of all managed care plans with a 49% acceptance rate vs 29% state-wide. The accepted provider organizations are spread across each of Partnership's sub-regions, including five (5) provider organizations recently contracted with Partnership from the 2024 expansion counties, eight (8) tribal health centers, and seven (7) provider organizations already engaged under Partnership's EPE program. DHCS is recalculating the final award amounts, due to the budget revisions. ○ EPT practices have as early as 11/01/2024 and up until 11/01/2025 to submit the next round of milestone deliverables: ▪ Empanelment and Access Milestone 1: Empanelment Assessment ▪ Empanelment and Access Milestone 2: Empanelment Policy and Procedure ▪ Data to Enable Population Health Management (PHM) Milestone 1: Data Governance and HEDIS Reporting Assessment and Data Governance Policy and Procedure.

	▪ Required Key Performance Indicator (KPI) Reporting on empanelment and access administrative metrics; Empanelment, Continuity, and Third Next Available Appointment. ○ EPT milestone deliverable templates to guide practices on their submissions are available on Population Health Learning Center's website: https://pophealthlearningcenter.org/milestones-and-deliverables/ • The Statewide Learning Collaborative (SLC) is meant to support practices awarded the PDPP funding in the implementation of practice transformation activities, sharing and spread of best practices, practice coaching activities, and achievement of quality and equity goals stated in their PDPP applications. Participation in the SLC is a requirement for all participants in the PDPP. ○ To remain in the EPT program, practices will need to demonstrate 80% attendance in the Practice Track and Learning Community sessions of the EPT Technical Assistance. ○ Login credentials to the eLearning Hub, PopHealth+, has been sent to EPT practices, Managed Care Plans (MCPs), and EPT stakeholders. ○ All of Partnership's EPT Practices are required to participate in the Redwood Learning Community session on 10/30/2024. ○ Beginning in September, Population Health Learning Center (PHLC) provided ad-hoc office hour sessions through Expert Consultation and will continue this month on the below topics. Practices will be able to attend and ask questions related to the content learned in PopHealth+, Practice Track meetings, and Learning Community sessions. ▪ Understanding and Reporting the Administrative Measure Key Performance Indicators (KPIs) - 10/02/2024 ▪ Data Governance and HEDIS Reporting Assessment - 10/04/2024 ○ In September, PHLC began hosting bi-monthly "All MCP EPT Meetings" to share updates related to EPT technical assistance and the program as a whole. The next meeting will be on 11/06/2024.
CAPACITY ENHANCEMENT GRANTS	• For the first time in Partnership's 30-year history, contract negotiations were not fulfilled prior to the expiration of a provider contract. Dignity Health's contract termination affected over 64,000 members in Nevada, Shasta, Siskiyou, Tehama, and Yolo counties for several weeks in April through June. In response to this disruption, the Capacity Enhancement Grant (CEG) was created and offered to providers who agreed to take member assignments previously with Dignity Health. ○ Seventeen (17) out of the nineteen (19) eligible Provider Organizations applied for the CEG and were awarded funding based on the number of Dignity members they would be absorbing. ○ The first installment of CEG funding was distributed on 06/12/2024. ○ CEG Providers submitted the required Progress Report Template on 09/13/2024. ○ The Progress Report Templates were reviewed by the Project Management team and QI leadership. ○ CEG providers summarized the successful and challenging outcomes of their short-term and long-term activities to boost capacity.

	▪ Short-term activities include initiatives to increase and/or retain staffing (sign-on bonuses, hiring additional medical and front-line staff, locum recruiting/employment), extending clinic hours and/or providing Saturday clinic hours, and increasing the number of visits per provider. ▪ Long-term activities include continued hiring/retention activities, work station expenses for additional staff, renovations to expand clinic spaces, purchasing equipment and furniture for newly opened exam rooms. ○ The second and final installment of CEG funding is being processed with Finance.
LOCUM PILOT INITIATIVE	The QI Locum Pilot Initiative was developed as a short-term solution to provide access to clinicians with the goal of improving HEDIS performance in preventative care, specifically well-child visits and cervical cancer screenings. This offering is designed as a limited Grant Program, whereby participating Provider Organizations are granted funds to select and hire a Locum Tenens Provider for a 4-week period. • A total budget of $250,000 was approved; participating Providers receive up to: ○ $45,000 when hiring a Physician; or ○ $31,600 when hiring an Advanced Practicing Clinician. • The Grant is paid in two installments: ○ 1st installment upon signing the Agreement, 50% of eligible funds ○ 2nd installment upon completing the 4-week assignment and post-program survey, remaining 50% • The initial cohort of providers was selected from those participating in the PCP Modified QIP. ○ Six (6) offers to apply were made and four applications were received. ○ All four (4) applications were reviewed and accepted into the pilot program. • Locum assignment periods will be carried out asynchronously through the end of 2024. Weekly Provider check-ins and data collection are conducted by a Partnership Improvement Advisor throughout the Locum Provider's employment. • Locum Providers are alleviating a backlog of well-child and adolescent visits. • Locum Providers are covering urgent care which allows patients to schedule visits with their preferred physician. • Additional data collection is being completed through a participant debrief meeting on 10/09/2024. • One provider continues to recruit for a Locum candidate and is experiencing limited opportunities due to a short assignment period, spanning less than 3 months. Alternative approaches are being explored. • We are exploring a three (3) month extension to continue funding Community Medical Center. The focus will be well-child visits with priority given to specific direct members designed to address DHCS withhold measures.

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Recipients of the Capacity Enhancements Grant who utilized Locum Tenens as short-term interventions will be surveyed for their experience and best practices to bolster pilot data.

<table>
<tr><th>Provider Organization</th><th>Total Grant</th><th>Locum Assignment and Status</th></tr>
<tr><td>Hill Country Community Clinic</td><td>$31,600</td><td>Start date: September 23, 2024</td></tr>
<tr><td>Pit River Health Service</td><td>$31,600</td><td>Focus: Well Child Visits & Immunizations
07/29/2024 – 08/16/2024 (Part-time) other dates TBD</td></tr>
<tr><td>Round Valley Indian Health</td><td>$45,000</td><td>Actively recruiting. Start date to be determined once matched with Locum.</td></tr>
<tr><td>Community Medical Center</td><td>$31,600</td><td>Focus: Child/Adolescent Well Care & Immunizations
Initial program complete; possible extension is being explored.</td></tr>
</table>
</td></tr>
<tr><td>QUALITY MEASURE SCORE IMPROVEMENT
MOBILE MAMMOGRAPHY PROGRAM</td><td>

Between 07/01/2024 to 09/30/2024, Partnership sponsored 23 Mobile Mammography event days with 14 provider organizations at 22 provider sites, resulting in an estimated 470 completed screenings (i.e. final screening data is pending).

Northwest Region: seven (7) event days with two (2) provider organizations at seven (7) provide sites.
Northeast Region: seven (7) event days with five (5) provider organizations at six (6) provider sites.
Southwest Region: four (4) event days with four (4) provider organization at four (4) provider sites.
Southeast Region: two (2) event days with two (2) provider organizations at two (2) event sites.
Eastern Region: three (3) event days with one (1) provider organization at three (3) provider site.

One (1) event day in the Northwest Region was held at a Tribal Health Center in Humboldt County.
One (1) event day in the Northeast Region was held at a Tribal Health Center in Trinity County.
Upcoming Mobile Mammography events in October include:

Northeast Region: two (2) event days with two (2) provider organizations at two (2) provider sites.
Southwest Region: one (1) event day at one (1) provider organization at one (1) provider site.

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</table>

	○ Eastern Region: two (2) event days at two (2) provider organizations at two (2) provider sites. • Planning for Mobile Mammography event days for November and December is underway. Targeted providers include those who have Primary Care Provider Quality Incentive Program Breast Cancer Screening (PCP QIP BCS) rates below the 50th percentile benchmark and are located in imaging center deserts with little or no access to local imaging services. • The Primary Care Provider Quality Incentive Program (PCP QIP) Breast Cancer Screening 50th percentile benchmark has been met in the Southwest Region for the measure year.
QI TRILOGY PROGRAM	• The following documents were completed and are currently pending Board approval, in October: ○ FY 2024/25 QI Program Description ○ FY 2023/24 QI Work Plan (Final Updates) ○ FY 2023/24 QI Program Evaluation ○ FY 2024/25 QI Work Plan (Goal Submissions)
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS® (CAHPS) PROGRAM	• The final 2023/24 Member Experience Grand Analysis (ME 7) will be presented formally at IQI and QUAC in November and the Consumer Advisory Committee (CAC) in December. • Pre-planning discussions for the regulated and non-regulated CAHPS® Survey (MY 2024) are underway. A few considerations include: ○ Oversampling strategy, modifications to the mixed protocols (i.e., phone calls, mailers), and supplemental questions. ○ Formal population submission for 2025 NCQA Patient Experience Health Plan Star Rating. • Fiscal Year 2024-25 Organization Goal #4: Access to Care and Member Experience Improvement: ○ MY2025 PCP QIP Specifications: Modifications to the Unit of Service Patient Experience measure description are currently under review.
GEOGRAPHIC EXPANSION: QI PROGRESS	• The Quality Improvement (QI) Project Plan to onboard the East Region Expansion Counties to QI functions and programs began in June 2023 and will continue over the course of 2024. Status updates include: ○ Resource planning to recruit, hire, and onboard staff dedicated to Expansion Counties is nearly complete. One (1) Improvement Advisor position is planned for posting later in 2024. An additional HEDIS Analyst and Program Coordinator are also planned for posting later this fall. • Provider onboarding events in 2024 are underway with continued planning to build out further offerings, including: ○ PCP QIP focused communications and monthly office hours to assure providers have all the technical assistance needed to make a strong start in the PCP QIP.

- Thirteen (13) external Expansion Region invitees representing eight (8) Expansion organizations attended the September office hour session.
- The October session is canceled; the next session will be on 11/04/2024.

- Perinatal QIP focused communications and orientations to assure all providers have all the support needed to participate in the Perinatal QIP.
  - Onboarding meetings and Letters of Agreement (LOAs) are complete from the following participating East Region providers:
    - Peach Tree
    - Northern Valley Indian Health
    - Ampla Health
    - Chapa-De Indian Health
    - Samuel Van Kirk, MD
    - Tahoe Forest Hospital
    - Well-Space Health
    - Enloe Health
- The HEDIS team began hosting Office Hours in July 2024, and will conclude in November 2024. Thank you to those who have participated in July, we look forward to meeting with you in the upcoming sessions, click on the links below to register:

10/30/2024	MY2023 Annual Summary of Performance • HPA (Health Plan Accreditation) • Managed Care Accountability Set (MCAS)
11/13/2024	Hybrid Measure Overview • Blood Pressure Diabetes • Controlling Blood Pressure • Cervical Cancer Screening • Childhood Immunization Status • Eye Exam for Patients with Diabetes • Hemoglobin A1c Control for Patients With Diabetes • Immunizations for Adolescents • Lead Screening Children • Prenatal and Postpartum Care • Weight Assessment and Counseling on Nutrition and Physical Activity for Children and Adolescents – Body Mass Index

- Partnering with PCP organizations in Regional Performance Improvement initiatives and interventions, like Mobile Mammography.
- Providing in-depth Site Review trainings to address DHCS Site Review changes.
- Regional Engagement is expected later this year to include regional strategic planning on PCP QIP needs and selected participation in the Joint Leadership Initiative.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: **08/27/2024 TO 09/26/2024**	• 36 PQI referrals were received during this time. 30 of which were from Grievance and Appeals, 5 from other sources, and 1 from Utilization Management. • 20 cases were processed and closed during this period. • 81 cases are currently open. • Two new cases were presented and scored in the Peer Review Committee on 09/18/2024. • One focus review is being conducted. • Provider Preventable Condition education given to the Hospital Director of Accreditation and Licensing/ Director of Quality and Safety at a local acute hospital. • IT has started the process to upgrade/enhance the SugarCRM PQI application.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: **08/26/2024 TO 09/27/2024**	• As of 09/30/2024, we have a total of 454 PCP and OB sites with an additional 28 reviews due to multiple check-ins (totaling 482 reviews). • CHDP training is being offered to providers. This is available as a 1:1 training or online. • We will be reaching out to new counties in efforts to provide Site Review education on new site review tool requirements. **Primary Care and OB Reviews:**

Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued
Auburn	3	4	2	3
Chico	3	5	1	3
Eureka	2	2	0	1
Fairfield	4	4	1	1
Redding	4	4	1	4
Santa Rosa	1	1	0	1

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE

Annual HEDIS® Projects	MY2023 Performance Overview:
	• Partnership received the Final Audit Report (FAR) with zero findings for both audits:
	  ○ DHCS Managed Care Accountability Set (MCAS)
	  ○ NCQA Health Plan Accreditation (HPA)

	• NCQA releases the Health Plan Ratings (HPR) each September. NCQA rates the health plans across the U.S. by assessing how plans perform in key quality areas, based upon the performance of HEDIS® and CAHPS® results. NCQA then rates health plans from 1 to 5 stars. On 09/16/2024, NCQA published the HPR of Partnership at 3.5 stars for MY2023, as projected. • MY2023/ RY2024 final Healthplan Accreditation (HPA) Star Rating was calculated based on the MY2023 Adult CAHPS® (regulated) survey results and plan-wide HEDIS rates per the NCQA Health Plan scoring methodology. 
HEDIS® Program Overall	HRP: Conversion of PHC's core claims system from Amisys to HRP • Another round of testing is planned to begin in October 2024 to support the overall pending implementation of Health Rules Payer-Health Edge (HRP) Geographic Expansion: • Preparation is underway to begin plan-wide reporting as required by DHCS (MCAS) and NQCA (HPA) reporting. • Additional County-Level Oversampling will be conducted for all 24 counties, as proposed and accepted by DHCS. CMS DSNP Preparation: • Planning is underway to prepare for baseline data capture & integration to support the DSNP implementation planned for January 2026.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	• NCQA released the new 2025 HPA Standards and Guidelines on 08/30/2024. The NCQA Program Management Team prepared a summary of changes, which included a crosswalk between the 2024 and 2025 HPA Standards and Guidelines. This summary was shared with Business Owners who provided their questions or requests for clarification. The NCQA Program Management Team met with our

	NCQA consultant to assess the changes made to the 2025 HPA Standards and Guidelines and obtained clarification, as needed, for Business Owners. • As part of the HPA Key Activities for FY 24-25, Milestones 2 and 3 require Business Owners to review, and update as needed, the annual HPA Workbook, which consists of the HPA Work Plan and Evidence Submission Library, and the 2024-2026 HPA Report Schedule. The annual workbooks and current report schedules were shared with Business Owners on 09/19 and 09/20/2024. Business Owners are asked to submit their completed workbooks and report schedules by 10/18/2024.
NCQA Health Equity Accreditation (HEA)	• HEA Key Activities for FY 24-25: ○ Milestone 2 requires that all Business Owners review, and update as needed, the annual HEA Workbook, which consists of the HEA Work Plan and Evidence Submission Library. The annual HEA Workbooks were shared with Business Owners on 09/26 and 09/27/2024. Business Owners are asked to submit their completed HEA Workbooks by 10/25/2024. ○ Milestone 3 requires Business Owners to provide their acknowledgement by 10/25/2024 that documented processes meet the scope of review throughout the look-back period. Note: Any revisions that impact NCQA requirements must be finalized in November 2024.

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

Consent Calendar

Oct. 16, 2024

Items on the Consent Calendar have minor or no changes and are recommended by staff for approval.

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Primary Care Provider Quality Incentive Program (PCP/QIP) Summary of Proposed Measure Changes for Measurement Year 2025

(A) Core Measurement Set Measures

Providers have the potential to earn a total of 100 points in four measurement areas: 1) Clinical Domain; 2) Appropriate Use of Resources; 3) Access and Operations; and 4) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

Key:

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

2024 Measures	2025 Recommendations
Clinical Domain	
Family Medicine: 1. Breast Cancer Screening 2. Cervical Cancer Screening 3. Child and Adolescent Well Care Visits 4. Childhood Immunization Status: Combo 10 5. Colorectal Cancer Screening 6. Comprehensive Diabetes Care: HbA1c Control 7. Diabetes Management: Eye Exams 8. Controlling High Blood Pressure 9. Immunizations for Adolescents – Combo 2 10. Well-Child Visits in the First 15 Months of Life 11. Lead Screening in Children	**Family Medicine:** 1. Breast Cancer Screening (50-74yo) 2. Breast Cancer Screening (40-49yo) - **Monitoring** 3. Cervical Cancer Screening 4. Child and Adolescent Well Care Visits 5. Childhood Immunization Status: Combo 10 6. Colorectal Cancer Screening 7. Comprehensive Diabetes Care: HbA1c Control 8. Diabetes Management: Eye Exams 9. Controlling High Blood Pressure 10. Immunizations for Adolescents – Combo 2 11. Well-Child Visits in the First 15 Months of Life 12. Lead Screening in Children 13. Chlamydia Screening in Women (both age groups: 16-24yo) – **Monitoring** 14. Well-Child Visits in the first 15-30 months of life – **Monitoring** 15. Topical fluoride in Children – **Monitoring** 16. **Reduction of Inequity Adjustment (Participation is Optional)**
Clinical Domain	
Internal Medicine: 1. Breast Cancer Screening 2. Cervical Cancer Screening 3. Colorectal Cancer Screening	**Internal Medicine:** 1. Breast Cancer Screening (50-74yo) 2. Breast Cancer Screening (40-49yo) - **Monitoring** 3. Cervical Cancer Screening

4. Comprehensive Diabetes Care: HbA1c Control 5. Controlling High Blood Pressure 6. Diabetes Management: Eye Exams	4. Colorectal Cancer Screening 5. Comprehensive Diabetes Care: HbA1c Control 6. Controlling High Blood Pressure 7. Diabetes Management: Eye Exams 8. Chlamydia Screening in Women (21-24yo) - **Monitoring** 9. **Reduction of Inequity Adjustment (Participation is Optional)**
Clinical Domain	
Pediatric Medicine: 1. Child and Adolescent Well Care Visits 2. Childhood Immunization Status: Combo 10 3. Immunizations for Adolescents – Combo 2 4. Well-Child Visits in the First 15 Months of Life 5. Lead Screening in Children	**Pediatric Medicine:** 1. Child and Adolescent Well Care Visits 2. Childhood Immunization Status: Combo 10 3. Immunizations for Adolescents – Combo 2 4. Well-Child Visits in the First 15 Months of Life 5. Lead Screening in Children 6. Chlamydia Screening in Women (16-20yo) 7. Well-Child Visits in the first 15-30 months of life 8. Topical fluoride in Children - **Monitoring** 9. **Reduction of Inequity Adjustment (Participation is Optional)**

Appropriate Use of Resources	
Family Medicine & Internal Medicine: 1. Ambulatory Care Sensitive Admissions 2. Risk Adjusted Readmission Rate (RAR)	**Family Medicine & Internal Medicine:** 1. Ambulatory Care Sensitive Admissions 2. ~~Risk Adjusted Readmission Rate (RAR~~) 3. Follow-up within 7 days after Hospital Discharge
Access and Operations	
All Practice Types: 1. Avoidable ED Visits 2. PCP Office Visits	**All Practice Types:** 1. Avoidable ED Visits 2. PCP Office Visits
Patient Experience	
All Sites: 1. Patient Experience	**All Sites:** 1. Patient Experience

(B) Unit of Service Measures

Providers receive payment for each unit of service they provide.

Unit of Service

All Sites: 1. Advance Care Planning Attestations 2. Extended Office Hours 3. PCMH Certification 4. Peer-led & Pediatric Group Visits 5. Health Information Exchange 6. Health Equity 7. Blood Lead Screening 8. Dental Fluoride Varnish Use 9. Tobacco Use Screening 10. Electronic Clinical Data Systems (ECDS)	**All Sites:** 1. Advance Care Planning Attestations 2. Extended Office Hours 3. PCMH Certification 4. Peer-led & Pediatric Group Visits 5. Health Information Exchange 6. Health Equity ~~7. Dental Fluoride Varnish Use~~ 8. Tobacco Use Screening 9. Electronic Clinical Data Systems (ECDS) 10. Early Administration of the 1st HPV Dose 11. Early Administration of Flu Initiation and Booster Doses 12. Academic Detailing

Programmatic Changes:

I. Descriptions of Potential 2025 Measure Changes for Core Measurement Set

A. Change(s) to Existing Measures – Core Measurement Set

i. Retire Risk Adjusted Readmission Rate (RAR) and replace with Follow-up within 7 days after Hospital Discharge. See rational in section I.B.

B. Potential Additions as New Measures – Core Measurement Set

i. Breast Cancer Screening (Family Practice & Internal Medicine: ***Monitoring*** for age group: 40-49yo) – In April 2024, the US Preventive Services Task Force (USPSTF) published updated guidance on screening for breast cancer. The new recommendation is that all persons assigned as female at birth should be screened for breast cancer every other year beginning at age 40 and continuing through 74 years of age. (The previous recommendation was to begin screening at age 50 years). According to the USPTF report, more women in their 40s are getting breast cancer, with rates increasing by about 2% per year. Initiating screening at age 40 years could save about 20% more lives from breast cancer overall. Additional data suggests that this change could have an even greater effect on the Black population, saving up to 40% more lives in this demographic (USPSTF Bulletin April 30, 2024).

Because members and providers are used to the recommendation to start at age 50 years, an adjustment period is indicated to allow member and provider to “get caught up” on screening of eligible members aged 40-49 years. For this reason, this new measure will be a monitoring measure only for 2025. All Primary Care Providers seeing members from the eligible population (all persons assigned as

female at birth aged 40-74 years) should initiate screening now, in accordance with the guidelines. As the screenings are recommended for every other year, any screening done in 2025 will count for numerator compliance when the measure moves to an active measure in 2026 (anticipated).

ii. Chlamydia Screening in Women (Family Practice: *Monitoring* for age groups: 16-24yo, Internal Medicine: *Monitoring* for age group: 21-24yo, Pediatrics: **Active** for age group: 16-20yo) – The National Committee for Quality Assurance (NCQA) highlights the importance of screening for Chlamydia among youths, ages 16-24 years, assigned female at birth or identifying as female. They provide the following rationale: "Chlamydia is the most commonly reported bacterial sexually transmitted disease in the United States. It occurs most often among adolescent and young adult females. Untreated chlamydia infections can lead to serious and irreversible complications. This includes pelvic inflammatory disease (PID), infertility and increased risk of becoming infected with HIV". Chlamydia infections can be asymptomatic in more than 75% of cases, with longer term infections increasing the risk for complications. Screening and treatment are both easy, inexpensive and well tolerated. (NCQA HEDIS® Measures and Technical Resources – Chlamydia Screening in Women)

iii. Well-Child Visits in the first 15-30 months of life (Family Practice: *Monitoring* & Pediatrics: **Active**) – Members who turned 15 months and 1 day - 30 months old during the MY and had two or more well child visits. This measure will be separate from the W15. According to the American Academy of Pediatrics (AAP), well-child visits at 18 and 24 months are important because they allow for developmental and behavioral screening, including specific autism-spectrum disorder (ASD) screening. These visits also support timely vaccination, laboratory testing and opportunities for parents to ask questions, receive guidance, and support their child's healthy habits.

iv. Topical fluoride in Children (Family Practice & Pediatrics: *Monitoring*) – Age range will mirror HEDIS, 1-4yo, with a minimum of 2 applications per MY. This will be a 2025 monitoring measure for Family Medicine & Pediatrics. Topical fluoride varnish (TFV) application is recognized as one of the most effective strategies for preventing dental caries and improvement of oral health in all children (8). In addition to prevention, TFV has the potential to re-mineralize existing caries and halt the progression from caries to cavities. According to the CDC, the prevalence of untreated cavities (tooth decay) in the primary teeth of children (aged 2 to 5) from low-income households is about three times higher than that of children from higher income households. Young children are seen in primary care settings earlier and more frequently than in dental offices, making well child visits an ideal opportunity for early detection of caries and varnish application.

v. Reduction of Inequity Adjustment – Participation is optional. Partnership HealthPlan of California (PHC) is actively engaged in HE initiatives that bring equitable awareness and result in improved quality performance within the 24 counties we serve. We highly encourage provider organizations to partner with us in these efforts and together, we can help move our communities toward equitable access to healthcare. In reviewing the performance of our clinical measures, we recognize there are underlying disparities among our member populations based on location, access and Social Determinants of Health (SDOH). To help our provider organizations with identifying and addressing disparities in their member populations, we have created the Disparity Analysis dashboard housed within eReports which promotes the identification of disparities across all PCP QIP clinical measures based on race/ethnicity groups. This new clinical measure will incentivizing participating sites with set dollar amount if they improve performance in a specific priority group within an identified measure of focus (Child and Adolescent Well Care Visits being the main focus, followed by Childhood Immunization Status Combo 10, Immunization in Adolescents, Breast Cancer Screening & Colorectal Cancer Screening). The sites selected priority group must be performing below the 25th percentile in a particular measure of focus with the goal to improve performance by at least 20% or reaching the 50th percentile at the end of the measurement year.

vi. Follow-up within 7 days after Hospital Discharge (Family Practice & Internal Medicine) – A readmission occurs when a patient is discharged from a hospital and then admitted back into a hospital within a short period of time. A high rate of patient readmissions may indicate inadequate quality of care in the hospital and/or a lack of appropriate post-discharge planning and care coordination. Unplanned readmissions are associated with increased mortality and higher health care costs. They can be prevented by standardizing and improving coordination of care after discharge and increasing support for patient self-management (Plan All-Cause Readmission, n.d). Inclusion of this measure and benchmark determination is supported in alignment with external healthcare measurement entities, including NQF Plan All-Cause Readmissions (#1768). A follow up with a hospitalist, a primary care clinician or a specialist within a week after discharge from the hospital can help reduce readmissions back to the hospital. While this can be a struggle, a good strategy to attain this goal is to have a proper discharge summary which can be communicated with the follow-up provider.

II. Descriptions of Potential 2025 Measure Changes for Unit of Service Measurement Set

A. Change(s) to Existing Measures – Unit of Service

i. Peer Led and Pediatric Group Visits – Expanding the qualifying pediatric well child group visit from exclusively Well-Child Visits in the First 15 Months to both Well-Child Visits in the First 15 Months and Well-Child Visits in the First 15-30 months of Life

ii. Retired Dental Fluoride Varnish Use – In comparing Partnership's reporting to the State's DentiCal reporting, we have identified large gaps of discrepancies between the data. These discrepancies are not an accurate reflection of the services provided to the PCPs assigned patients and their overall performance. This is an opportunity for Partnership to continue to work with the State in ensuring we are receiving the most appropriate dental varnish application data for our members.

B. Potential Additions as New Measures – Unit of Service

i. Academic Detailing - Medication management is an important component of disease state management, such as diabetes, hypertension, and asthma. Effective medication management requires the clinician and care team to have complete, accurate, and current data on pharmacy claims. PHC Pharmacy Academic Detailing partners clinicians with the PHC clinical staff to provide a review of actionable pharmacy claims data to address gaps in care such as medication non-adherence, suboptimal asthma medication therapy, and gap in statin therapy for people with diabetes and/or cardiovascular disease. Pharmacy academic detailing helps clinicians improve medication management, improve quality measure performance, and achieve better clinical outcomes for their patients. The purpose of this new unit of service measure is to incentivize provider organizations for hosting a two-part academic detailing meeting with PHC Pharmacy Team/Medical Director.

Palliative Care Quality Incentive Program
Summary of Proposed 2025 Measures

Key:

New Measure | Change to Measure Design

2024 Measures	2025 Recommendations
Utilization	
1. Avoiding Hospitalization & Emergency Room Visits • $240 PMPM if no inpatient or ED use per calendar month	**1. Avoiding Hospitalization & Emergency Room Visits** • $240 PMPM if no inpatient or ED use per calendar month *CHANGE:* *No recommended changes*
Quality	
2. Completion of POLST & Use of Palliative Care Quality Collaborative (PCQC) Tool • $120 PMPM once a signed POLST is documented in PCQC	**2. Completion of POLST & Use of Palliative Care Quality Collaborative (PCQC) Tool** • $120 PMPM once a signed POLST is documented in PCQC
3. Completion of Standardized PCQC Assessments & Use of Palliative Care Collaborative (PCQC) Tool • $120 PMPM if two (2) standardized PCQC assessments are documented in PCQC, with all essential data elements included. Thresholds: • ≥ 85% of data elements entered on assessments = Full points ($120 PMPM) • 70-84.9% of data elements entered on assessments = Partial points ($60 PMPM)	**3. Completion of Standardized PCQC Assessments & Use of Palliative Care Collaborative (PCQC) Tool** • $120 PMPM if two (2) standardized PCQC assessments are documented in PCQC, with all essential data elements included. Thresholds: • ≥ 85% of data elements entered on assessments = Full points ($120 PMPM) • 70-84.9% of data elements entered on assessments = Partial points ($60 PMPM) *CHANGE:* *No recommended changes*

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPQP1008 (previously QP100108 & KK QI201)			**Lead Department: Health Services**	
Policy/Procedure Title: Conflict of Interest Policy for QI Activities			☒ **External Policy** ☐ **Internal Policy**	
Original Date: 04/25/1994		**Next Review Date:** ~~11/08/2024~~11/13/2025 **Last Review Date:** ~~11/08/2023~~11/13/2024		
Applies to:	☒ **Medi-Cal**		☐ **Employees**	
Reviewing Entities:	☒ **IQI**	☐ **P & T**	☒ **QUAC**	
	☐ **OPERATIONS**	☐ **EXECUTIVE**	☐ **COMPLIANCE**	☐ **DEPARTMENT**
Approving Entities:	☐ **BOARD**	☐ **COMPLIANCE**	☐ **FINANCE**	☒ **PAC**
	☐ **CEO** ☐ **COO**	☐ **CREDENTIALING**	☐ **DEPT. DIRECTOR/OFFICER**	
Approval Signature: *Robert Moore, MD, MPH, MBA*			**Approval Date:** ~~11/08/2023~~11/13/2024	

I. RELATED POLICIES:
- A. CMP10 – Confidentiality
- B. MPQP1053 – Peer Review Committee
- C. MPQP1002 – Quality/Utilization Advisory Committee
- D. MPCR200 Credentialing Committee and CMO Credentialing Program Responsibilities

II. IMPACTED DEPTS:
Health Services

III. DEFINITIONS:
N/A

IV. ATTACHMENTS:
A. Conflict of Interest Agreement

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

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

VII. REFERENCES:
N/A

Policy/Procedure Number: MPQP1008 (previously QP100108)		**Lead Department: Health Services**
Policy/Procedure Title: Conflict of Interest Policy for QI Activities		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994	**Next Review Date:** ~~11/08/2024~~11/13/2025 **Last Review Date:** ~~11/08/2023~~11/13/2024	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

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

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

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

PARTNERSHIP HEALTHPLAN of CALIFORNIA

CONFLICT of INTEREST AGREEMENT

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

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

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

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

_____
SIGNATURE

_____
PRINTED NAME

_____
DATE

_____ _____
WITNESS DATE

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCUG3032 (previously UG100332)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Orthotic and Prosthetic Appliances Guidelines</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 02/21/1995</td><td colspan="4">Next Review Date: ~~11/08/2024~~11/13/2025
Last Review Date: ~~11/08/2023~~11/13/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
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<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/08/2023~~11/13/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3013 – Durable Medical Equipment (DME) Authorization

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

VI. GUIDELINE / PROCEDURE:

A. Partnership HealthPlan of California (PHC) covers orthotic and prosthetic appliances when such appliances are necessary for the restoration of function or replacement of body parts, as prescribed in writing by a physician, a podiatrist or a non-physician medical practitioner functioning within the scope of their license. PHC utilizes Medi-Cal and InterQual® criteria to determine medical necessity for authorizations of orthotic and prosthetic devices. External independent consultants may be utilized on a case-by-case basis. Exceptions to these guidelines may be made based on the individual needs of the member or the unique characteristics of the delivery system.
B. The definition of medical necessity is health care services that are necessary to prevent significant illness or significant disability, or to alleviate severe pain. Therefore, prescribed appliances will be covered only as medically necessary to restore bodily functions essential to activities of daily living, to prevent significant disability or serious deterioration of health, or to alleviate severe pain. The prescribing physician or podiatrist must supply the vendor with information required to document the medical necessity for the item.
C. A Treatment Authorization Request (TAR) is required when the cost for repair/maintenance, purchase or rental exceeds $250 for orthotics or $500 for prosthetics.

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

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

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

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

H. Custom Foot Orthotics
   1. Orthotics are covered when medically necessary for the following acute or chronic foot conditions:
      a. Rehabilitative foot orthotics following foot surgery or trauma
      b. Plantar fasciitis
      c. Inflammatory conditions such as bursitis of the foot, tenosynovitis, plantar fascial fibromatosis
      d. Neurologically impaired feet
      e. Vascular conditions of the foot including poor circulation or peripheral vascular disease
      f. Musculoskeletal deformities such as bunions, hallux valgus, talipes deformities, toe deformities
   2. Foot orthotics are not medically necessary and are not covered for the following conditions:
      a. Back pain
      b. Knee pain
      c. Pes planus (flat feet)

d. Pronation
e. Corns or calluses
f. Hip osteoarthritis
g. Lower leg injuries

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

VII. REFERENCES:
A. Medi-Cal Provider Manual/ Guidelines: Orthotic and Prosthetic Appliances and Services *(ortho)*
B. InterQual® Durable Medical Equipment Criteria
C. Title 22 California Code of Regulations (CCR) 51315 and 51315.1

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

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

X. REVISION DATES: 06/1/00; 09/20/00; 12/19/01; 11/20/02; 09/15/04; 10/19/05; 08/20/08; 11/18/09; 05/18/11; 02/20/13; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 11/13/19; 10/14/20; 10/13/21; 10/12/22; 11/08/23; 11/13/24

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

PREVIOUSLY APPLIED TO: N/A

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCUP3020 (previously UP100320)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Hospice Services</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 12/12/1995</td><td colspan="4">Next Review Date: ~~11/08/2024~~11/13/2025
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<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~11/08/2023~~11/13/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
B. MCUP3039 - Direct Members
~~B.~~C. MCUP3137 - Palliative Care: Intensive Program (Adult)
~~C.~~D. MCUP3140 - Palliative Care: Pediatric Program for Members Under the Age of 21

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

Terminal Illness: A condition caused by injury, disease, or illness from which, to a reasonable degree of certainty, there can be no restoration of health, and which, absent artificial life-prolonging procedures, will inevitably lead to natural death.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

The purpose of the guideline is to delineate the requirements for authorization of hospice services and the reimbursement mechanisms for this service.

VI. POLICY / PROCEDURE:

A. Criteria for Admission to a Hospice Program
   1. A patient will be admitted to the hospice program when the following conditions are met:
      a. The patient has a limited life expectancy of 6 months or less, if the terminal illness follows its normal course. The patient's physician or the hospice medical director must certify that the ~~member~~Member has a terminal illness by providing specific clinical findings or other documentation to support a life expectancy of 6 months or less.
      b. Cure of the disease process is no longer the goal of treatment. (For specific pediatric hospice guidelines, please see VI.B.3. below.)
      c. The primary goal for the patient is to focus on comfort, pain control, and emotional, spiritual, and psychological support.
      d. It is appropriate to direct treatment to improve the quality of the remaining days for the patient and family.

e. It is agreed by doctor and patient and/or family that advanced technology is used solely for the purpose of sparing the patient discomfort or limitations they would otherwise suffer.
f. The patient, family, and physician are all willing to participate in the program with the understanding that withdrawal is possible at any time.

2. Election of hospice care occurs when the ~~member~~Member (or guardian) voluntarily completes and signs the Hospice Election Form and selects a hospice provider. Signing this form indicates ~~that~~ the ~~member~~Member's understanding that hospice care is intended to alleviate pain and suffering, rather than to cure the disease, and that certain benefits are waived by election of this service.
~~g.~~a. A member who lives in an area remote from Medi-Cal Hospice providers may be cared for under the intensive palliative care benefit at a higher reimbursement rate as described in policy MCUP3137 Palliative Care: Intensive Program (Adult).

B. Hospice Benefit
1. Members who elect hospice become case managed Direct Members. When the Partnership HealthPlan of California (~~PHC~~Partnership) Claims Department receives the first claim for hospice related services from the hospice provider, the claim will be routed to the Health Services/Utilization Management Team. The Utilization Management (UM) Designee will contact the hospice provider to obtain a copy of the hospice election form signed by the ~~member~~Member or legal representative. The status change effective date is the date the hospice election form was signed by the ~~member~~Member or legal representative.
2. All services related to the terminal illness must then be provided or authorized by the hospice provider. Services not related to the terminal illness are the responsibility of ~~PHC~~Partnership. The ~~member~~Member can continue to obtain services that are unrelated to the terminal illness from any Medi-Cal provider subject to ~~PHC~~Partnership's Treatment Authorization Request (TAR) processes. (Refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process for a list of services that require a TAR.)
3. A ~~member~~Member under 21 years of age may be eligible for hospice services concurrently with curative care under the Patient Protection and Affordable Care Act (ACA) Section 2302, as detailed in CMS Letter #10-018.
4. The following services are billable by the hospice agency, however only one service may be billed for each day:
   a. Routine Home Care (code Q5001) is provided in the ~~member~~Member's home but it is not continuous home care. Payment is made on an all-inclusive per diem basis without regard to the volume or intensity of routine home care provided on any given day.
   b. Continuous Home Care (code Q5009) consists of continuous, predominately skilled nursing care provided on an hourly basis, for a minimum of eight hours only during a brief crisis period. Any ~~member~~Member of the hospice team may provide these services, including home health aide and homemaker services. The hospice provider is responsible for determining the medical necessity for this type of care and will bill the hourly continuous home care rate for each hour of the service.
   c. Respite Care (code Q5006) occurs when the ~~member~~Member receives care in an approved Long Term Care (LTC) facility on a short-term basis to provide relief for family ~~member~~Members or others caring for the individual. The hospice provider is responsible for determining the medical necessity for this type of care. Each episode is limited to no more than 5 days. The hospice provider will pay the LTC per diem rate as agreed upon in the LTC/hospice contract.
   d. Inpatient Care (code Q5005) related to the terminal illness for pain control or acute/symptom management that cannot be managed in other settings. Acute inpatient hospital services are subject to approval by the hospice provider. The hospice provider pays the acute, subacute or LTC facility and then bills ~~PHC~~Partnership for inpatient care related to the terminal illness code (Q5005). The hospice provider pays the hospital or subacute facility per diem at the rate agreed

upon in the hospital/hospice contract. While the ~~member~~Member is in the inpatient facility, the Hospice is responsible for payment to the LTC facility for a bed hold day for up to 7 days (if included in the Hospice/LTC contract) and will bill Code 658 to ~~PHC~~Partnership for a ~~member~~Member who resides in a Skilled Nursing Facility (SNF) or an Intermediate Care Facility (ICF). If responsibility for payment of bed hold days is not included in the Hospice/LTC facility contract, the LTC facility will not be able to obtain payment for the bed hold.

e. If the ~~member~~Member chooses to revoke his/her hospice enrollment and the ~~member~~Member remains in a LTC facility, it is the responsibility of the facility to obtain a new TAR from ~~PHC~~Partnership for these services.

f. Physician services for the ~~member~~Member are coordinated between the attending physician, the hospice team, and the hospice medical director as indicated. The attending physician bills ~~PHC~~Partnership using the regular Medi-Cal codes. The hospice physician fees are included in the hospice per diem rate. If specialist consultation is necessary to evaluate a complication related to the terminal condition, the specialist physician bills the hospice and the hospice should bill ~~PHC~~Partnership using code Q5010.

5. The following services are part of the hospice benefit and separate payment is not made. The hospice provider is responsible for having contracts with the appropriate providers and for paying the rate agreed upon in the contract for the service. Payment for these services comes out of the hospice per diem. The hospice provider must authorize all of the services related to care of the terminal illness.
   a. Nursing services
   b. Medical social services
   c. Hospice physician services
   d. Counseling services
   e. Home health aide and attendant care services
   f. Medical supplies and durable medical equipment
   g. Physical, occupational, and speech therapy
   h. Medications and infusion therapy (based on the Hospice Formulary)
   i. Nutritionist services
   j. Respite care at a SNF
   k. In-patient care at hospital or subacute facility
   l. Medical transportation

C. Treatment Authorization Request
1. A ~~PHC~~Partnership TAR is not required for the following services;
   a. Routine home care
   b. Continuous home care
   c. Respite Care
   d. Hospice Care room and board provided in a SNF or Intermediate Care Facility (ICF)
2. If a ~~member~~Member currently resides in an Independent Care Facility-Developmentally Disabled (ICF-DD) facility or is admitted to an ICF-DD facility, ~~PHC~~Partnership continues to be financially responsible for the ICF-DD per diem payment.
3. Non-emergency inpatient care related to the terminal illness requires preauthorization by ~~PHC~~Partnership. The Hospice provider must submit a TAR using inpatient code (Q5005) and attach a copy of the Hospice Inpatient Information Form.
4. Emergency admission related to the terminal illness is reviewed for medical necessity by the UM nurse and if appropriate, a length of stay assigned. ~~PHC~~Partnership must be notified within 24 hours of any emergency admission related to the terminal illness. The hospice provider must submit a TAR using inpatient code (Q5005) and attach a copy of the Hospice Inpatient Information Form.

5. The hospice provider is financially responsible for emergency room services related to complications of the terminal illness if the Hospice provider authorized the service.
6. ~~PHC~~Partnership continues to authorize and be financially responsible for outpatient, inpatient and emergency medical services not related to the terminal illness.
7. For ~~member~~Members with Medicare/Medi-Cal coverage, Medicare is the first payer for the hospice daily care. Medi-Cal (~~PHC~~Partnership) is financially responsible for medications not related to the hospice diagnosis[1] and the room and board per diem if the ~~member~~Member resides in a LTC facility (bed code 658 for SNF or ICF). The claim must include a copy of the Medicare Explanation of Medical Benefits (EOMB) that shows that Medicare payment was made for hospice services during the period covered.
8. For ~~member~~Members with other coverage, Medi-Cal is the secondary payer and the hospice must submit a copy of the Explanation of Benefits (EOB) from the other insurer when billing Medi-Cal.

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

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

F. Revocation of Hospice Care Services
1. An individual's voluntary election may be revoked or modified at any time during an election period. To revoke the election of hospice care, the individual or individual's representative must file a signed statement with the hospice agency revoking the individual election for the remainder of the election period. The effective date may not be retroactive. At any time after revocation, an individual may execute a new election for any remaining election period. An individual or representative may change the designation of a hospice provider once each election period; this is not a revocation of the hospice benefit.

VII. REFERENCES:

A. Medi-Cal Guidelines - Hospice Care (*hospic*)
B. Title 22, California Code of Regulations (CCR) / Hospice Care 51349

[1] Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy (prescription) benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 *Revised*, "Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx," and all medications (Rx and OTC) which are ~~provided by~~dispensed from ~~a~~ pharmacies and covered under Medi-Cal Rx~~y~~ must be billed to the State Medi-Cal/~~Magellan~~ DHCS-contracted pharmacy administrator instead of ~~PHC~~Partnership. Refer to the ~~PHC~~ Partnership website page for pharmacy authorization criteria: http://www.partnershiphp.org/Providers/Pharmacy/Pages/Formularies.aspx

C. Title 22, CCR ICF Sections 51118, 51120 and 51510; SNF 51121, 51123, 51124, 51215, 51511
D. Title 42 Code of Federal Regulations (CFR) Sections 418.28 and 418.30
E. Social Security Act 1812(d)(1)
F. Section 2302 of the Patient Protection and Affordable Care Act (ACA)
G. Department of Health Care Services (DHCS) All Plan Letter (APL) 18-020 Palliative Care (12/07/2018)
H. Centers for Medicare and Medicaid Services (CMS) Letter 10-018 Hospice Care for Children in Medicaid and CHIP (09/09/2010)

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

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

X. REVISION DATES: 06/21/00; 11/28/01; 01/15/03; 02/01/03 vs. code changes; 09/15/04; 09/21/05; 08/20/08; 04/21/10; 03/20/13 – effective 04/01/13; 03/18/15; 03/16/16; 03/15/17; 06/21/17; *09/12/18; 08/14/19; 08/12/20; 01/13/21; 11/10/21; 11/09/22; 11/08/23; 11/13/24

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

PREVIOUSLY APPLIED TO: N/A

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- If used as the basis of a decision to modify, delay or deny services in a specific case, the criteria will be disclosed to the provider and/or enrollee upon request

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MPUP3116</td><td colspan="4">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: Positron Emission Tomography Scans (PET Scans)</td><td colspan="4">☒ External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 09/19/2012
Effective 01/01/2013</td><td colspan="5">Next Review Date: ~~11/08/2024~~11/13/2025
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</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3037 - Appeals of Utilization Management/Pharmacy Decisions

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Medical Necessity - Medical Necessity means reasonable and necessary services to protect life, to prevent significant illness or significant disability, or to alleviate severe pain through the diagnosis or treatment of disease, illness or injury.
B. Standard of Care – The level and type of care that a reasonably competent and skilled health care professional, with a similar background and in the same medical community, would provide under the same circumstances.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To adopt evidence based criteria from the National Comprehensive Cancer Network (NCCN) for use in evaluating the medical necessity of positron emission tomography (PET) scans for ~~member~~Members diagnosed with a malignancy. This policy will also address the use of PET Scans in other areas besides oncology.

VI. POLICY / PROCEDURE:

A. Treatment Authorization Requests (TARs) for PET scans for those ~~member~~Members diagnosed with cancer or being evaluated for possible diagnosis of cancer are reviewed using the current guidelines from the National Comprehensive Cancer Network which may be found on these webpages: https://www.nccn.org/professionals/physician_gls/default.aspx or https://www.NCCN.org/professionals/imaging/content
If the clinical situation is not covered in NCCN, InterQual® Positron Emission Tomography (PET) Whole Body is a reliable resource.
1. Requests for PET Scans related to cancer can be approved by Utilization Management Nurse Coordinators without referral to the Chief Medical Officer or Physician Designee for further

evaluation in the following circumstances:

a. The request is part of the initial work up for a malignancy and there has been a biopsy that is positive for a malignancy. This is part of the initial staging for a malignancy.
b. The request is part of a re-staging of a malignancy following treatment such as chemotherapy or radiation therapy or post-operative after resection of a tumor. There must be a minimum of three months between PET Scans and there must have been active treatment during that time.
c. The request is part of a routine screening for a malignancy following treatment. There must have been at least six months of time elapsed since the end of treatment.
d. Requests for PET Scans that do not fit these criteria will be referred to the Chief Medical Officer/Physician Designee for review.

B. PET Scan authorization requests for clinical problems other than malignancies will be reviewed on a case by case basis by the ~~PHC~~Partnership Chief Medical Officer or Physician Designee.
   1. Decisions about appropriate use of PET Scans will be based on existing Standard of Care and/or reasonableness of the procedure for advancing the diagnosis and treatment of a clinical problem. Standard of Care can be developed using policies from other healthcare providers and consultation with experts in the field as well as review of current and relevant medical literature and on-line references including UpToDate.
   2. Review decisions will be based on the definition of Medical Necessity.

C. For any request, denials for medical necessity will only be made by a physician. All medical necessity denials are subject to ~~PHC~~Partnership's appeal process.

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

VII. REFERENCES:

A. National Comprehensive Cancer Network (NCCN) criteria
B. InterQual® Criteria
C. Medi-Cal Provider Manual/Guidelines
~~C.~~D. UpToDate: (*Topic specific to the disease process being evaluated)*

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors
B. ~~PHC~~Partnership Provider Manual

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

X. REVISION DATES:

Medi-Cal
01/20/16; 11/11/16; 11/15/17; *02/13/19; 02/12/20; 01/13/21; 01/12/22; 11/09/22; 11/08/23; 11/13/24

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

PREVIOUSLY APPLIED TO:

Healthy Kids MPUP3116 (Healthy Kids program ended 12/01/2016)
01/20/16; 11/11/16 to 12/01/2016

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

Policy/Procedure Number: MPUP3116		Lead Department: Health Services
Policy/Procedure Title: Positron Emission Tomography Scans (PET Scans)		☒ **External Policy** ☐ **Internal Policy**
Original Date: 09/19/2012 Effective 01/01/2013	**Next Review Date: 11/08/202411/13/2025** **Last Review Date: 11/08/202311/13/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

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

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

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

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: CGA022</td><td colspan="2">Lead Department: Administration</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Member Discrimination Grievance Procedure</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 11/08/2016</td><td colspan="3">Next Review Date: ~~01/10/2025~~11/13/2025
Last Review Date: ~~01/10/2024~~ 11/13/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td></td><td colspan="2">☒ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☒ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☒ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: ~~Sonja Bjork, CEO~~ ~~Katherine Barresi, RN, Chief Health Services Officer and Acting Chief Executive Officer~~Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~01/10/2024~~11/13/2024</td></tr>
</table>

I. RELATED POLICIES:

A. CGA024 Medi-Cal Member Grievance System
B. CMP10 Confidentiality
C. CMP13 Permitted Use, Disclosure, and Minimum Necessary Use of Member Information
D. CMP15 Amendment of Member's Protected Health Information
E. MC305 Distribution of Member Rights and Responsibilities
~~E.~~F. MCNP9004 Regulatory Required Notices and Taglines
~~F.~~G. MP316 Provider Request to Discharge Member & Assistance with Inappropriate Member Behavior
~~G.~~H. MPPR200 PHC Provider Contracts
~~H.~~I. MPQP1053 Peer Review Committee

II. IMPACTED DEPTS:

A. All Departments

III. DEFINITIONS:

A. Adverse Benefit Determination: is generally a benefit that has been denied, limited, or stopped. This also includes not paying for covered benefits. The Department of Healthcare Services (DHCS) formally defines it as encompassing all previously existing elements of "Action" under federal regulations with the addition of language that clarifies the inclusion of determination involving medical necessity, appropriateness, setting, covered benefits, and/or financial liability which includes the following:
   1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, medical necessity, appropriateness, setting, or effectiveness of a covered benefit.
   2. The reduction, suspension, or termination of a previously authorized service.
   3. The denial, in whole or in part, of payment for a service.
   4. The failure to provide services in a timely manner.
   5. The failure to act within the required timeframes for standard resolution of Grievances and Appeals.

6. ~~For a resident of a rural area, t~~The denial of the Member's request to obtain services outside the network.
7. The denial of a Member's request to dispute financial liability.

B. Civil Rights Coordinator: is a specialized Grievance Case Analyst trained in Civil Rights Laws. This person is responsible for handling end-to-end investigations of all Member Discrimination Grievances. This person answers questions related to State and Federal Civil Rights Laws, including disability related questions, for Partnership HealthPlan of California (Partnership) staff and Members.

C. Civil Rights Laws: includes section 1557 of the Patient Protection and Affordable Care Act (ACA). Section 1557 incorporates and enforces other Federal civil rights laws such as Title VI of the Civil Rights Act of 1964, Title IX of the Education Amendments of 1972, Section 504 of the Rehabilitation Act of 1973, and the Age Discrimination Act of 1975. California State laws that protect Members from Discrimination include California Government Code Section 12926, California Government Code Section 11135, and California Penal Code 422.56.

D. Complaint: is the same as a Grievance.

E. Discrimination**:** is when a person is treated unfairly, differently, or unequally from others, because of the reasons described in the Civil Rights Laws definition.

F. Grievance: is generally a Complaint about the experience or services received while using your Partnership Medi- Cal plan. DHCS formally defines it as an expression of dissatisfaction about any matter that is not an Adverse Benefit Determination.

G. Member: is a person who is eligible for Medi-Cal and receives health care benefits through Partnership.

H. Provider: is a person, group, or facility that is licensed, accredited, or certified to treat or offer health care services to Partnership Members. Some examples are a physician, a hospital, lab, ambulance, skilled nursing facility, or pharmacy.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To ensure that all Members are aware of their ~~D~~discrimination rights, how to report a violation, and the investigation process.

VI. POLICY / PROCEDURE:

A. How Partnership Communicates Members' Rights

1. Partnership includes our notice of non-discrimination in the Partnership Member Handbook. The Partnership Member Handbook is available on our website 24 hours a day 7 days a week at www.partnershiphp.org. It is also available by calling Partnership Member Services department at 1-800-863-4155 (TTY: (800) 735- 2929 or 711).
2. Partnership expects our Members to be treated fairly and to treat their providers fairly. "Your ~~r~~Rights" and "~~responsibilities~~Your Responsibilities" are outlined in the Partnership Member Handbook. It is also explained in Partnership Policy MC305 titled Distribution of Member Rights and Responsibilities.

B. How Partnership Practices Non-Discrimination

1. Partnership follows all State and Federal Civil Rights Laws. Partnership does not discriminate, exclude people, or treat them differently because of any reasons below.
   a. *Disability* – a person with a physical or mental problem that limits major life activities. Some examples are seeing, hearing, and sleeping.

b. *Basis of Sex* – a person's gender identity and sex stereotypes. It also includes a person who is or has a medical condition related to pregnancy, false pregnancy, abortion, or childbirth.
c. *Gender* – a person who is male, female, neither, or both.
d. *Gender Identity* – a person's belief about their gender. This could be different from a person's gender assigned at birth.
e. *Gender Expression* – a person's appearance and behavior, whether or not it is commonly accepted according to the gender they were born with.
f. *Sex Stereotypes* – a person who represents or communicates their masculinity or femininity in uncommon ways.
g. *Sexual Orientation* – a person who is heterosexual, homosexual, or bisexual.
h. *Nationality* – where a person is born, their citizenship, cultural, or language characteristics.
i. *Race or Ethnicity* – a person's ancestry, color, or ethnic background.
j. *Religion* – a person's religious belief, practice, or things observed.
k. *Language Assistance Services* – interpretation services that help people with a Limited English Proficiency communicate in English.
l. *Limited English Proficiency* – a person whose first language is not English and has trouble reading, writing, speaking, or understanding English.
m. *Group or Character Association* – a person who identifies with or is associated with a specific group or club. The person or group has characteristics protected under Disability, Gender, Nationality, Race, Ethnicity, Religion, or Sexual Orientation.
n. *Auxiliary Aids & Services* – services used by a person who is deaf, blind, hard of hearing or seeing to help them communicate. These services include sign language, text telephones, or other such devices to get information. This also includes any effective method to improve reading such as large print.
o. *Age* – a person because of how old they are.
p. *Genetic Information* – a person or family members requesting genetic tests, receiving genetic tests, or joining a clinical research about genetic tests. This also includes symptoms of a disease or disorder in a family member.

2. Partnership investigates all allegation(s) of ~~D~~discrimination because Members should not have unlawful barriers to healthcare while using their Partnership Medi-Cal benefits.
3. Partnership Members have the right to receive healthcare services through Partnership Medi-Cal plan free from ~~D~~discrimination.
   a. A Member should not be denied any covered services or availability of a service because of a reason defined in Section VI.B.1, except where medically indicated.
   b. A Member should not be provided any covered service differently from another Member because of a reason defined in Section VI.B.1, except where medically indicated.
   c. A Member should not be separated from others or subjected to a different treatment in order to receive any covered service because of a reason defined in Section VI.B.1., except where medically indicated.
   d. A Member should not be restricted in receiving any covered service because of a reason defined in Section VI.B.1, except where medically indicated.
   e. A Member should not be treated differently from others to determine whether they satisfy any requirement or condition to be provided any covered service because of a reason defined in Section VI.B.1, except where medically indicated.

f. A Member should not be assigned a time or place to receive covered services because they have characteristics associated with any reason defined in Section VI.B.1., except where medically indicated.

g. A Member should not be discriminated against because of their health status during enrollment, re-enrollment, disenrollment, or termination

4. It is against the law for Partnership to retaliate against any person who files a Grievance or participates in the investigation of a Grievance.

C. What a Member Should Do If Discrimination Occurs

1. As a Member, you will file a Grievance if you believe Partnership or a provider discriminated against you.
2. As a Member, you will file a Grievance if you believe Partnership or a provider did not treat you fairly.
3. As a Member, you will file a Grievance by phone, writing, online, or in person.
   a. *Phone* – Call Partnership Member Services at 1-800-863-4155. TTY/TDD 1-800-735-2929 or 711.
   b. *Writing* – Write and mail a letter to:
      Partnership HealthPlan of California
      ATTN: Grievance & Appeals Department
      4665 Business Center Drive
      Fairfield, CA 94534
   c. *Online* – Visit Grievance & Appeals section under Members at www.partnershiphp.org
   d. *In person* – Visit your doctor's office or a Partnership local office. Say you want to file a Grievance.
4. Your Grievance must describe how you were discriminated against, the result of the ~~D~~discrimination, and how you want it fixed.
5. As a Member, you have the right to submit any evidence.
6. As a Member, you will support the Grievance process by sharing your experience with the Civil Rights Coordinator. You will be available for any questions.
7. As a Member, you have the right to pursue other legal or administration remedies, while filing a Discrimination Grievance with Partnership. This includes filing a Grievance with the U.S. Department of Health and Human Services, Office for Civil Rights.

   Office for Civil Rights
   U.S. Department of Health and Human Services
   200 Independence Avenue, SW
   Washington, DC 20201

   1-800-368-1019
   TDD Toll-Free: 1-800-537-7697
   Email: 1557@hhs.gov
   Website: www.hhs.gov/ocr

8. Any person filing a Discrimination Grievance on behalf of a Member
   a. Any person who believes a Partnership Member has been subjected to ~~D~~discrimination may file a Grievance. Per Partnership Policy CMP15 titled Amendment of Member's Protected Health

Information, Partnership will ask the Member for their authorization in order to begin the investigation.

b. Partnership has the right to open a Grievance on the Member's behalf if we suspect ~~D~~discrimination has occurred.

c. A Member has the right to withdraw their Grievance case.

d. If the case is withdrawn, Partnership reserves the right to continue the investigation. This may occur if Partnership decides the allegation(s) is dangerous, grossly inappropriate, threatening, or unlawful.

D. Understanding the Investigation Process

1. Free assistance with communication
   a. Partnership offers free aids and services to a person with a disability to help them communicate better so they can participate in the Grievance process.
   b. Partnership offers free language services to a person whose primary language is not English so they can participate in the Grievance process.
2. Safeguarding your information
   a. Partnership will monitor the confidentiality of all files and records. Our practice is defined in Partnership Policy CMP10 titled Confidentiality.
   b. Partnership will share information only with those who have a need to know during the investigation process. Our practice follows the requirements identified in Partnership Policy CMP13 titled Permitted Use, Disclosure, and Minimum Necessary Use of Member Information.
3. The investigation process for alleged Discrimination
   a. Discrimination Grievances follow the investigation process defined in Partnership Policy CGA024 titled Medi-Cal Member Grievance System, with a few additional steps.
   b. All Discrimination Grievances are assigned a Civil Rights Coordinator who oversees the investigation of the case.
   c. The Civil Rights Coordinator will assess the allegation(s) to determine if the Member's Rights and Responsibilities were violated, as defined in the Partnership Member Handbook. If the investigation finds the Member was unfairly treated, the offending party will be educated on Partnership Member's Rights and Responsibilities. Furthermore, Partnership will request the supervisor of the employee be notified of the G~~g~~rievance and take appropriate corrective action, in accordance with that organization's human resources policy.
   d. The Civil Rights Coordinator will further assess the allegation(s) to determine if it falls under any category identified in Section VI.B.1. If so, the case will be referred to ~~-~~Partnership's Health Equity department ~~ducation, Cultural & Linguistic (HEC&L) unit~~ to review the case ~~evidence~~ details and offer an additional opinion if ~~D~~discrimination was likely or unlikely. The Civil Rights Coordinator will review ~~HEC&L's~~the Health Equity department's perspective and if their determination differs, the case will be escalated to a three-person panel for review and determination. To comply with All Plan Letter (APL) 21-004, the Civil Rights Coordinator will forward the following information to DHCS within 10 calendar days of mailing the Notice of Resolution Letter:
      i The Civil Rights Coordinator's contact information
      ii The contact information of the Member
      iii The problem as stated by the member or authorized representative
      iv The accused party's response to the Grievance and their contact information
      v All correspondence to and from the member, including the final Notice of Resolution Letter
      vi Copies of any corrective action plan(s) taken in response to the Grievance

e. The Member will receive a Notice of Resolution Letter describing the results of the investigation. It will include additional information about their rights to pursue further administrative or legal solutions. In the event the Member is dissatisfied with Partnership's outcome of the ~~D~~discrimination Grievance, the Member can ask for a Second Level Grievance. A different Civil Rights Coordinator, who was not involved in the original decision, will reinvestigate the case. A new decision will be made and communicated to the Member in a second Notice of Resolution Letter.

f. In the event that Partnership determined that discrimination likely occurred, the Civil Rights Coordinator will send a letter to the provider. This letter will inform the provider that a member has alleged ~~D~~discrimination against them, with a brief explanation of the category of ~~D~~discrimination. The letter also offers support to the provider by supplying information on trainings to improve interactions with patients to avoid similar incidents in the future. The G&A department tracks discrimination allegations against our providers. In the event a provider receives a second discrimination allegation within a rolling three-year period, the Civil Rights Coordinator will send an additional letter to the provider, including follow-up training requirements. Additionally, the G&A department will notify the Credentialing team upon confirmation of the second incident.

g. Allegations of ~~D~~discrimination against any Partnership provider are subject to review by Partnership's Peer Review Committee. Information about this committee can found in Partnership Policy MPQP1053 titled Peer Review Committee.

VII. REFERENCES:

A. 45 CFR 92 et. seq.,(Section 1557 of ACA):
B. California Government Code Section 12926 (sex, gender expression);
C. California Government Code Section 11135 (sex, race, color, disability, national origin, age);
D. California Penal Code Section 422.56;
E. 42 U.S.C. § 2000d et seq., Title VI of the Civil Rights Act of 1964 (race, color, national origin);
F. 20 U.S.C. § 1681 et seq., Title IX of the Education Amendments of 1972 (sex);
G. 42 U.S.C. § 6101 et seq., the Age Discrimination Act of 1975 (age);
H. 42 U.S>C. § 1211 et seq., Americans with Disabilities Act of 1990
I. 29 U.S.C. § 794, Section 504 and 508 of the Rehabilitation Act of 1973 (disability);
~~DHCS Contract 08-85215, Amendment 19, Attachment 2~~
J. DHCS Contract 22-20196

VIII. DISTRIBUTION:

A. www.partnershiphp.org
B. Partnership Provider Manual
C. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

Director, Grievance & Appeals

X. REVISION DATES:

03/14/18; 06/12/19; 10/14/20; 10/13/21; 01/11/24; 11/13/24

PREVIOUSLY APPLIED TO: N/A

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Oct. 16, 2024 Quality/Utilization Advisory Committee (Q/UAC) meeting. Please look over the changes to each and note any questions or comments you may have to help keep a progressive meeting agenda.

Policy Number & Name	**Page Number**	**Summary of Revisions** (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	**External Documentation** (Notice required outside of originating department)
Policy Owner: Care Coordination – *Lisa Brundage O'Connell, MHA, Director of Enhanced Health Services*			
MCCP2032 – CalAIM Enhanced Care Management (ECM)	79 - 109	**Related Policies.** Changed MPPR200 policy title to *Partnership* Provider Contracts. Added: MCCP2033 Community Health Worker (CHW) Services Benefit MCCP2034 Transitional Care Services (TCS) **Impacted Departments**: Added Enhanced Health Services **Definitions.** Added: • Closed Loop Referral • CHW, differentiating it from • CHW Services • Point-Click-Care. **Section VI.A.** Based on the Department of Health Care Services (DHCS) All Plan Letter (APL) 23-032, we made some additional edits to be in compliance. The adult individual experiencing homeless population of focus definition to include under other homeless deferral status. Re the Serious Mental Health/Substance Use Disorder Population, the policy was missing the original criteria of "Are experiencing at least one complex social factor influencing their health." **Section VI.B.** Justice Involved Initiative DHCS requirements added to prepare for the JI ECM population of focus and ECM JI provider requirements. **Section VI.C.** Adding Target Case Management (TCM) programs and CHW services benefit to ECM exclusion criteria. **Section VI.D.5.d.4):** Removed "palliative care" from the enhanced coordination of care section as it caused provider confusion. Palliative care is duplicative of ECM. **Section VI.D.6.a.** Changed "PHC's Care Coordination Department" to "Partnership's designated staff." **Section VI.D.7.** Adding new ECM referral and standards language based on the DHCS 2024 August ECM policy guide and ECM Referral Standards and Form Templates guidance. **Section VI.G.** Continuity of Care additions based on DHCS requirements that include if a pre-existing relationship has been established and the ECM provider is part of Partnership's ECM network or agrees to a LOA until an agreement is reached, Partnership will assign the member to their existing ECM provider to ensure the member's relationship is not disrupted. **Section VI.I.** Specific language added around ECM provider network development that covers DHCS requirements around collaborating with other MCPs, building a sufficient network, and achieving network overlap	Claims Configuration Compliance Enhanced Health Services Finance Grievance and Appeals Utilization Management Member Services Project Management Office Provider Relations

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Section VI.J.1.a.2)e)i. Model of Care for Justice Involved providers includes specific DHCS JI ECM provider requirements around a JI MOC with warm hand off plan, meeting with member within 1-2 days of release, ensuring a 2nd follow up ECM appointment happens within 1 week of release, and leverage of the re-entry plan for ECM care management planning. **References:** • Updated the ECM policy guide link, August 2024 https://www.dhcs.ca.gov/CalAIM/ECM/Documents/ECM-Policy-Guide.pdf • Added ECM Referral Standards and Form Templates link https://www.dhcs.ca.gov/CalAIM/Documents/ECM-Referral-Standards-and-Form-Templates.pdf	
Policy Owner: Population Health – *Hannah O'Leary, MHA, Manager of Population Health*			
MCND9002 – Cultural & Linguistic Program Description	*111 – 187 CLEAN policy copy begins on p. 165*	**Annual Update includes extensive revisions and has expanded to continue alignment with NCQA Health Equity requirements.** Added language: • As suggested by Partnership's NCQA consultant • Expanding references to Health Equity, including references to the Quality Improvement & Health Equity Transformation Program (QIHETP) • Detailing our current Language Data Collection processes and criteria for threshold languages, including how we collaborate around this with Local Health Jurisdictions (LJHs) • Expanding the Language Assistance Services section, including more info around where and how nondiscrimination notices and language assistance taglines are posted and distributed, and more details around the requirements we meet for translations, interpreters, and alternative formats • Detailing Partnership's commitment to its evidence-based DEI trainings and program • Detailing the Population Needs Assessment Committee and the Quality Improvement & Health Equity Committee (QIHEC), the latter which replaced the PHM&HE Committee, including recruiting criteria • Expanding the 2024-2025 Goals section, including a list of approving committees and per-goal descriptions from the C&L/QIHETP Work Plan New 2024 goal section: to provide at least 1 mailing in a member's preferred alternate format to 90% of members who have a standing request on file • Updating PHM position names and responsibility descriptions • Updated all diagrams • Added new hyperlinked references and footnotes	Grievance & Appeals Health Equity Member Services Pharmacy Utilization Management Communications Quality Improvement

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Updated Attachment F: FAC Charter • Updated with new expansion counties • Minor updates throughout (instances of PHC changed to "Partnership," etc.)	
Policy Owner: Health Equity – *Mohamed "Moe" Jalloh, Pharm.D, Director of Health Equity (Health Equity Officer)*			
MCED6001 – Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description	*189 – 228 CLEAN copy begins on p. 211*	• Updated the duty descriptions of the Medical Officer for Quality and the Director of Population Health Management. • Removed mentions of Population Health Management and Health Equity (PHMHE) Committee due to its dissolution and the concurrent creation of the Population Needs Assessment (PNA) Committee. ○ The Population Needs Assessment Committee (PNA) is an internal subcommittee of IQI and serves as a multi-departmental body whose goal is to support the advancement, growth, and execution of population health and health equity interventions at Partnership. The committee consists of Partnership staff representing member, community, regional, and provider-facing departments; it also incorporates representatives from Human Resources, Regulatory Affairs, IT, and Health Analytics. The committee meets every other month to align interdepartmental efforts promoting health equity through member and systemic interventions outlined in the relevant Needs Assessment (PNA) Action Plans. The PNA Committee activities and recommendations will be shared with IQI, Q/UAC, QIHEC, PAC, and Partnership's Board of Commissioners. • Updated the NCQA Accreditation Program Management section, noting the timeline to HEA implementation by Jan. 1, 2026. • Updated Data Sources section with "DHCS Bold Goals" that step out identification and evaluation of racial/ethnic disparities in well-child and immunization measures, maternity care for Black and Native American persons, and to improve maternal and adolescent depression screening and follow-up for mental health and substance use disorders to close gaps by 50%. • Revised how Pop Health, Grievance and Appeals, and Human Resources departments will collaborate with Health Equity. • Updated Annual Program Evaluation components to include Community Reinvestment Act recommendations, and regional Quality and Health Equity team compositions per Medi-Cal guidelines. • Updated title page date to PAC date and updated signature page with this year's dates and the current Board Chair's name	Health Equity Health Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Utilization Management – *Tony Hightower, CPhT, Associate Director, Utilization Management Regulations*			
MCUG3038 – Review Guidelines for Member Placement in Long Term Care (LTC) Facilities	229 - 238	This policy has been updated to include language for subacute care facilities as per DHCS 23-027: Subacute Care Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care. **Section I:** The new Provider Relations policy MPPRXX – Long Term Support Services Liaison has been added as a Related Policy. **Section III.E and F.:** The definition of Subacute Care Facilities was updated and the acronym SCU was defined as Subacute Contracting Unit. **Section VI.A.1.a. – c.** The three facility types discussed in this policy, SNF, Subacute, and ICF, were referred back to Section III. for full Definitions. **Section VI.A.5.b.** Added language to specify that "For members approved for subacute services, Partnership verifies those services are received from a provider that has a contract with the Department of Health Care Services' (DHCS') Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU." **Section VI.C.1.** Added language to specify that at TAR is required with each admission to a LTC Facility "In alignment with Manual of Criteria R-15-98E." **Section VI.C.2.g.** Added "SNF to Subacute" as a potential level of care scenario. **Section VI.E.1.** Replaced "LTC" with "SNF" for facility type that is discussed in this paragraph. **Section VI.E.2.** Added language to say that "Extensions of stay in subacute care facilities are reviewed in alignment with Manual of Criteria R-15-98E and require reauthorization by Partnership every two months. Prolonged care may be authorized for up to a maximum of four months. Extensions are based on the same criteria as initial authorizations. **Section VI.F.** Throughout this section, language was updated to cite the Continuity of Care requirements that were effective January 1, 2024 through June 30, 2024 for Members residing in a Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care. Previously, this section of the policy described a similar COC provision for Members transitioning for a SNF in 2023. At the end of section VI.F. we specify that automatic continuity of care does not apply after the specified time frames (ended 07/01/2023 for SNFs and 07/01/2024 for Subacute). Thereafter, Members newly enrolling with Partnership must request continuity of care following the process established by APL 23-022. **Section VI.H.4.** Updated Bed hold scenario to include "When a Member residing in a nursing facility or subacute care facility is transferred to an acute care hospital or has an approved leave of absence." **Section VI.H.4.b.** Added language where we specify that a Maximum bed hold is 7 calendar days to also say "The facility must hold a bed vacant when requested during the entire hold period, except when notified in writing by the attending physician that the patient requires	Provider Relations Member Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		more than seven days of hospital care. The facility is then no longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days." **Section VII. Added the following References:** A. Medi-Cal Provider Manual Guidelines: Subacute Care Programs: Level of Care for Adults and Children (subacut lev); Subacute Care Programs: Adult (subacute adu); Subacute Care Programs: Pediatric (subacut ped); Leave of Absence, Bed Hold, and Room and Board (leave) B. InterQual® Criteria D. Title 22 CCR sections: 51535, 51535.1, 72520 E. Title 42 Code of Federal Regulations (CFR) Section 483.15e F. Welfare and Institutions Code (WIC) §14132.25 L. DHCS APL 23-027: Subacute Care Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (09/26/2023) M. DHCS Subacute Care Program and Manual of Criteria R-15-98E C	
MCUG3058 – Utilization Review Guidelines ICF/DD. ICF/DD-H, ICG/DD-N Facilities	239 - 243	This policy has been updated according to DHCS APL 23-023 Revised Intermediate Care Facilities for Individuals With Developmental Disabilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (11/28/2023) **Section I:** Policy MCCP2016 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) has been added as a Related Policy. **Section III:** A definition was added for MCP to explain that Partnership HealthPlan of California is contracted as a Department of Health Care Services (DHCS) Managed Care Plan (MCP). Definitions of acronyms for NF-A and NF-B were removed as these types of nursing facilities are not discussed in this policy. **Section VI.A.** New paragraph was added to specify that Partnership provides all medically necessary covered services for Members residing in an ICF/DD and also provides the appropriate level of care coordination, as outlined in DHCS All Plan Letter (APL) 23-023. **Section VI.B.4.a.7)** Policy MCCP2016 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT) was added as a reference **Section VI.C.2.a.1)** Paragraph for non-developmentally disabled recipients was removed as that is not the topic of this policy. **Section VI.C.2.a.1)a)** Sentence was added to specify that a physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled. **Section VI.D.1.** Various settings were described for when a bed hold would apply for a Member residing in a ICF/DD facility.	Health Services Claims Member Services

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page Number	Summary of Revisions (Please include why the change was made, i.e. NCQA, APL, Medi-Cal guidelines, clarification etc.)	External Documentation (Notice required outside of originating department)
		Section VI.D.3.a. and a.5): Language regarding NF-A and NF-B facilities was removed as provisions for LOAs from those facilities is not the topic of this policy. **Section VII. Added the following References:** A. Medi-Cal Provider Manual/Guidelines: Utilization Review: ICF/DD, ICF/DD-H and ICF/DD-N Facilities (util review) H. DHCS Population Health Management Guide **Section IX.** Updated Position Responsible For Implementing Procedure to be Chief Health Services Officer	
MCUP3049 – Pain Management Specialty Services	245 - 266	**Section IV. Attachments:** Attachment A, the Partnership TAR Requirements List, was removed from the list of Attachments. Attachment B, Partnership Medical Necessity Criteria for Pain Management Procedures, was moved up to become Attachment A. **Section VI.E.:** In lieu of previous Attachment A to this policy, (which was a shared document between three policies), a reference and hyperlink was added in this section to refer the reader to policy MCUP3041 Treatment Authorization Request (TAR) Review Process -Attachment A (Partnership TAR Requirements) for a list of pain management services that require a TAR. **Section IX.** Updated Position Responsible For Implementing Procedure to be Chief Health Services Officer **Attachment A:** This document was updated minimally for code corrections. These changes will be applied where the Partnership TAR Requirements list is also shared as MCUP3041-A and MCUG3007-B. • Code 62287 was moved from the Pain Management CPTs Requiring a TAR list to the Outpatient Surgical Procedures CPTs Requiring TAR list. • On page 8, codes 63658, 63661 and 63688 were deleted for the list. Then this Attachment A will be ARCHIVED from this particular policy. The reasoning for this is to reduce confusion by narrowing to one source document for our Partnership TAR Requirements list. **Former Attachment B - New Attachment A:** Former Attachment B, Partnership Medical Necessity Criteria for Pain Management Procedures, was moved up to become Attachment A. Codes 62633 and 62264 were added with criteria. Code 63688 was removed.	Health Services Claims Member Services

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="3">Policy/Procedure Number: MCCP2032</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Policy/Procedure Title: CalAIM Enhanced Care Management (ECM)</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 03/09/2022
Effective Date: 01/01/2022 vs. DHCS</td><td colspan="3">Next Review Date: <s>11/08/2024</s>11/13/2025
Last Review Date: <s>11/08/2023</s>11/13/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td>☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date:
<s>11/08/2023</s><s>TBD</s>11/13/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3143 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports
B. MPCD2013 – Care Coordination Program Description
C. MCCP2007 – Complex Case Management
D. MCCP2019 – Identification and Care Coordination for Seniors and Persons with Disabilities and/or California Children's Services
E. MCND9001 – Population Health Management Strategy & Program Description.
F. MPCR100 – Credential and Re-credential Decision Making Process
G. MPPR200 – ~~PHC~~Partnership Provider Contracts
H. MCUP3041 – Treatment Authorization Request (TAR) Review Process
I. MCCP2024 – Whole Child Model for California Children's Services (CCS)
J. MCUP3037 – Appeals of Utilization Management / Pharmacy Decisions
K. CMP36 – Delegation Oversight and Monitoring
L. MCCP2033-Community Health Worker (CHW) Services Benefit
M. MCCP2034 Transitional Care Services (TCS)

II. IMPACTED DEPTS:

A. Claims
B. Configuration
C. Compliance
D. Enhanced Health Services
~~D.~~E. Finance
~~E.~~F. Grievance and Appeals
~~F.~~G. Utilization Management
~~G.~~H. Member Services
~~H.~~I. Project Management Office
~~I.~~J. Provider Relations

III. DEFINITIONS:

A. California Children's Services (CCS): A state program for children up to 21 years of age, who have been determined eligible for the CCS program due to the presence of certain diseases or health problems.
~~B. Point Click Care (PCC) A contracted external vendor platform designated as~~

~~Partnership HealthPlan of California (PHC~~Partnership~~)'s ECM data sharing and information exchange system. The use of the platform will be to advance communication and share information between ECM Members' care teams, integrate services, improve health outcomes, and streamline the ECM benefit delivery.~~

B. Closed Loop Referral: means bidirectional information sharing between two or more parties to communicate requests for services and the associated outcomes of the requests. The frequency and format of this information sharing varies by service provider and by the degree of formality that may be required according to local community norms. Depending on the type of service needed, this process may include referral to medical, dental, behavioral, and/or social services or community agencies. While a warm hand off may occasionally be appropriate, a closed loop referral does not imply that a warm hand off is required.

C. Community Health Worker (CHW): Individuals know by a variety of job titles, such as promotores, community health representatives, navigators, and other non-licensed public health workers, including violence prevention professionals, who connect and engage with their community to provide equitable health care through culturally competent services. CHWs are trusted members of their community who help address chronic conditions, preventive health care needs, and health related social needs within their communities.

D. Community Health Worker (CHW) Services: CHW services are preventive health services as defined in 42 CFR health 440.130(C) delivered by a CHW to prevent disease, disability, and other health conditions or their progression; to prolong life; and to promote physical and mental health and well-being. CHW services can help members receive appropriate services related to perinatal care, preventive care, sexual and reproductive health, environmental and climate-sensitive health issues, oral health, aging, injury, and domestic violence and other violence prevention services.

~~C.~~E. Community Supports (CS): Pursuant to 42 CFR 438.3(e)(2), In-Lieu of Services (ILOS) are optional services or settings that are offered in place of services or settings covered under the California Medicaid State Plan (Medi-Cal) and are medically appropriate, cost-effective alternatives to services or settings under the State Plan. These services or settings require Department of Health Care Services (DHCS) approval. Under CalAIM, these services are known as Community Supports (CS).

~~D.~~F. Enhanced Care Management (ECM): a whole-person, interdisciplinary approach to care that addresses the clinical and non-clinical needs of high-need and/or high-cost Members through systematic coordination of services and comprehensive care management that is community-based, interdisciplinary, high-touch, and person-centered.

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

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

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

J. Point Click Care (PCC) A contracted external vendor platform designated as Partnership HealthPlan of California (Partnership)'s ECM data sharing and information exchange system. The use of the platform will be to advance communication and share information between ECM Members' care teams, integrate services, improve health outcomes, and streamline the ECM benefit delivery.

~~H.~~K. Release of Information (ROI): The process of providing access to Protected Health Information (PHI) to an individual or entity authorized to receive or review it.

~~I.~~L. Release of Information (ROI) Consent Form for ECM: A valid ROI form including the Member's signature and specified time frame to allow ~~PHC~~Partnership, ECM provider(s), lead case manager, community organizations, and relevant affiliates or entities of the Member's care team to share their health information.

~~J.~~M. Substance Use Disorder (SUD): A complex condition in which there is the uncontrolled recurrent use of a substance, which causes harmful consequences such as clinically significant impairment, health problems, and disabilities.

~~K.~~N. Serious Mental Health (SMH): A diagnosed mental, behavioral, or emotional disorder resulting in serious functional impairment that interferes with or limits the quality of life.

~~L.~~O. Whole Child Model (WCM): A comprehensive program for the whole child encompassing care coordination in the areas of primary, specialty, and behavioral health for any pediatric Member insured by ~~PHC~~Partnership.

~~M.~~P. Whole Person Care (Whole Person Care): A five-year pilot program under California's 1115 Medicaid waiver to service high-risk populations using a collaborative approach across public and private entities to integrate and coordinate health, behavioral health, and social services. ~~PHC~~Partnership's Counties participating in the WPC pilot program were Marin, Mendocino, Napa, Shasta, and Sonoma.

IV. ATTACHMENTS:

A. Individualized Care Plan Example
B. Enhanced Care Management (ECM) Release of Information Form (ROI)

V. PURPOSE:

To describe Partnership HealthPlan of California's (~~PHC~~Partnership's) Enhanced Care Management (ECM) benefit for ~~PHC~~Partnership Medi-Cal eligible Members, and to outline the collaboration between ~~PHC~~Partnership, ECM providers, and other community partners in the delivery of ECM services pursuant to the California Department of Health Care Services (DHCS) All Plan Letter (APL) ~~21-012~~23-032. The ECM benefit is unique and distinct from other care management programs. ECM builds on both the design and the learning from California's Whole Person Care Pilots (WPC) and Health Home Program (HHP). ECM, with Community Supports (CS), ~~will replace~~replaces both models, scaling up the interventions to a statewide care management approach. ECM ~~will offer~~offers
comprehensive, "whole person" care management to high-need, high-cost ~~PHC~~Partnership Members. ECM services primarily:

A. Are delivered in-person to Members and/or their caregivers, Authorized Representative (AR), parents/guardians wherever Members may live, seek care, or prefer to access services within their community.
B. Focus largely on Social Determinants of Health (SDOH) such as housing/shelter, food instability, transportation and community supports to improve medical health outcomes and healthcare costs.
C. Populations of Focus within ~~PHC~~Partnership's membership that often need to access six or more separate delivery systems for care, benefits and/or support (e.g. ~~PHC~~Partnership, Medi-Cal fee-for-service, mental health, substance use disorder, developmental, dental, In Home Supportive Services, etc.).
D. Have goals and interventions that aim to improve care coordination, integrate the delivery of services, facilitate community resources and improve health outcomes, while decreasing inappropriate health care utilization.

VI. POLICY / PROCEDURE:

A. ECM ELIGIBILITY
1. Member must be assigned to ~~PHC~~Partnership for Medi-Cal benefits.
2. ECM is voluntary, Members can decline or end ECM services upon initial outreach and engagement, or at any other time.
3. Member must be identified as meeting criteria in one of the following Populations of Focus eligible for ECM benefits:
   a. Adult Populations of Focus: Homelessness, At Risk for Avoidable Hospital or ED Utilization, Serious Mental Health (SMH) or Substance Use Disorder (SUD), Transitioning from Incarceration, At Risk of Institutionalization / Eligible for Long-Term Care Services, Nursing Facility Residents Transitioning to the Community, and/or Pregnant and Postpartum; Birth Equity.
   b. Children & Youth Populations of Focus: Homelessness, At Risk for Avoidable Hospital or ED Utilization, Serious Mental Health (SMH) and/or Substance Use Disorder (SUD), Enrolled in California Children's Services (CCS) or CCS Whole Child Model (WCM) with Additional Needs Beyond CCS Condition, Involved with Child Welfare, Intellectual or Developmental Disability (I/DD), and/or Pregnant and Postpartum; Birth Equity.
4. Adult Specific ECM Population of Focus Eligibility Criteria are defined as:
   a. Effective through June 30, 2023, Individuals Experiencing Homelessness – Adults 21 years of age or older and their families who:
      1) Have at least one complex physical, behavioral, or developmental health need with an inability to successfully self-manage for whom coordination of services would likely result in improved health outcomes and/or decrease in utilization of high-cost services, and
      2) Are experiencing homelessness defined as meeting one or more of the following conditions defined by the U.S. Department of Health and Human Services (HHS) 42 CFR §11302 criteria:
         a) Lacking adequate nighttime residence
         b) Having a primary residence that is a public or private place not designed for or ordinarily used for habitation
         c) Living in a shelter
         d) Exiting an institution into homelessness
         e) Will imminently lose housing in next 30 days
         f) Fleeing domestic violence, dating violence, sexual assault, stalking and other dangerous, traumatic, or life-threatening conditions relating to such violence
   b. Effective July 1, 2023, Individuals Experiencing Homelessness – Adults 21 years of age or older without dependent children/youth living with them who:
      1) Have at least one complex physical, behavioral, or developmental health need with an inability to successfully self-manage for whom coordination of services would likely ~~5~~ ——result in improved health outcomes and/or decrease in utilization of high-cost services, and
      2) Are experiencing homelessness defined as meeting one or more following conditions defined by the U.S. Department of Health and Human Services (HHS) 42 CFR § 11302 criteria:
         a) L~~l~~acking adequate nighttime residence
         b) Having a primary residence that is a public or private place not designed for or ordinarily used for habitation
         c) Living in a shelter
         d) Exiting an institution into homelessness

e) Will imminently lose housing in next 30 days
f) Fleeing domestic violence, dating violence, sexual assault, stalking and other dangerous, traumatic, or life-threatening conditions relating to such violence
~~f~~g) Defined as homeless under other federal statutes

c. At risk for Avoidable Hospital or ED Utilization – Adults, 21 years of age or older who:
   1) Have five (5) or more Emergency Department (ED) visits in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence, and/ or
   2) Have three (3) or more unplanned hospital and/or short-term skilled nursing facility stays in a six-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

d. SMH or SUD – Adults, 21 years of age or older who:
   1) Meet the eligibility criteria for participation in or obtaining services through:
      a) Specialty mental health services (SMHS) delivered by the county's Mental Health Plan (MHP)
   2) The Drug Medi-Cal Organized Delivery System (DMC-ODS) or the Drug Medi-Cal (DMC) program, and are actively experiencing at least one complex social factor influencing their health, and
   ~~2)~~3) Are experiencing at least one complex social factor influencing their health, and
   ~~3)~~4) Meet one or more of the following criteria:
      a) High risk for institutionalization, overdose and/or suicide
      b) Use crisis services, emergency rooms, urgent care, or inpatient stays as the sole source of care
      c) Two or more ED visits or two or more hospitalizations due to SMH or SUD in the past 12 months
      d) Pregnant and post-partum Members (12 months from delivery)

e. Transitioning from Incarceration – Adults 21 years of age or older who:
   1) Are transitioning from a correctional facility or transitioned from a correctional facility within the last 12 months, and
   2) Have at least one (1) of the following conditions:
      a) Mental illness
      b) Substance Use Disorder (SUD)
      c) Chronic Condition/Significant Clinical Condition
      d) Intellectual or Developmental Disability (I/DD)
      e) Traumatic Brain Injury (TBI)
      f) HIV/AIDS
      g) Pregnancy or Postpartum

f. At Risk for Institutionalization & Eligible for Long-Term Care – Adults, 21 years of age or older who are:
   1) Living in the community who meet the Skilled Nursing Facility (SNF) Level of Care (LOC) criteria; or who require a lower-acuity skilled nursing, such as a time-limited and/or intermittent medical and nursing services, support, and/or equipment for prevention, diagnosis, or treatment of acute illness or injury; and
   2) Actively experiencing at least one complex social or environmental factor influencing their health; and
   3) Able to reside continuously in the community with wraparound supports

g. Nursing Facility Residents Who Want to Transition to the Community – Adults, 21 years of age or older who are:
   1) Interested in moving out of the institution, and

2) Likely candidates to do so successfully, and
3) Able to reside continuously in the community

h. Birth Equity – Adults, who are:
1) Pregnant or Postpartum (through 12-month period); and
2) Meet one of more of the following conditions:
a) Eligible in any other adult or youth ECM Population of Focus;
b) Effective January 1, 2024 - Subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

5. Children and Youth Specific ECM Population of Focus Eligibility Criteria are defined as:
a. Effective July 1, 2023, Individuals Experiencing Homelessness – Homeless Families or Unaccompanied Children/Youth who:
1) Are experiencing homelessness as defined by the U.S. Department of Health and Human Services (HHS) 42 CFR § 11302 criteria:
a) Lacking adequate nighttime residence
b) Having a primary residence that is a public or private place not designed for or ordinarily used for habitation
c) Living in a shelter
d) Exiting an institution into homelessness
e) Will imminently lose housing in next 30 days
f) Fleeing domestic violence, dating violence, sexual assault, stalking and other dangerous, traumatic, or life-threatening conditions relating to such violence
2) Sharing the housing of other persons due to loss of housing, economic hardship, or a similar reason;
a) Living in motels, hotels, trailer parks, or camping grounds due to lack of alternative adequate accommodations
b) Living in emergency or transitional shelters
c) Abandoned in hospitals or unable to discharge from the hospital to a safe place

b. At Risk for Avoidable Hospital or ED Utilization – children and youth under the age of 21 who:
1) Have three (3) or more Emergency Department (ED) visits in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence, and/ or
2) Have two (2) or more unplanned hospital and/or short-term skilled nursing facility stays in a 12-month period that could have been avoided with appropriate outpatient care or improved treatment adherence.

c. SMH or SUD – Children and youth under the age of 21 who:
1) Meet the eligibility criteria for participation in, or obtaining services through:
a) SMHS delivered by MHPs
b) The DMC-ODS or the DMC program.

d. Transitioning from Incarceration – Children and youth under the age of 21 who are:
1) Transitioning from a youth correctional facility or transitioned from being in a youth correctional facility within the past 12 months.

e. Children and Youth Enrolled in CCS or CCS WCM with Additional Needs Beyond the CCS Condition – Children and youth under the age of 21 who are:
1) Enrolled in CCS or CCS WCM; and
2) Experiencing at least one complex social factor influencing their health.
a) Lack of access to food,
b) Lack of access to stable housing,
c) Difficulty accessing transportation

d) Have a high measure (four or more) of ACEs screening;
e) History of recent contacts with law enforcement, or crisis intervention services related to mental health and/or substance use symptoms.

f. Children and Youth Involved in Child Welfare – children and youth who meet one or more of the following conditions:
1) Under age 21 and are currently receiving foster care in California;
2) Under age 21 and previously received foster care in California or another state within the last 12 months;
3) Aged out of foster care up to age 26 in California or another state
4) Under age 18 and are eligible for and/or in California's Adoption Assistance Program;
5) Under age 18 and currently receiving or have received services from California's Family Maintenance program within the last 12 months.

g. Intellectual and Developmental Disability (I/DD) – children and youth who are:
1) Diagnosed I/DD
2) Eligible in any other adult ECM Population of Focus

h. Pregnancy, Postpartum and Birth Equity – children and youth who are:
1) Pregnant or Postpartum (through 12-month period); and
2) Meet one of more of the following conditions:
a) Eligible in any other adult or youth ECM Population of Focus;
b) Effective January 1, 2024 - Subject to racial and ethnic disparities as defined by California public health data on maternal morbidity and mortality.

6. ECM may be offered to Members who do not meet DHCS' Population of Focus criteria but would benefit from the services. ~~PHC~~Partnership will handle these requests on a case-by-case basis.

B. JUSTICE INVOLVED MANAGED CARE TRANSITION

1. ~~PHC~~Partnership will use the DHCS ~~member~~Member assignment data when the ~~member~~Member's pre-release service aid code is activated and identified to ensure the ~~member~~Member receives coordination of care.
2. ~~PHC~~Partnership will support the creation and development of the reentry care plan for individuals as requested by the pre-release care management provider and/or their team of the ECM provider. This includes the following but is not limited to:
a. Receiving ~~member~~Member data
b. Warm handoff
c. Pre-release and post release
d. Receipt of person-centered care
e. Behavioral health links
f. Ensuring post-release ECM provider participates in behavioral health transition meetings, warm handoffs, follow-up planning, and ensure that warm handoffs include follow up-planning, including confirming transportation.
g. Assist with appointment scheduling for behavioral health services.
3. ~~PHC~~Partnership will ensure that the ECM provider supports scheduling for required post-release physical, behavioral health, and social services.
4. ~~PHC~~Partnership will ensure that the ECM provider connects individuals with needed services such as Community Supports, and benefits like Non-Emergency Medical Transportation, to assist the ~~member~~Member with reentering the community.

~~B.~~C. ECM EXCLUSION CRITERIA:

1. The following Members are excluded from receiving ECM benefit:
a. Member is sufficiently well managed through self-management or through another care management program.

b. Member is enrolled in Hospice or Intensive Outpatient Palliative Care.
c. Member enrolled in County-based Target Case Management (TCM) programs.
   1) DHCS has allowed a one-year exception from July 1, 2024 to June 30, 2025 for cases where the member is receiving County-based TCM for addressing a communicable disease or for the sole purpose of receiving a home visiting program supporting the healthy development and well-being of children and families.
~~c.~~d. The Member is unresponsive to outreach attempts.
~~d.~~e. The Member displays unsafe or threatening behavior.
~~e.~~f. Member's physical environment poses a safety or security risk.
g. The member is receiving the Community Health Worker services benefit.
~~f.~~h. The Member is currently enrolled in duplicative care management waiver or DHCS demonstration programs such as:
   1) Multipurpose Senior Services Program (MSSP)
   2) Assisted Living Waiver
   3) Home and Community-Based Alternatives (HCBA) Waiver;
   4) HIV/AIDS Waiver
   5) HCBS Waiver for Individuals with Developmental Disabilities (DD)
   6) Self-Determination Program for Individuals with I/DD
   7) Cal MediConnect
   8) Fully Integrated Dual Eligible Special Needs Plans (FIDESNPs)
   9) Program for All-Inclusive Care for the Elderly (PACE)
   10) Family Mosaic Project
   11) California Community Transitions (CCT) Money Follows the Person (MFTP)
~~g.~~i. The Member is currently enrolled in ~~PHC~~Partnership's Basic Case Management or Complex Case Management Programs. For these Members, ~~PHC~~Partnership Care Coordination staff will work with the Member, ~~his/her~~their caregiver, Authorized Representative, and/or interdisciplinary care team to evaluate and coordinate the appropriate level of case management support.

~~C.~~D. ECM CORE SERVICE COMPONENTS:

1. The ECM benefit is to be delivered primarily in-person where a Member seeks or receives care. If the ECM provider is unable to connect with the Member in-person, or the Member has expressed an alternative communication method, outreach and engagement may be performed by teleconferencing, telehealth, televideo, or other protected communication tool in an effort to help build relationships as a supplement to in-person visits.
2. An assigned Lead Care Manager will act as the Members' primary point of contact and is responsible for coordinating care, at minimum, across the following delivery systems, including but not limited to; medical, behavioral, developmental, dental, long-term care supports and community resources/supports, Community Supports, regardless of setting or payor.
3. The ECM Provider will designate a Lead Care Manager who may be any of following: a nurse, a social worker, a care navigator, a housing navigator, or a community health worker. The Lead Care Manager is responsible for the delivery of ECM services as outlined in the ECM core services components below, and shall possess the appropriate experience and expertise in servicing the Member's Population of Focus.
4. If the Member has other Care Managers assisting or supporting them, it is the responsibility of the Member's ECM Lead Care Manager to coordinate with those individuals and/or entities to ensure a seamless experience for the Member, and to ensure non-duplication of services.
5. ~~PHC~~Partnership will ensure all ECM enrolled Members receive the following ECM core

service components from their assigned ECM provider:

a. Outreach and engagement
   1) The ECM provider shall use available data to prioritize outreach and engagement of Members addressing Members with the most immediate needs first.
   2) The ECM provider will maintain regular contact with Members to ensure there are not gaps in the activities designed to address an individual's health and social service needs. Upon engagement, the ECM Provider shall obtain the Member's, the Member's parent/guardian or authorize representative's written consent for ECM services using the attached ROI form in Attachment B.
      a) The ECM Provider shall store a copy of this executed ROI form with the Member's ICP in the Point Click Care Platform to communicate back to ~~PHC~~Partnership the Member's data sharing preferences.

b. Comprehensive Assessment
   1) The ECM provider will perform a comprehensive assessment and/or risk screening to determine ECM engagement level and to inform the Member's ICP.
   2) Identifying necessary clinical and non-clinical resources that may be needed to appropriately assess Member health status and gaps in care
   3) For Members with long-term services and supports (LTSS) needs, the Lead Care Manager shall utilize approved assessments and tools to develop care plans in accordance with federal requirements under 42 CFR 438.208(c), including:
      a) The ability for the Member to include people of their choosing to participate in the care planning process;
      b) The necessary information and support to ensure that the Member/individual directs the process to the maximum extent possible, and is enabled to make informed choices and decisions;
      c) Reflects cultural considerations of the Member and is conducted by providing information in plain language and in a manner that is accessible to the Member with disabilities and persons who are limited English proficient;
      d) Includes strategies for solving conflict or disagreement between Members and their care managers within the process, and also includes or references clear conflict-of-interest guidelines for all planning participants;
      e) Offers choices regarding the services and/or supports the Member may receive and from whom;
      f) Includes a method for the Member/individual to request updates to the plan as needed
      g) Records the alternative home and community-based settings that were considered in the care planning process with the Member/individual
      h) When available, ~~PHC~~Partnership shall share the results of the Health Risk Assessment (HRA), which includes the required LTSS referrals questions, with ECM providers when a Member is assigned to them.
      i) The ECM provider shall use the Members' responses to the HRA in developing the Members' Individualized Care Plan (ICP).

c. Individualized Care Plan (ICP)
   1) The ECM provider shall work with the Member, guardian, caregiver, AR, and/or other authorized person(s) as appropriate to assess strengths, risks, needs, goals and preferences to make recommendations for service needs.
   2) The Lead Care Manager is responsible for documenting and updating the Member's ICP as needed to ensure there are no gaps in care.

3) The ICP shall contain at minimum, needs, strategies, and patient prioritized goals surrounding care coordination needs for services including but not limited to the following
   a) Physical health
   b) Mental health
   c) Developmental health
   d) Substance Use Disorder (SUD)
   e) Long Term Support Services (LTSS)
   f) Oral health
   g) Necessary community-based and/or social services
   h) Health Promotion
   i) Transitional Care Needs
   j) Member and/or Family Supports
4) The Lead Care Manager shall make available to the Member a copy of the ICP upon enrollment in ECM and/or upon Member request.
5) The ECM Provider shall ensure that the Member's ICP contains appropriate clinical oversight.

d. Enhanced Coordination of Care
   1) Organizing patient care activities, as laid out in the ICP, and sharing information with those involved as part of the Member's multi-disciplinary care team.
   2) Implementing activities identified in the Member's ICP.
   3) Maintaining regular contact with all Providers that are identified as being a part of the Member's multi-disciplinary care team, whose input is necessary for successful implementation of Member goals and needs.
   4) Ensuring care is continuous and integrated among all service Providers and referring to and following up with primary care, physical and developmental health, mental health, SUD treatment, long-term support services (LTSS), oral health~~, palliative care,~~ trauma-informed care, and necessary community-based and social services, including housing, as needed.
   5) Providing support to engage the Member in their treatment, including coordination for medication review and/or reconciliation, scheduling appointments, providing appointment reminders, coordinating transportation, accompaniment to critical appointments, and identifying and helping to address other barriers to Member engagement in treatment.
   6) Communicating the Member's needs and preferences timely to the Member's multi- disciplinary care team in a manner that ensures safe, appropriate, and effective person- centered care.
   7) Ensuring regular contact with the Member and their family member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s), when appropriate, consistent with the Individualized Care Plan (ICP).

e. Health Promotion
   1) Working with Members to identify and build on successes and potential family and/or support networks
   2) Providing services to encourage and support Members to make lifestyle choices based on healthy behavior, with the goal of supporting Members' ability to successfully monitor and manage their health
   3) Supporting Members in strengthening skills that enable them to identify and access resources to assist them in managing their conditions and preventing other chronic conditions.

f. Transitional Care Services

1) Develop strategies to reduce avoidable Member admissions and/or readmissions to acute or skilled settings.
    a) For Members who are currently hospitalized, the ECM Lead Care Manager shall provide Transitional Care Services pursuant to the DHCS Population Health Management (PHM) Strategy Guide. At minimum, the ECM Lead Care Manager shall:
        1) Prior to discharge, compete a discharge assessment to assess the Member's risk of re-institutionalization, re-hospitalization, and risk of ~~mental health~~SMH [AC1][DBR2]and/or SUD;
        2) Ensure that medication reconciliation is conducted pre- and post-transition;
        3) Ensure Closed Loop Referrals to Community Supports and coordination with county social service agencies and waiver agencies for In-Home Support Services (IHSS) and/or other Home and Community Based Services are coordinated as appropriate;
        4) When applicable, ensure Members with SUD and mental health needs receive treatment for those conditions upon discharge;
        5) Provide a discharge planning document to the Member, Member's parents, legal guardians, or authorized representatives, as appropriate, when being discharged from a hospital, institution or facility. This discharge plan must include information about the hospital, institution or facility to which the Member was admitted; the Member's pre-admission status (ex: living arrangements, physical and mental function, SUD needs, social support, DME uses, etc.); pre-discharge factors (ex: medical condition(s), physical and mental function, financial resources, social supports at the time of discharge, etc.); recommendations made for the Member after discharge (ex: placement, DME, follow-up, etc.); summary of the nature and outcome of participation of Member, Member's parents, legal guardians, or authorized representatives in the discharge planning process; anticipated problems in implementing post-discharge plans, and information regarding available care, services, and supports that are in the Member's community once the Member is discharged from a hospital, institution or facility, including the scheduled outpatient appointment or follow-up with the Member.
        6) Tracking each Member's admission and/or discharge to or from an emergency department, hospital inpatient facility, skilled nursing facility, residential or treatment facility, incarceration facility, or other treatment center and communicating with the appropriate care team members.
        7) Coordinating medication review/reconciliation
        8) Providing adherence support and referral to appropriate services.

g. Member and Family Supports, which shall include, but are not limited to:
    1) Documenting a Member's authorized family member(s), guardian, Authorized Representative, caregiver, and/or other authorized support person(s) and ensuring all required authorizations are in place to ensure effective communication between the ECM Providers; the Member and/or their family member(s), Authorized Representative, guardian, caregiver, and/or authorized support person(s)
    2) Activities to ensure the Member and/or their family member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s) are knowledgeable about the Member's condition(s), with the overall goal of improving the Member's care planning and follow-up, adherence to treatment, and medication management, in accordance with federal, state, and local privacy and confidentiality laws.

3) Ensuring the Member's ECM Lead Care Manager serves as the primary point of contact for the Member and/or family member(s), guardian, Authorized Representative, caregiver, and/or other authorized support person(s)
4) Identifying supports needed for the Member and/or their family member(s), Authorized Representative, guardian, caregiver, and/or authorized support person(s) to manage the Member's condition and assist them in accessing needed support services
5) Providing for appropriate education of the Member and/or their family member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s) about care instructions for the Member
6) Ensuring that the Member has a copy of their ICP and information about how to request updates

h. Coordination of and Referral to Community and Social Support Services
1) Determining appropriate services to meet the needs of Members, including services that address social determinants of health needs, including housing, and services offered by Contractor as Community Supports (CS) under CalAIM, see ~~PHC~~Partnership Policy MCUP3142 CalAIM Community Supports.
2) Coordinating and referring Members to available community resources and following up with Members to ensure services were rendered (i.e., "closed loop referrals").

6. Members enrolled in the ECM benefit shall participate in differing levels of engagement as determined by both the Member and ECM Provider through the development of the Member's ICP. At minimum, ~~PHC~~Partnership expects that the ECM provider attempts and/or makes successful engagement with the Member once a month via in-person, telehealth, telephonic or televideo where appropriate.
7. Through the delivery of ECM both the ECM provider and/or Member's Lead Care Manager shall use culturally and linguistically appropriate methods of communication with the ~~member~~Member.
8. ~~PHC~~Partnership shall recruit ECM Providers that have diverse care management staff reflecting the populations they serve.

D. MEMBER IDENTIFICATION & AUTHORIZATION OF ECM SERVICES
1. In accordance with ~~PHC~~Partnership's Population Health Management Program and activities, ~~PHC~~Partnership proactively screens, stratifies, segments and assigns risk tiers for ~~PHC~~Partnership's ~~member~~Membership population using ~~PHC~~Partnership's proprietary Risk Score Model and additional ~~member~~Member demographic, utilization, and social data. Through this process, ~~PHC~~Partnership identifies and prioritizes those ~~member~~Members who present with the highest needs and risks and directs them to appropriate interventions and services; including the Enhanced Care Management benefit. See policy MCND 9001 Population Health Management Strategy & Program Description.
2. ~~PHC~~Partnership will also proactively analyze data and/or information received directly from DHCS, counties, providers, members and/or others to identify additional ~~member~~Members eligible for the ECM benefit. Sources may include, but are not limited to:
a. Enrollment data
b. Utilization/claims data including
1) Encounter data
2) Pharmacy data
3) TAR clinical data (ex: Minimum Data Set Survey data from LTCs, CBAS Individualized Plan of Care, etc.)

4) Laboratory data, as available

c. Screening or assessment data (ex: Health Risk Assessment for Seniors or Persons with Disabilities (SPD), etc.)
d. Clinical information on physical and/or behavioral health
e. SMH[AC3][DBR4]/SUD data, as available Risk stratification information for children in ~~PHC~~Partnership's Whole Child Model (WCM) program
f. Information about social determinants of health, including standardized assessment tools and/or current ICD codes
g. Regional Center data feeds
h. Results from any available Adverse Childhood Experience (ACE) screening
i. Other cross-sector data and information, including housing, social services, foster care, criminal justice history, school absentee or truancy and other information relevant to the ECM Populations of Focus (e.g., Homeless Management Information System (HMIS), available data from the education system, etc.).
j. Plan Data Feed from DHCS
k. 1915c waiver wait lists
l. Claims, laboratory, request for services and/or encounters shall be used to internally identify ~~member~~Members who are pregnant or postpartum and meet other ECM Population of Focus criteria.
m. Other data and/or risk stratification reports

3. ~~PHC~~Partnership shall compile a monthly report of potentially eligible ECM ~~member~~Members based upon ~~PHC~~Partnership's available data and analysis.
   a. The list of ~~member~~Members on this report shall be prioritized; with the ~~member~~Members believed to have the immediate needs and in need of outreach and engagement listed first.
   b. This prioritized report shall be shared and assigned to the appropriate ECM provider(s) so that outreach and engagement with ~~member~~Members can be initiated.
4. In addition to using available data, ~~PHC~~Partnership encourages direct referrals for ~~member~~Members to access ECM services. Information on directly referring ~~member~~Members to ECM, along with ~~PHC~~Partnership's ECM referral form can be found on ~~PHC~~Partnership's website as well as information in the ~~PHC~~Partnership ~~member~~Member/provider newsletter. In addition, ~~PHC~~Partnership shares information about how to refer ~~member~~Members for ECM services at community partner meetings, provider roundtables and/or community events.
5. Direct referrals for ECM can come from a multitude of sources, including but not limited to:
   a. Providers, ECM providers, and/or community-based organizations via phone, mail, or fax.
   b. Members and/or their family ~~member~~Member(s), guardian, Authorized Representative, caregiver, and/or authorized support person(s) via phone, mail, or ~~PHC~~Partnership ~~member~~Member portal.
   c. ~~PHC~~Partnership Care Coordination Department
   d. Internal ~~PHC~~Partnership Department (ex: Claims, Utilization Management, Pharmacy, Member Services, Population Health Management, etc.)
   e. County partners (ex: Health and Human Services, Behavioral Health, Public Health, Social Services, Child Welfare, Continuums of Care, etc.)
   f. Hospitals, including CCS Specialty Care Centers
   g. Probation and/or parole departments
   h. Nursing Homes / Skilled Nursing Facilities
   i. Home Health Agencies
   j. Community Based Adult Services (CBAS) providers
   k. Home and Community Based Waiver Providers

l. Area Agencies on Aging
m. Centers for Independent Living
n. Regional Centers
o. Schools
p. Local Foster Care Offices
q. First 5
r. Community Based Organizations
s. Local Perinatal Programs
t. Community Supports Providers
u. Correctional facilities, prisons, jails, youth/juvenile facilitates

6. Upon receipt of a direct ECM referral, ~~PHC~~Partnership's ~~Care Coordination Department~~designated staff shall conduct an initial screening for ECM services, and assign ~~member~~Members who may qualify for ECM to an in-network ECM provider for a Comprehensive Assessment and ICP.
   a. For ~~member~~Members who meet the initial screening criteria, ~~PHC~~Partnership's ~~Care Coordination Department~~designated staff shall:
      1) Inform the ~~member~~Member and/or their AR of the ~~member~~Member's referral assignment via telephone, mail and/or ~~member~~Member portal when appropriate, and
      2) Electronically inform the ECM provider of the referral assignment in the electronic systems denoted below in section VI.H.
7. Partnership will require specific ECM referral information from entities in accordance with DHCS ECM referral standards and form template guidance.
   a. Partnership will acknowledge receipt of the ECM referral.
   b. Partnership will notify the individual or entity if there are errors that must be corrected before submission.

~~7.~~8. For ~~member~~Members who do not meet initial screening criteria, ~~PHC~~Partnership's Care Coordination Department shall offer other available case management and/or care coordination services (e.g. Complex Case Management, etc.) For ~~member~~Members who qualify for the ECM benefit, ~~PHC~~Partnership requires that a Treatment Authorization Request (TAR) be submitted to ~~PHC~~Partnership for review and approval of ECM services. See ~~PHC~~Partnership policies MCUP3041 - Treatment Authorization Request (TAR) Review Process and MCUP3143 Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS).

E. ECM PROVIDER ASSIGNMENT
1. The ~~member~~Member's assigned ECM provider must meet the following standards:
   a. Must be experienced in serving the ECM Population(s) of Focus they will serve. For ~~member~~Members with long-term services and supports (LTSS) needs, the Lead Care Manager will be experienced and/or have received training in person-centered planning as required by federal law.
   b. Have experience and expertise with the services they provide.
   c. Comply with all applicable state and federal laws and regulations and all ECM program requirements.
   d. Have the capacity to provide culturally appropriate and timely in-person care management activities in accordance with Exhibit A, Attachment 6, Provision 13, Ethnic and Cultural Composition.
2. Members will be assigned to their approved ECM provider after taking into account their known preferences, previous provider relationships, and/or health needs.
   a. If the ~~member~~Member's assigned Primary Care Provider (PCP) is a contracted ECM Provider, ~~PHC~~Partnership shall assign the Member to the PCP as the ECM Provider, unless the

~~member~~Member has expressed a different preference or ~~PHC~~Partnership identifies a more appropriate ECM Provider given the ~~member~~Member's individual needs and health conditions.

b. If a ~~member~~Member receives services from a Specialty Mental Health Plan for severe emotional disturbance (SED), substance use disorder (SUD), and/or serious mental health (SMH) and the ~~member~~Member's behavioral health Provider is a contracted ECM Provider, ~~PHC~~Partnership shall assign that ~~member~~Member to that behavioral health Provider as the ECM Provider, unless the ~~member~~Member has expressed a different preference or ~~PHC~~Partnership identifies a more appropriate ECM Provider given the ~~member~~Member's individual needs and health conditions.

c. For ~~member~~Members enrolled in ~~PHC~~Partnership's Whole Child Model for CCS, ~~PHC~~Partnership shall assign that ~~member~~Member to a CCS Case Manager affiliated with a contracted ECM provider for ECM services, unless the ~~member~~Member or family has expressed a different preference or ~~PHC~~Partnership identifies a more appropriate ECM Provider given the ~~member~~Member's individual needs and health conditions. For more information on case management and care coordination services provided under the Whole Child Model for CCS, see ~~PHC~~Partnership Policy MCCP2024.

3. Members can request to change their assigned ECM provider by contacting ~~PHC~~Partnership's Care Coordination department via phone, mail or ~~PHC~~Partnership's Member Portal. Upon receipt of a ~~member~~Member's request for reassignment, ~~PHC~~Partnership's Care Coordination department shall contact the ~~member~~Member to acknowledge the request, and to work collaboratively with the ~~member~~Member for reassignment to a new ECM provider within 30 days of the request date.
4. ~~PHC~~Partnership will ensure that ECM provider communication of a ~~member~~Member's assignment to designated ECM provider occurs within ten (10) business days of authorization. ~~PHC~~Partnership shall communicate the ~~member~~Member's assignment using the information platform described in section VI. H.
5. ~~PHC~~Partnership will document the Member's ECM Lead Care Manager in its internal electronic platform and systems.
6. As contracted network providers, both ECM providers and PCPs alike can work with ~~PHC~~Partnership's Provider Relations Department representatives to provide feedback regarding ECM referrals or concerns they may have about ECM ~~member~~Member assignments.

F. DISCONTINUATION OF ECM

1. The ECM provider shall notify ~~PHC~~Partnership, and the interdisciplinary care team, when a ~~member~~Member discontinues ECM services. Examples of discontinuation include:
   a. The ~~member~~Member has graduated and is no longer in need of intensive case management or care coordination services. Graduation criteria for ECM shall include:
      1) The ~~member~~Member has met all identified goals on their ICP addressing any needs for their medical, behavioral health, dental, long-term supports, or community referral needs as indicated. (e.g. connection to primary/specialty care, appropriate utilization of health care services, connection to mental health, connection to dental care, connection to Community Based Adult Services (CBAS) or In-Home Support Services (IHSS), referrals and linkages to Community Supports, etc.).
      2) The ~~member~~Member has demonstrated an ability to self-manage their health. (e.g. able to make their own appointments, understands warning signs or triggers for their medical and/or mental health conditions and can implement strategies to prevent acute exacerbations, ability to manage their medications or treatment regimens, verbalizes an understanding of who to call if new health problems arise, has

obtained all necessary durable medical equipment (DME), etc.).

3) The ~~member~~Member is connected to appropriate community service(s) and/or Community Supports to address their short-term and long-term needs (e.g. housing, meal delivery, transportation, disease management programs/classes, support groups, etc.).

b. The ~~member~~Member expresses that they no longer wish to receive ECM
c. The ~~member~~Member is unresponsive or unwilling to engage in ECM outreach & engagement attempts by the ECM provider
d. The ~~member~~Member, who was previous enrolled in ECM, no longer responds to the ECM provider's attempts to contact, locate or engage the ~~member~~Member
e. The ~~member~~Member is deceased
f. The ~~member~~Member loses ~~PHC~~Partnership Medi-Cal eligibility
g. The ~~member~~Member moves out of ~~PHC~~Partnership's service area
h. The ~~member~~Member becomes incarcerated for more than 30 days
i. After attempts to reassign the Lead Care Manager or remedy ECM service delivery, the ECM provider can no longer provide services. (ex: patient behavior, unsafe environment, etc.)
j. The ~~member~~Member is transitioned to an alternative care management or care coordination program/services that can better meet the ~~member~~Member's goals, preferences and care needs.

1) In order to prevent gaps in care or duplication of ECM services, ECM providers are to plan and coordinate to transfer a ~~member~~Member's care needs within 30 days to an alternative care management or care coordination provider. Examples of such providers/programs include, but are not limited to:
   a) Hospice
   b) ~~PHC~~Partnership's Intensive Outpatient Palliative Care Program
   c) Long-Term Dialysis
2) When appropriate, the ECM provider and care team are to coordinate services and transition the ~~member~~Member to a lower level or alternative care management program based on the ~~member~~Member's needs, goals, preferences and progress on ICP, including but not limited to ~~PHC~~Partnership's Complex Case Management Program.

2. Upon discontinuation of ECM, ~~PHC~~Partnership shall:
   a. Notify the ECM provider
   b. Issue a Notice of Action (NOA) to the ~~member~~Member regarding discontinuation of ECM services. The notification will serve to inform the ~~member~~Member of their rights per DHCS, including their right to appeal the decision as described in Exhibit A, Attachment 13, Provision 8, Denial, Deferral, or Modification of Prior Authorization Requests, and Attachment 14, Member Grievance and Appeals and APL 21-011: Grievance and Appeals Requirements, Notice and "Your Rights" Templates. For more information, see policy MCUP3037 Appeals of Utilization Management / Pharmacy Decisions.

G. CONTINUITY OF CARE
1. Beginning January 1, 2022 for ~~member~~Members who are in process or currently enrolled in a Whole Person Care Pilot program, who are identified by the WPC Lead Entity as belonging to an ECM Population of Focus, ~~PHC~~Partnership will automatically authorize ECM services for six (6) months pursuant to DHCS implementation schedule.
   a. Transitioning ~~member~~Members must be assessed within six (6) months of their initial authorization, or other timeframes provided by DHCS, to determine most appropriate

level of care management services and ECM benefit eligibility per the criteria as outlined above. ECM providers shall:

1) Complete a comprehensive assessment, ICP and submit to ~~PHC~~Partnership a Treatment Authorization Request (TAR) pursuant to ~~PHC~~Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process for continued ECM services.
2) Transition ~~member~~Members who no longer meet the criteria for ECM services as outlined in section VI.F. Discontinuation of ECM.
3) Notify ~~PHC~~Partnership of transitioning ~~member~~Members who have been discharged as outlined in section VI.F. above.

b. ~~PHC~~Partnership shall utilize existing data exchange platforms described in section VI.H. to coordinate with WPC Lead Entities to ensure a smooth transition and warm hand-off for mutual ~~member~~Members entering into or being discharged from the ECM benefit.

c. Both the WPC Lead Entity and ~~PHC~~Partnership shall work collaboratively to inform ~~member~~Members via written notice of the transition to the ECM benefit pursuant to DHCS' guidance.

2. ~~PHC~~Partnership shall attempt to contract with each WPC Lead Entity as an ECM provider to provide ~~member~~Members with ongoing care coordination and continuity of care in WPC Pilot Counties.

a. ~~PHC~~Partnership shall submit to DHCS for prior approval any requests for exceptions to the WPC contracting requirement. Permissible exceptions to contracting are:

1) There is a justified quality of care concern with the ECM Provider(s)
2) ~~PHC~~Partnership and ECM Provider(s) are unable to agree on contracted rates
3) ECM Provider(s) is/are unwilling to contract
4) ECM Provider(s) is/are unresponsive to multiple attempts to contract
5) ECM Provider(s) is/are unable to comply with the Medi-Cal enrollment process or vetting by the Contractor; and/or
6) For ECM Provider(s) without a state-level pathway to Medi-Cal enrollment, ECM Provider(s) is/are unable to comply with the ~~PHC~~Partnership processes for vetting qualifications and experience

b. For transitioning ~~member~~Members for whom ~~PHC~~Partnership is not able to enter into a contract with the WPC Lead Entity, ~~PHC~~Partnership shall authorize ECM services with an in-network ECM provider.

3. Members transitioning to ~~PHC~~Partnership from another managed care plan and /or fee-for-service Medi-Cal who are currently enrolled in ECM, shall automatically be authorized for ECM services. For these ~~member~~Members:

a. ~~PHC~~Partnership shall use available utilization data to proactively identify any new ~~member~~Members who are in receipt of ECM within the previous 6 months of their assignment to ~~PHC~~Partnership, and initiate continued ECM authorization.

~~1.~~ Newly assigned ~~PHC~~Partnership ~~member~~Members or their AR may contact ~~PHC~~Partnership directly to request continued ECM benefits and ~~PHC~~Partnership shall expedite this request.

b.

c. If a pre-existing relationship has been established and the ECM provider is part of ~~PHC~~Partnership's ECM network or agrees to a letter of agreement until an agreement is reached, ~~PHC~~Partnership will assign the ~~member~~Member to their existing ECM provider to ensure the ~~member~~Member's relationship is not disrupted.

~~b. PHCPartnership is not obligated under DHCS continuity of care requirements to keep the memberMember assigned to the same ECM provider, however, whenever possible~~

~~PHCPartnership shall make a good faith effort to keep the member~~Member~~'s ECM provider the same.~~

~~c.~~d. ~~PHC~~Partnership shall contact and work with the ~~member~~Member's previous health plan and/or ECM provider to obtain access to the Member's ICP and ensure services are connected appropriately.

~~d.~~e. ECM services shall be authorized for up to six (6) months. At which time, the ~~member~~Member shall be reassessed for services in accordance to the policy criteria shared above in sections VI. A, B, and F.

H. DATA SHARING TO SUPPORT ECM

1. ~~PHC~~Partnership has an Information Technology (IT) and data analytic infrastructure to support the delivery of the ECM benefit. Key features of ~~PHC~~Partnership's systems include, but are not limited to:
   a. Systems and agreements with agencies that support the information captured for ECM ~~member~~Member identification as outlined in section VI.D.
   b. Secure data sharing between, ~~PHC~~Partnership, ECM provider, the ~~member~~Member, and other providers in support of ECM.
   c. The ability to receive, process, and send encounters from ECM providers to DHCS.
   d. The ability to receive and process supplemental reports from ECM providers.
2. ECM providers shall use the "Point Click Care" module of the cloud-based Point Click Care Platform (see III. B) in the delivery of ECM services. This platform shall allow ~~PHC~~Partnership and ECM providers to:
   a. Share real-time information between ECM ~~member~~Members' care teams and providers.
   b. Serve as a mechanism for ~~PHC~~Partnership and ECM providers to share ECM ~~member~~Member assignment files (e.g. targeted engagement lists, referrals, discontinuation or disenrollment from ECM services, etc.)
   c. Track Emergency Department and Inpatient Hospital Admissions as they are occurring.
   d. Perform and run periodic reports of performance on certain quality measures and/or metrics.
3. ~~PHC~~Partnership will use defined Federal and State standards, specifications, code sets, and terminologies when sharing physical, behavioral, social, and administrative data with ECM Providers and with DHCS, to the extent practicable.

I. ECM PROVIDER NETWORK DEVELOPMENT

1. ~~PHC~~Partnership will contract with providers that meet DHCS' and ~~PHC~~Partnership requirements
2. ~~PHC~~Partnership will collaborate with other Managed Care Plans (MCP) in the applicable county to identify qualified ECM providers with which to contract.
3. ~~PHC~~Partnership will make every effort to contract and build a sufficient network of ECM providers
4. ~~PHC~~Partnership will collaborate with other MCPs in the county/counties in which it operates to achieve mandatory overlap of the provider network

~~I.~~J. ECM PROVIDER OVERSIGHT & QUALITY MONITORING

1. ~~PHC~~Partnership will perform oversight of ECM providers, holding them accountable to all ECM requirements contained in the DHCS Contract amendment and DHCS APL 21-012: Enhanced Care Management Requirements.
   a. ~~PHC~~Partnership will perform quarterly audits, or more frequently as needed, to evaluate ECM provider performance and compliance to ensure State, Federal, and contractual requirements are met. At a minimum, the following shall be reviewed:
      1) ECM Files:
         a) Visit documentation showing minimum number of visits
         b) Delivery of the Core Services components of ECM
         c) Release of Information (ROI)
      2) ECM provider's policies and procedures as they relate to the delivery of ECM,

including but not limited to:
a) Internal policies
b) Job descriptions
c) Training Materials
d) Organizational charts
e) Model of Care for Justice Involved providers that includes:
i. Provisions for a "warm handoff" between ECM providers within the correctional facility and those who will provide ECM services upon release at least 2 weeks prior to date of expected release.
ii. Ensuring the ECM provider meets the ~~member~~Member within 1-2 days of release wherever possible
iii. A second follow up ECM appointment occurs within 1 week of release.
~~i.~~iv. The ECM provider leverages the reentry plan that was developed in the pre-release period as the post-release care management plan.

3) Quality and monitoring reports to guide improvement across the network
a) Point Click Care reports
b) ~~PHC~~Partnership internal monitoring reports & dashboards
c) Member experience surveys
d) Referral patterns
e) ECM Provider Capacity Reports

b. ~~PHC~~Partnership has developed its ECM contracts using the DHCS ECM Provider Standard Terms and Conditions and incorporated all of its ECM provider requirements, including all monitoring and reporting expectations and criteria.

2. ~~PHC~~Partnership shall support ECM Provider peer sharing meetings to report on activities at a frequency of every two (2) months for new sites, during the first six (6) months of services, and at a frequency of every six (6) months for existing sites or at a frequency deemed appropriate for support as monitored by ~~PHC~~Partnership.
a. Topics shall include, but not be limited to: billing, authorizations, best practices for operational efficiencies, successful strategies to improve outreach and engagement efforts, case management and care coordination approaches for complex populations, health equity, ECM policy updates, etc.
3. ECM providers shall conduct ~~member~~Member experience surveys of enrolled ~~member~~Members at least once annually and share a summary of this survey with ~~PHC~~Partnership.
4. Over time, ~~PHC~~Partnership shall review key performance indicators of ECM providers and ECM benefit to provide benefit monitoring and oversight as well as address quality standards and to identify areas of improvement. Examples include, but are not limited to:
a. ECM ~~member~~Member-level outcomes related to medical cost, utilization and/or health status'
b. ECM referral sources and patterns
c. ECM provider key performance indicators, including but not limited to: ~~member~~Member capacity, successful outreach attempts, # of FTEs providing ECM, etc.
d. Results of ECM ~~member~~Member surveys
5. ~~PHC~~Partnership will inform PCPs, ~~member~~Members, family ~~member~~Member(s) guardian, caregiver, and/or other authorized support person(s) and community partners about the ECM benefit through routine ~~member~~Member communication pathways, including but not limited to:

a. ~~PHC~~Partnership Member Handbook
b. ~~PHC~~Partnership Website
c. Required DHCS notices
d. Webinars
e. Member/Provider newsletters

J. HEALTH EQUITY FOR ENHANCED CARE MANAGEMENT (ECM)
1. Health Equity is a priority for DHCS and ~~PHC~~Partnership. ~~PHC~~Partnership shall ensure that ECM services are delivered in a culturally relevant, person-centered manner by:
   a. Encouraging ECM providers to hire and train care management staff with experience and expertise in serving the unique Population of Focus' under ECM.
   b. Screen potential ECM providers through ~~PHC~~Partnership's ECM Readiness Assessment and contracting process
   c. Include Health Equity measures as part of ~~PHC~~Partnership's oversight and quality monitoring of ECM, such as disparities in engagement, disparities in access and/or patterns of utilization of ECM services for the health plan.

K. ECM SUBCONTRACTOR DELEGATION
1. ~~PHC~~Partnership may allow an ECM provider to subcontract with other entities to administer ECM services under the following conditions:
   a. The ECM provider maintains the responsibility for oversight and compliance of all of its subcontractors for the delivery of ECM as set forth in this policy and in DHCS APL 21-012. Examples of compliance include, but are not limited to:
      1) Ensure the subcontractor meets the DHCS required provider experience thresholds for the delivery of ECM for the Population(s) of Focus.
      2) Ensure the subcontractor has appropriate staffing ratios and capacities.
      3) ~~PHC~~Partnership shall provide oversight and monitoring of the ECM provider's ability to perform delegation of the ECM benefit.
      4) Maintain current contracts and make available to ~~PHC~~Partnership any subcontractor agreements upon DHCS request. Such agreements will contain minimum required information specified by DHCS, including the method and amount of compensation, Population(s) of Focus served, service area, case ratios and ECM capacity.
   b. ~~PHC~~Partnership will ensure the agreement between ECM delegated entity and subcontractor mirrors the requirements outlined in the DHCS Contract and the ECM provider Standard Terms and Conditions, as applicable to the subcontractor.
   c. ~~PHC~~Partnership will make every effort to collaborate with its ECM provider delegated entities and subcontractors on the best approach to streamline the ECM experience and minimize the divergence for ECM ~~member~~Members and providers.
2. ~~PHC~~Partnership will hold ECM entities and subcontractors to the same ECM provider requirements.
3. ~~PHC~~Partnership shall maintain appropriate structures and mechanisms to ensure delegation oversight, including pre-delegation evaluation as applicable, no less than annual review of delegation agreement/grid, monitoring of performance data, and oversight auditing of delegated functions. ~~PHC~~Partnership's delegation oversight is designed to effectively review, evaluate, and verify satisfactory performance and compliance with regulatory and accreditation standards.

L. DHCS ECM OVERSIGHT
1. ~~PHC~~Partnership will submit the following data and reports to DHCS to support DHCS' oversight of ECM:
   a. Encounter data using national standard specifications and code sets defined by DHCS.
      1) ~~PHC~~Partnership is responsible for submitting all encounter data to DHCS for ECM services to its ~~member~~Members, regardless of the number of levels of delegation

and/or sub-delegation between ~~PHC~~Partnership and the ECM provider.

2) In the event the ECM provider is unable to submit the ECM encounters to ~~PHC~~Partnership using the national standard specifications and codes set by DHCS, ~~PHC~~Partnership will be responsible for converting the ECM provider's data information before DHCS submission.

b. Supplemental reporting on a schedule and in the DHCS specified format.

2. ~~PHC~~Partnership will track and report to DHCS in a DHCS specified format, information about outreach efforts related to potential ECM ~~member~~Members.

VII. REFERENCES:

A. DHCS Contract Exhibit A, Attachment 5 Utilization Management and Attachment 6, Provision 13, Ethnic and Cultural Composition

B. DHCS All Plan Letter (APL) ~~21-012~~23-032 Enhanced Care Management Requirements (~~09/15/2021~~12/22/2023 *supersedes APL 21-012*)

C. DHCS All Plan Letter (APL) 21-011 Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2021)

D. DHCS All Plan Letter (APL) ~~19-004~~22-013 Provider Credentialing / Recredentialing and Screening / Enrollment (~~06/12/2019~~07/19/22 *supersedes APL 19-004*).

E. Title 42 Code of Federal Regulations (CFR) Section 438.208(c).

F. Title 42 Code of Federal Regulations (CFR) Section 441.301(c).

G. DHCS ECM Policy Guide (~~July 2023~~August 2024)

~~G.~~H. DHCS ECM Referral Standards and Form Templates (August 2024)

VIII. DISTRIBUTION:

~~D.~~E. ~~PHC~~Partnership Department Directors

~~E.~~F. ~~PHC~~Partnership Provider Manual

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

X. REVISION DATES: 10/12/22; 11/08/23; 11/13/24

PREVIOUSLY APPLIED TO:

****

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

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

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

~~PHC~~Partnership's authorization requirements comply with the requirements for parity in mental health and

substance use disorder benefits in 42 CFR 438.910.

PARTNERSHIP HEALTHPLAN of CALIFORNIA
A Public Agency

ECM Care Plan Guide

Date: _____

Patient Information			
First Name:	Last Name:		DOB:
Sex:	Pronouns:	Primary Language:	
Address Information			
Street:			
City:	State:	Zipcode:	County:
Mailing Address Same as Home Address:		☐ Yes	☐ No
Street:			PO Box:
City:	State:	Zipcode:	County:
Contact Information			
Email:			
Phone #:			
Phone #:			
Other Contacts			
Family/Caregiver	Name:		May we contact if needed?
Email:		Phone #:	
Community Team	Name:		May we contact if needed?
Email:		Phone #:	
Program Representative	Name:		May we contact if needed?
Email:		Phone #:	
Insurance Information			
Medi-Cal ID:			
Primary Insurance	Plan:		Group #:
Policy #:		Member ID:	
Secondary Insurance	Plan:		Group #:
Policy #:		Member ID:	

Acuity			Self-Management Assessment		
☐ High Risk	☐ Low Risk	☐ No Risk	☐ Poor	☐ Moderate	☐ Good

Social Determinants of Health	
If current member has any changes to SDoHs, check the box and fill out only the changes: ☐	
Education:	Employment Status:
Income Status:	Food Security:
Housing Stability:	Transportation:
Support Networks:	

ECM Criteria (Select all that apply)				
Populations of Focus		***For current member, if no longer meets criteria, fill applicable criteria***	***If current member and new criteria identified, fill applicable criteria***	***If new member, fill applicable criteria***
Adult	*Unhoused*	☐	☐	☐
	Individuals At Risk for Avoidable Hospital or ED Utilization	☐	☐	☐
	At Risk of Institutionalization & Eligible for LTC Services	☐	☐	☐
	Nursing Home Transition to the Community	☐	☐	☐
	Serious Mental Health/Substance Use Disorder	☐	☐	☐
	Pregnant and Postpartum at Risk for Adverse Perinatal Outcomes	☐	☐	☐
	Transitioning from Incarceration w/ Complex Health Needs to Community	☐	☐	☐
Child	*Unhoused*	☐	☐	☐
	Individuals At Risk for Avoidable Hospital or ED Utilization	☐	☐	☐
	Serious Mental Health/Substance Use Disorder	☐	☐	☐
	Pregnant and Postpartum at Risk for Adverse Perinatal Outcomes	☐	☐	☐
	Birth Equity	☐	☐	☐
	Transitioning from Incarceration	☐	☐	☐
	Complex Medical / Behavioral / Development Needs	☐	☐	☐
	Involved in Child Welfare	☐	☐	☐
	Enrolled in California Children's Services (CCS) or Whole Child Model (WCM) w/ Additional Needs Beyond CCS Condition	☐	☐	☐

Physical Health

Active Medical Problems (chronic conditions, fall risk, speech, etc.)	Past Medical History

Not Req'd. for members less than 18		Members with diabetes or who are on antipsychotic medication	
Blood Pressure:	Date:	A1C Levels:	Date: _____ _____A1C%
	____Systolic / ____Diastolic		

Dental/Oral Health

Active Dental Problems/Concerns

Dental Provider's Name:	Last Visit Date:
Dental's Office:	Next Visit Date:

Mental Health History

	If PHQ-2 Score is normal, do not proceed to PHQ-9 Test. If PHQ-2 Score is not normal proceed to PHQ-9 Test	
	Date:	
	PHQ-2 Score	PHQ-9 Score

If prescribed Antidepressants or Psychotherapy, please provide more information below
(E.g.: adherence to medication regimen; improvements in mental health after therapy)

Substance Use Disorder Screening

Alcohol Use	Drug Use
Frequency:	Frequency: Drug Type
AUDIT-C Score	DAST-10 Score

If other information requires further disclosure, please provide below:

Hospitalizations	
Admissions in the last 6 mos:	Emergency Dept. visits in the last 6 mos:

Durable Medical Equipment		
___Hospital Bed	___Oxygen	**Other**
___Wheelchair	___Walker	

Physician Visits	
Primary Care Physician visits in the last 6 mos:	Last Visit Date:
Physician's Name:	Physician's Office:
Specialist visits in the last 6 mos:	Last Visit Date:
Specialist's Name:	Specialist's Office:

Medication List	Indication

Allergies

Long-Term Support Services	
Community Based Adult Services (CBAS)	Service Name
Multi-purpose Senior Services Program (MSSP)	Service Name
Home Health Agency	Service Name
Palliative Care	Service Name
Hospice Care	Service Name
In-Home Support Services (IHSS)	Hours/month

Advanced Care Planning			
Surrogate Decision Maker	☐ Has One	☐ Needs One	☐ Does Not Want One
Living Will	☐ Has One	☐ Needs One	☐ Does Not Want One
Advance Directive	☐ Has One	☐ Needs One	☐ Does Not Want One
POLST	☐ Has One	☐ Needs One	☐ Does Not Want One
Power of Attorney	☐ Has One	☐ Needs One	☐ Does Not Want One
Code Status	☐ DNR	☐ Full Code	☐ Limited Interventions

Goals	
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met
Goal:	
Intervention:	
Barriers:	
Outcome:	___Goal Met ___Goal Not Met ___Goal Partially Met

Referrals Needed

ECM Staff Member Name: Date

ECM Staff Member Signature: Date

ENHANCED CARE MANAGEMENT (ECM) SERVICES

Authorization for Use, Exchange, and/or Disclosure
of My Confidential Health Care and Personal Information

PURPOSE

Health care providers, health payers, and social services agencies have joined together to provide **Enhanced Care Management (ECM) services** to help promote your health and well-being. To allow Partnership HealthPlan of California ("**Partnership**"), and/or other entities to share your health care and other personal information with each other to help provide you with these ECM services, you must give your authorization first. By filling out this form, you are authorizing the use and release of your health care and other personal information by the following entities participating in ECM ("**ECM Entities**"): health care providers such as hospitals, physicians, and pharmacies; Partnership and other managed care plans that administer Medi-Cal benefits and pay for services you receive under Medi-Cal; community-based organizations that must comply with health care privacy laws; school-based providers such as nurses, social workers, and counselors; the California Departments of Health Care Services, Public Health, Social Services, and Developmental Services; and county agencies including, but not limited to, mental health plans; and providers and case managers at correctional facilities, but only for the purposes set forth below. Your authorization will permit ECM Entities to use and release your health care and other personal information for the following purposes ("**Purposes**"): (a) to provide you with, refer you to, or help you receive comprehensive care management services, including coordinating health and health-related care services and case management, ("**Services**") to meet your needs; (b) to identify, support, coordinate, improve and arrange payment for Services that may be provided to you; and (c) to help Partnership provide better care through evaluation, reporting, and population health management. The information may be shared in a secure electronic format, in writing, or verbally to coordinate Sservices for you.

Member Information

First Name:	Last Name:
Address:	
Phone Number:( )	Date of Birth:
Member ID/CIN:	

I authorize and ask that **Partnership HealthPlan of California** and **participating ECM Eentities** named in **Attachment A** to use and share any of my health care or other personal information with each other for the purpose stated ~~above~~in this Authorization.

Choose ONE of the following options:

INITIAL HERE	**Consent for communication by ECM Program:** By putting my initials here, I am allowing ALL of the ~~agencies~~ ECM Entities listed in **Attachment A** to use and share my health care and other personal information about my medical history, physical and mental condition, and receipt of social services, and to communicate with each other in order to provide ECM Sservices., ~~OR~~ The types of health and other confidential information that I am authorizing to be shared between ECM Entities include: (a) Protected health information ("**PHI**"), including information regarding my health

	care, medical history, lab test results, and current or future conditions and treatment; (b) Mental health information, including current and past diagnoses and treatments of my mental health conditions, excluding psychotherapy notes which are only shared if I sign a separate consent form; (c) Individualized Education Program information and other information about social services provided in school; (d) Medi-Cal eligibility/enrollment information, which includes income and certain other demographic and geographic information pertaining to my eligibility for Services and benefits; (e) Housing/homelessness information, including my housing status, history, and supports; and (f) Limited criminal justice information, including booking data, dates and location of incarceration, and supervision status. My consent does not apply to my criminal history, charges, and immigration status.
INITIAL HERE	**Decline to participate in ECM:** I understand that the ECM program allows ~~community partners~~ECM Entities to be in contact with each other to coordinate my care. I decline to participate in the ECM program. I can ask ~~for~~ to participat~~eion~~ in case management programs ~~that~~ for which I am eligible ~~for~~.

Further, by putting my initials below, I specifically authorize the release of the following information (this information will NOT be released unless you specifically authorize it)

INITIAL HERE	Mental health information, including diagnosis, treatment plan, and provider name. This does not include psychotherapy notes, which are only shared if I sign a separate consent form.
INITIAL HERE	HIV Test Results (Health & Safety Code § 120980 (g))

Substance Use Disorder Information

Substance use disorder ("**SUD**") records are protected by federal confidentiality rules (42 CFR Part 2). The federal rules do not ~~let~~ allow any further release of information that finds a patient as having or having had a substance use disorder either by reference to publicly available information, or through proof of such identification by another person unless further release is permitted by the written consent of the person whose information is being given or as otherwise permitted by 42 CFR Part 2. The federal rules restrict any use of the information to investigate or prosecute, with regard to a crime, any patient with a substance use disorder, except as provided at §§ 2.12(c)(5) and 2.65. By filling out this section, you are authorizing ECM Entities to use and release the following SUD information for the Purposes described in this form: your current and past drug or alcohol use diagnoses, medications, treatment, lab tests, trauma history, facility discharges, and any other SUD information about you that comes from a substance/alcohol use disorder provider subject to federal SUD confidentiality regulations (42 C.F.R. Part 2). SUD records (or information therein) that are used or disclosed for treatment, payment, or health care operations by certain ECM Entities, including health care providers, health plans and other third-party payors, may be redisclosed as permitted in the federal HIPAA regulations, except for uses and disclosures for civil, criminal, administrative, and legislative proceedings against you. Your SUD counseling notes will not be shared unless you sign a separate consent form.

INITIAL HERE	Initial here to allow the ECM Eentities in **Attachment A** to use and share ~~ALL of your drug and~~ ~~Alcohol~~your SUD information as described above, ~~including test results, treatment plans, programs attendance, communication with counselor, and diagnosis~~excluding SUD counseling notes.

Expiration of Form

Choose ONE of the following two options:

INITIAL HERE	**Standard expiration:** This authorization will expire ~~exactly 5 years~~ 1 year [DBR1]from today's~~—~~ date~~;,~~ OR
INITIAL HERE	**Early expiration:** This authorization will expire on:_____. This date may not be less than 6 months (to participate in the ECM program), or more ~~than~~ ~~5~~than 1 year~~s~~ from today's date.

I understand that:

- I can revoke this Authorization at any time by calling Partnership at (800) 863-4115 or by sending a signed revocation request to:

  Partnership HealthPlan of California
  Attn: Enhanced Health Services[DBR2]
  4665 Business Center Drive
  Fairfield, CA 94534
- A revocation is effective when received, but may not apply to information already shared, based on my prior consent to use or release information.
- I can choose to not sign this form and doing so will not affect my treatment or care, my eligibility for or ability to receive Services, or the payment for Services. ~~By not signing,~~ However, ~~I understand that this could affect~~ my ability to participate in the ECM program may be affected by not signing this Authorization.
- Even if I do not sign this form, under federal and state privacy laws, some of the ECM Entities may share my confidential information for treatment, payment, and other purposes, but providers subject to federal substance use confidentiality laws generally may not share my substance use disorder information without my consent (42 CFR Part 2).
- The information I authorize for use or release ~~Some information shared in this form~~ may be re-shared ~~with others~~by ECM Entities, but only in compliance with this Authorization and applicable law.
- ~~42 CFR part 2 does not allow re-disclosure of substance use records that are subject to that part without my authorization.~~
- I can get a copy of the health information that is being shared.
- I have the right to ask for a copy of this form and one will be sent to me.
- I may obtain a list of all ECM Entities to which my information has been disclosed, including those entities identified in **Attachment A**, by contacting Partnership.
- If I voluntarily include my phone number above, I consent to the receipt of texts or calls to communicate with me about my consent choices and how my health and other confidential information may be shared (standard message and data rates may apply).
- Each of the above rights extend to any representative I authorize under applicable law.

[*signature on next page*]

~~This authorization may be taken back at any time by calling Partnership at (800) 863-4155 or by sending your signed request to:~~

~~Partnership HealthPlan of California~~
~~Attn: Member Services~~
~~4665 Business Center Drive~~
~~Fairfield, CA 94534~~

~~The change will take effect when Partnership receives it, but does not affect information that has already been given.~~

Signature of Member

If you are signing this Authorization on your own behalf, fill out the first line. If you are signing on behalf of someone else, fill out the second line. If you are signing on behalf of a minor aged 12-17, the minor should fill out the first line and you should fill out the second line.

Beneficiary's Name	Beneficiary's Signature	Date (mm/dd/yyyy)
Representative's Name	Representative's Signature	Date (mm/dd/yyyy)

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Cultural & Linguistic Program Description

MCND9002

November 13, 2024

Original Date: ~~02/19/2014~~

Previously Applied to MPLD7001 02/19/14 to 09/09/20

Revision Dates: MCND9002 09/09/20; 09/08/21; 09/14/22; 11/8/23

Table of Contents

Program Purpose

To demonstrate the commitment of Partnership HealthPlan of California (Partnership) to deliver culturally and linguistically appropriate health care services to a culturally and linguistically diverse population of members and potential members. in a way that promotes Health Equity for all members.

Introduction

This Cultural and Linguistic (C&L) Program description defines how Partnership uses its resources to achieve the goals and commitments to delivering culturally and linguistically competent health care services to all Partnership members, including members with limitedLimited English proficiencyProficiency (LEP) or sensory impairment. This program description also describes how Partnership offers care and services in a way that is effective, health equity-driven, understandable, and respectful and responds to diverse cultural health beliefs and practices and linguistic/communication needs.[1]

Partnership also works to ensure there is equal access to the provision of high quality interpreter and linguistic services for LEP Membersmembers and potential members, and for members and potential members with disabilities, in compliance with federal and state law, and APL 21-004.[2] Partnership makes this commitment to the availability and accessibility of these C&L services, along with a commitment to nondiscriminatory treatment of members, regardless of sex, race, color, national origin, religion, ancestry, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or group as defined in Penal Code 422.56, Title VI of the Civil Rights Act of 1964 or Section 1557 of the Affordable Care Act of 2010. Partnership maintains, continually monitors, improves, and evaluates cultural and linguistic services that support covered services for all members, including members less than 21 years of age.[3]

All covered services and, member-facing programs, member facing (including health education) and/or outreach material are provided in a culturally and linguistically

[1] National Culturally and Linguistically Appropriate Services Standards National Culturally and Linguistically Appropriate Services Standards
[2] APL 21-004 and Threshold and Concentration Languages
[3] Penal Code 422.56

appropriate manner that promotes health equity for all members[1,2,3]. Member facing materials are routinely distributed in all of Partnerships threshold languages, meet the requirements of APL 18-016 Readability and Suitability of Written Health Education Materials,[4] and are available in accessible formats upon member request. Partnership also ensures that members receive all Member Information in a language or alternative format of their choice.

Objectives

Partnership's C&L Program objectives are accomplished through interdepartmental collaboration and include:

- Collecting and updating data on the race/ethnicity, language, sexual orientation and gender identity of Partnership members and sharing this information with providers. This effort is part of Partnership's goal to monitor and evaluate how CLAS may impact health equity and outcomes, which can better inform service delivery. Members will be advised of the intent to share their data and will be given the right to opt out of data sharing in accordance with their privacy rights.
- Ensuring Partnership's staff, providers' and delegates' Cultural and Linguistic services comply with the Department of Health Care Services (DHCS) and Federal regulations without limitations, particularly relating to communication assistance requirements and access for members with disabilities[4,5,6,7,8,5,6,7,8,9]
- Continually assessing, monitoring, improving and evaluating Partnership's C&L services that support covered services for members, including members under the age of 21.

[4] APL 18-016 Readability and Suitability of Written Health Education Materials
[4] 22 CCR 53876; 21202.5; 51202.5; 51309.5(a)
[5] 28 CCR 1300.67.04(c)(2)(A)-(B); 1300.67.04(c)(2)(G)(v)-(c)(4)
[6] 42 CFR 438.206(c)(2); 438.10; 438.404
[7] W&I Code 14029.91
[8] Medi-Cal Managed Care Plans, Exhibit A, Scope of Work 5.2.10
[5] 22 CCR 53876; 21202.5; 51202.5; 51309.5(a)
[6] 28 CCR 1300.67.04(c)(2)(A)-(B); 1300.67.04(c)(2)(G)(v)-(c)(4)
[7] 42 CFR 438.206(c)(2); 438.10; 438.404
[8] W&I Code 14029.91
[9] Medi-Cal Managed Care Plans, Exhibit A, Scope of Work 5.2.10

- Addressing deficiencies and gaps in Partnership's C&L services
- Communicating Partnership's C&L Services and Standards to staff, providers, delegates, and community members

Measurable objectives can be found later in this document and in the joint Quality Improvement Health Equity Transformation Program (QIHETP) and Cultural and Linguistics (C&L) annual work plan.

Programs and Services

Partnership's C&L programs and services outlined below encompass the services directly provided to members and potential members, as well as the support provided to Partnership staff, providers', and delegates' capacity in understanding the C&L needs of our member population. Partnership will take immediate action to improve its culturally and linguistically appropriate services when deficiencies are noted.

Language Data Collection

At least every three years, DHCS gathers language information for individuals enrolled in Medi-Cal and shares this information with Managed Care Plans (MCPs) ~~(see MCND9002 attachment C for threshold languages). According to APL 21-004 and its attachments, MCPs must provide translated written member information to the following groups if those groups reside in the Managed Care Plan's service area[9] and if:~~

- ~~There is a population group who speak a primary language other than English which meets the threshold of 3,000 or 5% of the eligible Medi-Cal Population, whichever is lower, or~~
- ~~There is a population of eligible Medi-Cal members who live in the MCP's service area who speak a non-English, primary language and who meet the concentration standards of 1,000 people in a single ZIP code, or 1,500 in two contiguous ZIP codes~~

~~This practice helps~~ to address potential changes to threshold and concentration standard languages~~,~~ (see MCND9002 attachment C for threshold languages) as well as any changes in state and/or federal law.[9] ~~This information is used as part of the assessment of language services for members, and when possible, to guide network development. Partnership retains a list of the DHCS-provided threshold and concentration standard languages and makes adjustments to the list based on DHCS'~~

[9] ~~APL 21-004 and Threshold and Concentration Languages~~

~~triennial timeline. In addition,~~ Partnership reviews overall language prevalence per state-published data every three years in order to identify emerging language patterns that may impact Partnership members or potential members. This data is also used to assess languages in a way that aligns with DHCS requirements as outlined in APL 21-004 as well as aligns with NCQA requirements for threshold languages of five (5) percent or 1,000 individuals), as well as languages spoken by one (1) percent or 200 individuals (whichever is less). According to APL 21-004 and its attachments, MCPs must provide translated written member information to specific groups in the MCP's service area as identified by DHCS in the Threshold and Concentration Language dataset.[10] Partnership also routinely collects and maintains records of member language preferences spoken by one (1) percent of the member population or less.

~~In 2023~~In addition to DHCS's language data collection and analysis process for Partnerships' member population, Partnership will conduct its own data analysis at the community and/or census level to determine and report out on the languages spoken by five (5) percent or 1,000 individuals, whichever is less, and by 1% of the population or 200 individuals, whichever is less. For more details on this process, please refer to the Community Language Assessment report.

At the time of the writing of this document, Partnership's concentration standard and/or threshold languages are Russian, Tagalog, and Spanish, as determined by DHCS~~.~~ ~~Partnership annually distributes a written notice in English and in up to 15 languages spoken by 1 percent of members served by the organization or by 200 individuals (whichever is less), that the organization provides free language assistance and how individuals can obtain it~~. For information on threshold languages as determined by Partnership, please refer to the Community Language Assessment report.

~~Non or limited-English proficient members can~~These practices help to address potential changes to threshold and concentration standard languages, as well as any changes in state and/or federal law. This information is used as part of the assessment of language services for members to improve the Cultural and Linguistics program offerings, and when possible, to guide network development. Partnership will retain a list of the DHCS-provided, and Partnership-determined threshold and concentration standard languages. Adjustments to the list will be based on findings from the Community Language Assessment report and DHCS's triennial timeline.

Partnership distributes a written notice in English and up to 18 languages spoken by 1 percent of the members served by the organization or by 200 individuals (whichever is less), informing members that the organization provides language assistance services

[10] APL 21-004 and Threshold and Concentration Languages

and how they can obtain it at no cost to the member. Non-speaking or Limited English Proficient (LEP) members can also request language and/or interpretation services, or even refuse interpreter services; this request is then documented in Partnership's member record[10].[11]. Partnership sharesmay use or disclose the member's preferred language with Partnership network practitioners/providers through, subcontractors, or other covered entities for the Provider Portal as permitted by member consentpurposes of ensuring communication and respecting the privacy of their care delivery in a culturally sensitive and linguistically appropriate manner. Members are informed when language information is directly collected that their language preferences may be shared.

Partnership also assesses and collects data on the cultural and linguistic needs of the member population through the written Population Needs Assessment. (PNA). Each year, Partnership assesses the overall environment, specific community needs, and the factors that influence the health and well-being of the assigned member population. This datainformation is collected from its member population data and integrated into the PNA, which then drives the goals of Partnership's Population Health Management Strategy along with, the Cultural & Linguistics Program, and their associated work plans. Both of these work plans are the driving force by which Partnership responds to the cultural and linguistic diversity and needs of Partnership's member population. The report is written in accordance with the requirements of both the California Department of Health Care Services (DHCS) as well as the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA)).).

Finally, in alignment with DHCS's Population Health Management Policy Guide, Partnership collects information on language needs as part of its collaboration with each Local Health Jurisdiction in its service area.[12] This collaborative work is referred to as the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) process. Based on this collaborative work, and input from various stakeholders, Partnership annually reviews and updates its strategies and work streams related to the DHCS goals, health equity, health education materials, wellness and prevention programs, and cultural and linguistic and quality improvement strategies to address identified health and social needs in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy.[13] Findings from both the PNA and CHA/CHIP

[10] APL 22-017 and APL 22-017 MMR Standards
[11] APL 22-017 and APL 22-017 MMR Standards
[12] DHCS Basic Population Health Management Policy Guide
[13] DHCS Comprehensive Quality Strategy

work are shared with our providers and other stakeholders as needed on a regular basis.

Language Assistance Services

Partnership ~~Members~~members are entitled to interpretation services and written translation of critical and vital informing materials in their preferred threshold language, including oral interpretation and American Sign Language, as well as their preferred alternate format. Partnership ~~Members~~members can request Interpreting and/or translation services by contacting the Member Services Department or any other member-facing department (Utilization Management, Population Health, Care Coordination, Grievance & Appeals, and Transportation). Members can also call a toll-free number with TTY/TDD.

Language Assistance Taglines, Nondiscrimination Notices, and Member Information

In alignment with APL 21-004[14] and other DHCS requirements, Partnership publishes nondiscrimination notices and language assistance taglines ~~on its external website. Language taglines and nondiscrimination notices~~. They are sent with all ~~major~~ member ~~correspondence,~~correspondences as well. Language assistance taglines are published in a conspicuously visible font size in English and California's top 18 non-English languages spoken by Limited English Proficient (LEP) individuals~~; language taglines~~ in the state; they inform members of all available language assistance services~~.~~ and how to access them (including written translation and interpretation). These taglines and nondiscrimination notices are in a font size no smaller than 12-point and are available in all Threshold Languages/Concentration Standard Languages and alternative formats (including Braille, large-size print font that is no smaller than 20-point, accessible electronic format, or audio format), and ~~through~~ Auxiliary Aids at no cost to the member, and upon request. Consideration is also given for the special needs of ~~Members~~members with disabilities or LEP members. ~~All member facing material is created using simple language, is provided at a 6th grade reading level, and is approved by DHCS before distribution.~~ Vital member correspondences include, but are not limited to:

- Partnership Member Handbook/Evidence of Coverage (EOC)
- Partnership Provider Directory
- Form letters and notices critical to obtaining services

[14] All Plan Letter 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services

- Notices of Action
- Notice of Appeal Resolution Letters
- Notices of Adverse Benefit Determination
- Grievance and Appeals letters
- Welcome Packets
- Marketing Information
- Preventive health reminders
- Member surveys
- Notices advising of the availability of free language assistance services
- Newsletters
- All member information, informational notices, and materials critical to obtaining services targeted to members, potential enrollees, applicants, and members of the public

The nondiscrimination notice and the notice with taglines includes Partnership's toll-free and Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services, and are posted:[15]

a) In a conspicuous place in all physical locations where Partnership interacts with the public;
b) In a location on Partnership's website that is accessible on the home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and
c) In the Member Handbook/EOC, and in all Member Information, informational notices, and materials critical to obtaining services targeted to Members, Potential Members, applicants, and the public at large, in accordance with APL 21-004 and APL 22-002, 42 CFR section 438.10(d)(2)-(3), and W&I section 14029.91(a)(3) and (f).

In alignment with DHCS requirements, all member facing material and correspondences are created using simple language, are culturally and linguistically appropriate, are provided at a 6th grade reading level, are in a format that is easily understood, in a font size no smaller than 12-point, are translated and sent in the member's preferred language (including Partnership's threshold languages) and format, and are approved by DHCS before distribution. Health education materials are approved by a Qualified

[15] All Plan Letter 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services

Health educator as defined by APL 18-016.[16] Translation of member facing materials are provided to members at no cost to them.

Partnership also provides members with requested information in their preferred format in a timely fashion. Preferred formats includes Braille, large-size print font no smaller than 20-point, accessible electronic format, audio compact disc (CD) format, or data CD format), and through Auxiliary Aids at no cost and upon member request. Partnership maintains a library of all member facing materials in all Partnership threshold languages, including the major correspondence, health education materials, and other benefit-related, member informing materials. Any mailed correspondence is sent according to the member's preferred threshold language or format. Other documents, such as letters or utilization review determinations are translated within 2 business days ~~per APL 21-011 and policy MCUP3041 Treatment Authorization Request (TAR) Review Process.~~ . Members may also request translation of other documents~~, and these~~. Translated materials are ~~provided~~completed within 2 business days of the request~~.~~ and members receive their fully translated materials in a timely manner.

Translation ~~Services~~Service

Partnership utilizes United Language Group (ULG) as the certified translation service of ~~vital~~all member-facing materials (including vital written materials) for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages. Members can inform Partnership of their preferred language to receive written translations of member materials in the identified Threshold Language, at no cost to the member.

Member requests are fulfilled in a timely manner. ULG services are provided at no cost to the member~~;~~. Partnership aims to have written member information ~~is~~ translated within 2~~-~~5 business days ~~for Partnership's~~depending on the complexity and rarity of the language requested; threshold and concentration ~~language, as~~languages are defined by DHCS APL 21-004~~.~~ . All translations are verified by separate, additional ULG translators to ensure cultural and linguistic accuracy as well as appropriate grammar and context (see attachment MCND9002~~-C~~ D Process for Culturally and Linguistically Appropriate Translations for further translation explanation).

Partnership has adopted the definition of a qualified translator/vendor as delineated in APL 21-004.[12] Per this APL, a translator interpreting for Partnership member must:

[16] APL 18-016 Readability and Suitability of Written Health Education Materials

- Adhere to generally accepted translator ethics principles, including client confidentiality,
- Have demonstrated proficiency in writing and understanding both written English and the written non-English language(s) in need of translation; and,
- Be able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.

Partnership has requirements for their translator certification process, as set forth by ULG Services in ~~Attachment MCND9002-C.~~ MCND9002 D Process for Culturally and Linguistically Appropriate Translations.

Interpreter Services

Partnership provides equal and timely access to high quality, oral and non-oral interpretation services to members ~~with Limited~~ who are monolingual, non-English ~~Proficiency~~-speaking, or LEP from a qualified interpreter on a 24-hour, 7 days a week basis at all key points of contact and at no cost to all members and potential members. Oral interpreter services are available for any language spoken by the member (see MCND9002 attachment A for criteria and authorization requirements for interpreting services). Key points of contact include the medical care setting, such as telephone, advice, Urgent Care, and other outpatient encounters with providers; and non-medical care settings, such as a member services, orientations, and appointment scheduling. Interpreter services are available in all of Partnership's threshold languages, and over 200 additional languages are available upon member request through Partnership's contracted language service provider~~. Any Partnership staff member who interacts with~~. Member's preferred language (if other than English) is also prominently noted in their medical record, as well as the request or refusal of language/interpretation services in accordance with Title VI of the Civil Rights Act of 1964[17]. Any Partnership staff member who provides interpreter services to members in a non-English language is tested for proficiency through Human Resources before engaging members in that language.

Partnership has contracted with AMN HealthCare as their language interpretation service provider. Sight translation (oral interpretation) of written information can also be provided upon member request. Partnership ensures that timely access to care will not be delayed due to lack of interpretation services. Language services through AMN

[17] Title VI of the Civil Rights Act of 1964

Healthcare are available for any member in need of an interpreter, member facing staff, and providers working with Partnership members. Member-facing delegates are also required to provide interpreter services for members, however, workflows vary per delegate.

Partnership uses the definition provided by APL 21-004 in vendor selection and to define a qualified interpreter as an interpreter ~~who~~[9]~~:~~who:[9]

- Has demonstrated proficiency in speaking and understanding both spoken English and the non-English language in need of interpretation,
- Is able to interpret effectively, accurately, and impartially, both receptively and expressively, to and from such language(s) and English, using any necessary specialized vocabulary and phraseology; and,
- Adheres to generally accepted interpreter ethics principles, including client confidentiality.

When providing high quality interpretive services for an individual with disabilities, Partnership uses qualified non-oral interpretation services either through a remote interpreting service or an onsite appearance per the requirements stated in APL 21-004. This definition asserts that an interpreter who provides interpretive services for an individual with disabilities is an interpreter who:

- Adheres to generally accepted interpreter ethics principals, including client confidentiality; and
- Is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology.

For an individual with a disability, qualified interpreters can include sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes). When providing Video Remote Interpreter (VRI) services, Partnership provides real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection. The connection is delivered through high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; and provide a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of body position. Partnership provides clear, audible transmission of voices, and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.

Partnership does not allow for the use of adult friends, family, or minor accompanying a member to interpret. The exceptions to this rule are as follows:

- In the middle of an emergency where a qualified interpreter is not available, or
- If the member explicitly requests the accompanying person to interpret, the accompanying person agrees to help, and it is appropriate for the situation.

Auxiliary Aids and Services

In accordance with APL 21-004 and APL 22-022, Partnership provides the following auxiliary aids and services to members, their authorized representative (AR) or someone with whom it is appropriate for Partnership to communicate with ("companion") by request or as needed, and at no cost to the member:

- Qualified oral and sign language interpreters on-site or through VRI services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones/telephone typewriters (TTYs) or Telecommunication Devices for the Deaf (TDD), videophones, captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and communication technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.
- Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials (no less than 20-point font); accessible information and communication technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision.

Please see MCND 9002 attachment B to learn how Partnership provides auxiliary aids and services for persons with disabilities.

Alternate Formats

In accordance with APL 21-004 and APL 22-002, Partnership provides member information to members and potential members in alternate formats to meet the ~~C&L~~cultural and linguistic needs of members, including Braille, large print text (20 point font or larger), audio, and electronic formats, at no cost. Partnership maintains record of ~~members'~~member's linguistic capability upon member enrollment, and as reported thereafter, using data provided by DHCS or reported to Partnership by the member

and/or their AR, or by Subcontractors. Partnership members ~~or,~~ their ARs, or someone with whom it is appropriate for Partnership to communicate with ("companion"), are encouraged to call Partnership or report their format preference via the DHCS AFS application system; this information is then passed on to Partnership for incorporation into the member record~~.~~ and implemented as appropriate.

~~Trainings~~

In alignment with APL 22-002, when a member contacts Partnership about electronic alternative formats, Partnership also informs the member that, unless they request a password-protected format, the requested member information will be provided in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. Partnership then communicates to the member that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the encrypted information.[18]

Trainings

In alignment with APL 23-025 Diversity, Equity, And Inclusion Training Program Requirements, Partnership educates and trains all ~~staff and leadership~~contracted network providers on diversity, equity and inclusion~~,~~ (including sensitivity, communication skills, cultural competency/humility training, health equity, and related trainings), as well as Partnership-specific culturally and linguistically appropriate policies and practices ~~on an annual basis. Partnership provides a minimum~~. Providers also separately receive a review of ~~two specific trainings annually: one mandatory annual internal training on cultural competency, sensitivity, inclusion, health equity, diversity, and communication skills to Partnership staff and Partnership contracted staff; and, an external DEI training for network providers, including completing required Continuing Medical Education on cultural competency and implicit bias. Network providers and delegates (Subcontractor, and Downstream Subcontractor) are also required to provide such trainings (as listed above) to their staff at all key points of contact with members, per their network provider and delegate agreement.~~ Partnership's ~~Health Education unit, in collaboration with the Health Equity Officer, reviews training materials to ensure they reflect current standards, and completion records are kept on file. The trainings include, at minimum:~~policies and procedures for language assistance services and how to access them. Partnership provides trainings for contracted Network Providers within 90 days of their start date, with retraining as needed during re-credentialing cycles.[19]

[18] APL 22-002 Alternative Format Selection for Members with Visual Impairments
[19] APL 23-025 Diversity, Equity, and Inclusion Training Program Requirements

- ~~An overview of Partnership's C&L Services and policies and procedures for language assistance.~~
- ~~How to work effectively with LEP Members and Potential Members.~~
- ~~How to work effectively with interpreters in person or through video, telephone, or other media.~~
- ~~Understanding the cultural diversity of Members and Potential Members, sensitivity to cultural differences related to delivery of health care interpretation services, and promoting access and the delivery of services in a culturally competent way to all members and potential members regardless of~~Also in alignment with APL 23-025, Partnership's Director of Health Equity reviews and oversees the evidence-based DEI trainings and program. The training content will be delivered as training modules via an electronic Learning Management System (LMS) to allow asynchronous training delivery throughout Partnership's 24 counties of service. It will review 3 major themes to ensure coverage of Partnership member demographics including, but not limited to, members' sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, ~~or~~ sexual orientation, or identification with any other ~~persons~~person or groups defined in Penal Code section 422.56~~20.~~ within specific regions. For details on the 3 themes described in the training, see the forthcoming policy Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.

- ~~Health inequities, and identified cultural groups in Partnership's service areas that includes but is not limited to groups' beliefs about illness and health, need for gender affirming care, methods of interacting with providers and the health care structure, and traditional home remedies that may impact what the provider recommends to treat the patient, and any language and literacy needs.~~
- ~~Health Inequities and their impact on Members, staff, Network Providers, Subcontractors, and Downstream Subcontractors.~~
- ~~The impacts of structural and institutional racism on health equity.~~
- ~~The promotion of equal access and delivery of services in a culturally and linguistically appropriate manner~~
- ~~A reinforcement of Partnership's nondiscrimination stance covered in Partnership's policy CGA022 Member Discrimination Grievance Procedure.~~

~~20 Penal Code 422.56~~

~~The Health Education~~The training program will be region specific and include consideration of health-related social needs that are specific to Partnership's servicing counties. Practitioners from different regions will receive different course recommendations that are specific to their region. Practitioners will also acknowledge review of their region's respective disparity report during the completion of the training. For more information on this training, please see the forthcoming policy on Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.

Partnership has two mandatory trainings required for Partnership staff. Permanent and temporary staff receive the cultural and linguistic program trainings upon hire. Upon hire and then annually, permanent, temporary, and contracted employees receive a diversity basics training with topics such as diversity, equity, and inclusion.

The Cultural and Linguistic unit audits ~~delegate's~~DHCS-identified delegates' annual ~~training~~trainings to ensure that they are in compliance with ~~the~~ required elements ~~listed above.~~.

Partnership's State Hearing Representative is expected to become a certified ADA ~~coordinator~~Coordinator, who advises Partnership on how and when accommodation requests should be honored. ~~Furthermore, the Health Education unit supports the development and promotion of trainings leveraging National standards for Culturally and Linguistically Appropriate Services (CLAS).~~ Partnership staff training records are maintained by Human Resources while the Provider training records are maintained by Provider Relations.

Beyond offering training to promote Cultural and ~~Linguistics~~Linguistic related topics, Partnership works to identify and act on at least one area of opportunity to improve the diversity, equity, inclusion (DEI) and cultural humility within the following groups per the findings of the Health Equity Accreditation workforce analyses:

- Staff
- Leadership
- Governing bodies
- Committees
- Providers

~~Finally, Partnership provides adequate training regarding its language assistance programs to all employees, contracted staff, providers and their staff who have routine contact with LEP Members or Potential Members and systematically address any identified gaps in the Contractor's ability to address Members' cultural and linguistic needs (see MCND attachment 9002-F and MCND attachment 9002-G for workflow on~~

~~how to access the telephone Language Services; see MCND attachment 9002 F and MCND attachment 9002 H for workflow on how to access the video Language Services). The training includes the following components:~~

- ~~Partnership's policies and procedures for language assistance;~~
- ~~How to work effectively with LEP Members and Potential Members;~~
- ~~How to work effectively with interpreters in person and through video, telephone, and other media; and,~~
- ~~Understanding the cultural diversity of Members and Potential Members, and sensitivity to cultural differences relevant to delivery of health care interpretation services, in accordance with Exhibit A, Attachment III, Subsection 5.2.11.~~

Assessment and Evaluation

Linguistic Capacity Assessments

Partnership identifies and tracks the language capabilities of clinicians and other provider office staff during the credentialing process. When available, Partnership contracts with qualified bilingual providers as a linguistic service to members and potential members at no cost and, when possible, to reflect the linguistic needs of Partnership's members. Using the results from an annual, self-reported survey of our primary care sites, as well as documentation of staff changes, Partnership publishes updates to the Provider Directory to best reflect the linguistic capabilities at provider offices. Annually, Partnership performs an audit of its contracted translation and linguistic services ~~provider~~providers (including employees, contracted staff, and other individuals who provide linguistic service) to ensure their services meet the needs of our members, including members under 21 years of age as well as their parents, guardians, and authorized representatives.~~-~~ Identified gaps are addressed as needed.

In accordance with Partnership's Policy HR509 Bilingual Standards, Partnership assesses the linguistic capabilities of bilingual staff members from member-facing departments to ensure they meet the necessary linguistic requirements to serve as qualified interpreters. Partnership's Human Resources Department maintains a record of staff members deemed as qualified interpreters, and their evaluation results.

Member-facing Departments include:

- Member Services
- Utilization Management
- Population Health Management
- Care Coordination
- Grievance & Appeals

- Transportation

Administrative Oversight & Compliance Monitoring

Internal Oversight

Within Partnership's Population Health department, the Senior Health Educator (a masters-prepared or MCHES-certified professional) monitors and oversees all regulatory requirements related to Cultural & Linguistics services program and requirements for compliance purposes and to ensure the delivery of culturally and linguistically appropriate health care services. Partnership recently created the Population Needs Assessment Committee to review findings and strategies to address C&L needs identified in the collaborative work referred to as the CHA and CHIP (please refer to MCND9001 for more detail). To protect the privacy of members, Partnership treats race/ethnicity, language, sexual orientation and gender identity as protected health information (PHI). Member PHI data cannot be used for denial of services, nor for coverage and benefits.

~~In accordance with MCND9001, the Population Health Management & Health Equity (PHM&HE) Committee meets quarterly to align interdepartmental efforts promoting health equity through both member-facing and systemic interventions outlined in the PNA Action Plan (see figure below). The PHM&HE Committee ensures Partnership is meeting state and NCQA requirements for health equity, culturally and linguistically appropriate services (including appropriate language access services at all points of contact), health education, and population health management to meet individual member needs.~~

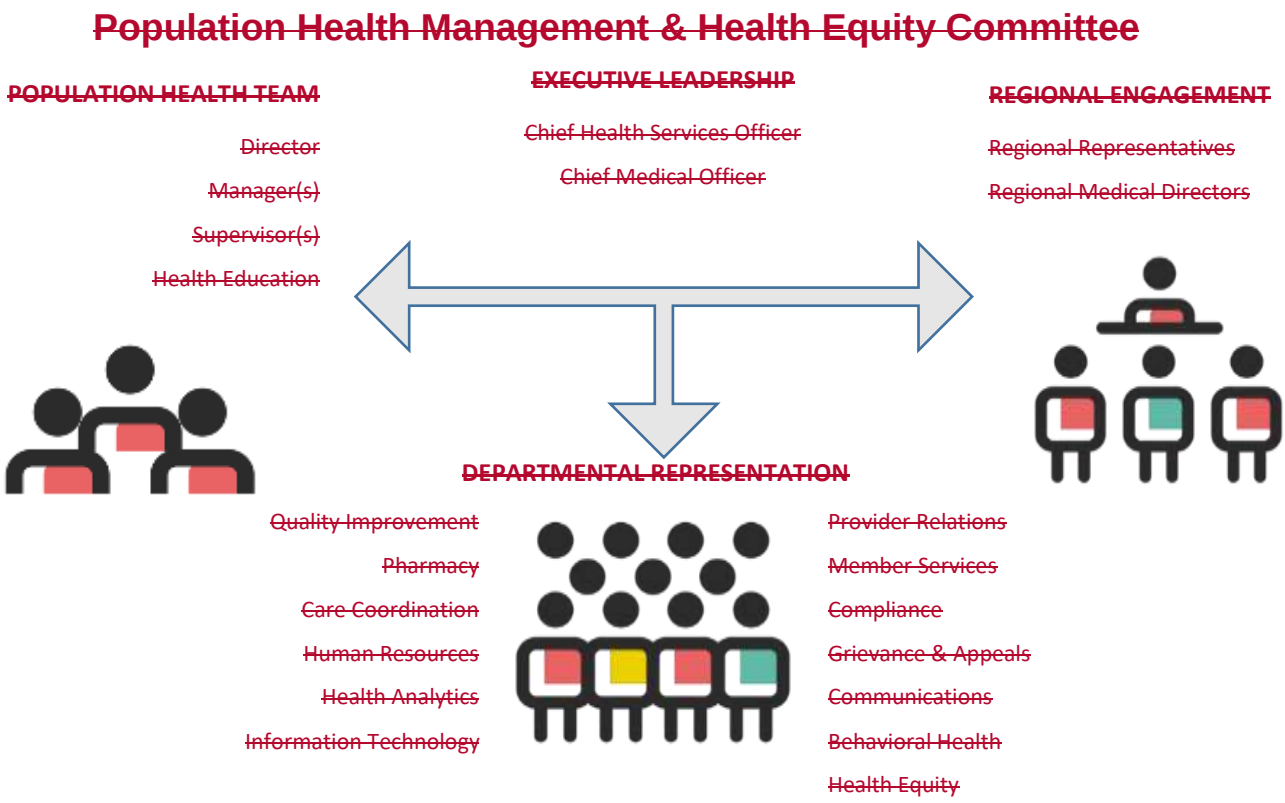
~~Lastly, the Quality Improvement and Health Equity Transformation Program QIHETP Committee is committee comprised of various clinical staff. These staff work towards the establishment, advancement, and sustainment of culturally and linguistically appropriate policies and leadership accountability within the organization in a way that promotes CLAS and health equity through policy, practices, and the way in which resources are allocated.~~ The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system. The goal of this system to address improvements in the quality of care delivered by all of its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to members. The Partnership QIHETP serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare services

- Ensure that healthcare service is delivered at the appropriate time and in an equitable manner

As part of the QIHETP, and in accordance with MCND9001, the Quality Improvement Health Equity Committee (QIHEC) is comprised of various stakeholders including community based organizations, academic institutions, clinical staff, and Partnership members. The Partnership ~~QIHETP~~QIHEC serves as an organized framework to:

- Review and develop equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services. This is done by engaging with a member and using a family-centric approach
- Review activities and identify opportunities to improve health equity throughout Partnership, with oversight and participation of the governing Board of Commissioners and the ~~Quality Improvement and Health Equity Committee (~~QIHEC~~).~~
- Promote participation from a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers for QIHETP development and performance reviews.
- Review health equity-related training activities and validate that the trainings review the impact of structural and institutional racism, and health inequities on members, staff, subcontractors, and downstream subcontractors per ~~DHCS'~~DHCS's published DEI training All ~~Plan~~Provider Letters (APLs).



This committee meets quarterly to align interdepartmental efforts promoting health equity through both member-facing and systemic interventions outlined in the C&L/QIHETP Work plan (see figure below). As described in MCEP6002, the QIHEC is responsible for analyzing and evaluating the results of quality improvement and health equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and findings and activities of internal Partnership-specific committees. This committee is also responsible for developing actions to address performance deficiencies and ensuring appropriate follow-up of identified performance deficiencies. The QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002).

QIHEC also makes a good faith effort to recruit individuals representing the racial/ethnic, linguistic, gender identity that are represented in our 24 counties. Ideally, the committee is looking to include individuals representing such groups in our network – especially groups that constitute at least 5% of the population at a minimum. Annually, the Health Equity Officer reviews the composition of the committee and will work with committee members to make a good faith effort to meet such thresholds.

Quality Improvement Health Equity Committee

HEALTH SERVICES TEAM

Chief Health Services Officer

Director(s)

Associate Director

Manager(s)

HEALTH EQUITY

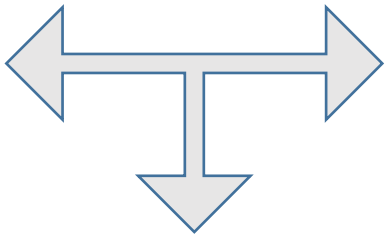
Director/Officer of Health Equity

Tribal Liaison

EXECUTIVE LEADERSHIP

Chief Operations Officer

Chief Medical Officer



REGIONAL ENGAGEMENT

Regional Representatives

Regional Medical Directors

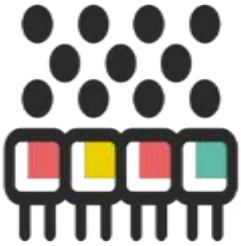
DEPARTMENTAL REPRESENTATION

Quality

Improvement

Health Equity

Human Resources



Provider Relations

Behavioral Health

OpEx/PMO

Transportation Services

Community Engagement

Partnership's Consumer Advisory Committee (CAC) and Whole Child Model Family Advisory Committee (FAC) serves as a linkage between Partnership and the community see attachment MCND9002-~~D~~E CAC Guiding Principles and attachment MCND9002-~~E~~F FAC Charter for additional details. The CAC and FAC consists of culturally and linguistically diverse Partnership members and community advocates. ~~At a minimum, the~~The advisory committee seeks to include individuals representing the racial/ethnic and linguistic groups that constitute at least 5% of the population~~.~~ at a minimum. When possible, Partnership works to include Seniors and Persons with Disabilities (SPD), persons with chronic conditions, Limited English Proficient (LEP) Members, and Members from diverse cultural and ethnic backgrounds or their representatives, to participate in establishing public policy.

One role of the CAC and FAC is to advise Partnership on the development and implementation of its C&L services program. The CAC and FAC also work to identify and help prioritize opportunities for improvement. The CAC can also provide input and advice, including, but not limited to, the following:

- Culturally and linguistically appropriate service or program design, including culturally and linguistically appropriate health education;
- Priorities for health education and outreach program;
- Member satisfaction survey results;
- Plan marketing materials and campaigns.
- Communication of needs for Network development and assessment;
- Community resources and information;
- Population Health Management (including wellness and prevention strategies) and Quality Interventions;
- Health Delivery Systems Reforms to improve health outcomes;
- Carved Out Services;
- Coordination of Care;
- Health Equity;
- Accessibility of Services;
- Health related initiatives;
- Resource allocation; and
- Other community-based initiatives

~~Other CAC duties are described in the Attachment I – Consumer Advisory Committee Guiding Principles.~~

Delegate/Vendor Audits

In alignment with DHCS requirements, Partnership delegates some C&L services to subcontractors, including interpreter services, translator services and the coordination of auxiliary aids and services~~.~~ in a culturally and linguistically and linguistically appropriate way. A formal agreement is maintained and inclusive of all delegate functions. Partnership's Health Education unit conducts an audit no less than annually on these delegated bodies. This audit helps to ensure that delegates have appropriate policies and procedures in place to meet compliance with state and federal language and communication assistance requirements as well as civil rights laws requiring access to members with disabilities and other C&L service requirements. The annual audits also help to ensure Subcontractors and Downstream Subcontractors deliver culturally and linguistically competent care, including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language. Any unmet requirements result in the delegate receiving preliminary CAPs. Any preliminary CAPs that were not closed within the timeframe given by the Audit team are deemed final CAPs. Any final CAPs will go to Delegation Oversight Review Sub-committee (DORS~~-~~) for additional review and direction, even if the delegate submits appropriate documentation before the DORS meeting.

Partnership acknowledges the type of relationship described above is known to the National Committee for Quality Assurance (NCQA) as a vendor relationship. Partnership has no known entities acting upon its behalf that would constitute a delegate as defined by the NCQA Health Equity Accreditation standards.

Goals and Work Plan

~~Partnership has measurable, culturally and linguistically appropriate goals for the improvement of CLAS standards and for the reduction of health care inequities that are presented annually in the C&L Work Plan. Partnership has an annual work plan that described the planned work for the coming year, along with the strategy and rubrics for monitoring against the measurable goals for the improvement of CLAS and reduction of health care inequities; this annual plan is approved by various committees, including:~~

- ~~The Population Health Management and Health Equity (PHM&HE) Committee,~~

- ~~The Quality Improvement and Health Equity Transformation Program (QIHETP) Committee, and~~
- ~~The Physician's Advisory Committee (PAC) as final approval.~~

Partnership has measurable, culturally and linguistically appropriate goals for the improvement of CLAS standards and for the reduction of health care inequities that are presented annually in the QIHEC/C&L Work Plan. Partnership has an annual work plan that described the planned work for the coming year, along with the strategy and rubrics for monitoring against the measurable goals for the improvement of CLAS and reduction of health care inequities; this annual plan is approved by various committees, including:

- The Quality Improvement and Health Equity Committee (QIHEC), and
- The Internal Quality Improvement (IQI) Committee
- The Quality Utilization Advisory Committee (Q/UAC)
- The Physician's Advisory Committee (PAC) as final approval.

Partnership communicates its progress in implementing and sustaining CLAS standards by way of the C&L work plan to all stakeholders, constituents, and the general public.

2024 ~~Goal~~-2025 Goals

Partnership ~~has~~ identified ~~the need to provide written materials to members in their choice of format (such as large print, Braille, audio format, or other) to ensure vision-impaired members are able to understand the information Partnership Healthplan shares. This goal is monitored through the annual C&L Work Plan. Partnership will monitor the percentage of members requesting materials in an alternate format who received a mailing in their preferred format to promote access~~multiple goals for ~~the vision-impaired. Goal:~~ 2024-2025. Goals 1-5 will carry over from 2024; goals 6-10 are new goals. These goals are listed below. Additional goal details can found in the C&L/QIHETP Work Plan:

- Goal 1: By December 31, 2024 90% of members requesting an alternate format will receive at least one mailing in their preferred format. ~~Member Services maintains records~~
    - This goal was chosen to ensure members are receiving information in a way that ~~track member format preferences,~~they can understand.
- Goal 2: By August 31, 2024, define the framework and ~~these records are shared with other member-facing departments. Member Services~~ processes by which the QIHETP Program Description, C&L/QIHETP Work Plan, and ~~Population~~

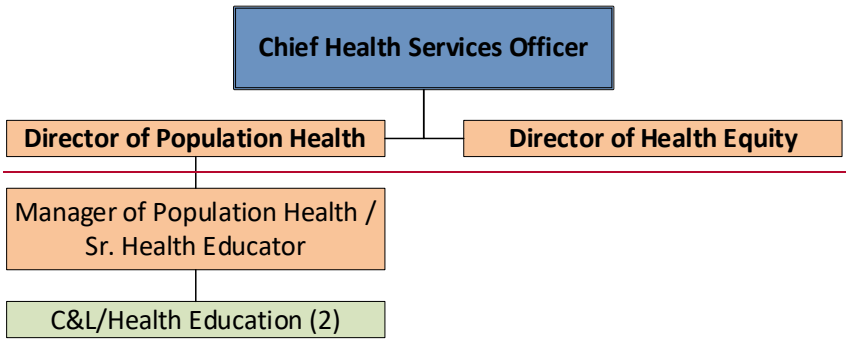
QIHETP Evaluation will be initiated in 2024 and maintained through approval of corresponding 2025 versions needed for HEA Initial Survey in June 2025.
    - This goal was chosen to strategize and streamline required initiatives to advance Health ~~will run quarterly reports that identify~~Equity.
- Goal 3: By September 30, 2024, submit DEI training to DHCS for review to fulfill Phase I APL-23-025 deliverables.
    - This goal was chosen due in part to new regulatory requirements around DEI trainings and to ensure all member facing individuals are equipped to provide appropriate care.
- Goal 4: By December 31, 2024, increase the number of ~~mailings sent and whether they~~ bilingual Member Service Representative (MSR) staff hired by 1% to move closer to organizational goal of 75% of bilingual MSR staff.
    - This goal was chosen in order to align with an existing organizational goal to have 75% of the Member Services staff possess bilingual skills.
- Goal 5: By December 31, 2024, improve controlled blood pressure rate among American Indian/Alaska Native members by 5%.
    - This goal was chosen due in part to the fact that American Indian/Alaska Native members are a current Population of Focus at Partnership.
- Goal 6: By December 2025, improve the rate of timely translations in the Utilization Management and/or Care Coordination department to achieve the threshold of at least- 90%.
    - Goal 6 was chosen due to the recognized need for quality translation ~~and interpretation~~ services and an overall positive member experience.
- Goal 7: By December 31, 2025, improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 22% in the next 5 years.
- Goal 8: By December 31, 2025, improve Well Care Visits rate among Black, White, and/or American Indian/Alaska native members by 5% overall or in at least 1.25% in at least one region.
    - Goals 7 and 8 were ~~sent according to the preferred format.~~chosen due to the recognized disparities in each goal's respective clinical measure and population of focus.

Partnership will continue to monitor these goals through the annual C&L Work Plan to ensure the goals are met. Progress toward this goal will be reviewed on a quarterly basis. Progress toward this goal will be also be reviewed no less than annually by the committees described above.

Population Health Department Structure

Population Health operations are supported by a leadership team and administrative staff that recruits, promotes, and supports a culturally and linguistically diverse structural and organizational environment that is responsive to ~~the~~ Partnership ~~member.~~ members.

Partnership's Population Health department is responsible for developing, maintaining, and overseeing implementation of Partnership's overall PHM strategy~~,~~ (MCND9001), and identifying the health disparities ~~and~~, wellness needs, and health education needs of Partnership's members~~; including~~. These efforts include making referrals to culturally and linguistically appropriate community service programs, and aligning organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. In order to accomplish these objectives, Population Health departmental resources are leveraged to engage internal stakeholders, external stakeholders, and members aligning existing projects and efforts to promote health equity for Partnership's population, including the provision of cultural and linguistic services. Population Health department staff are allocated to develop and share member education materials, ensure all member subpopulations have resources specific to their needs, identify and refer to culturally and ~~linguistic~~linguistically appropriate community service programs when available, engage with the community, educate community partners on Partnership programs and interventions, learn about resources available within communities, and promote collaboration of effort and reduce duplication of services~~.~~.



Team Roles and Responsibilities

Chief ~~Health Services~~Medical Officer:

~~At~~As the ~~senior level,~~principal manager of medical care, the Chief Medical Officer is responsible for the appropriateness and quality of medical care delivered through Partnership HealthPlan of California (Partnership) and for the cost-effectiveness of the utilization of services. This position provides overall direction to ~~the Heath Services (HS) Care Coordination/~~multiple departments, including the Population Health~~/Utilization~~ Management ~~Leadership~~ Team~~. This position~~ and has the ultimate responsibility of ensuring that departmental programs and services are consistent and meet all regulatory requirements in every office location. Required education includes ~~a Bachelor's degree in Nursing or equivalent, and seven (7) years of management experience in a health care organization, preferably leading and managing major clinical programs & initiatives.~~an MD/DO degree from an accredited program preferably in a primary care specialty required; minimum two (2) years' experience in a managed care plan preferred with duties comparable to those listed above, and experience administering medical programs. This role also requires board certification in a specialty and a minimum of seven (7) years clinical/medical practice experience.

Director of Population Health

Provides oversight of Population Health strategy, programs and services to improve the health of Partnership members. ~~Works with~~Reports to the Chief Medical Officer~~, Senior Director of Health Services, ~~. Works with the Senior Director of Quality and Performance Improvement~~, and other department leaders to meet organization and department goals and objectives while developing and tracking the measurable outcomes of department services. This professional must ~~be a Registered Nurse with a Bachelor's degree.~~

~~Master's~~have training in Public Health and ~~PHN preferred for this role.~~Population Health processes. This role also requires at least five (5) years of experience in a leadership/management role.

Associate Director of Population Health

Assists the Director of Population Health in the development, implementation and evaluation of ~~PHC's~~Partnership's population health interventions and program oversight. The Associate Director oversees the Managers of Population Health and the operational workings of the Population Health department. The Associate Director reviews and submits issues, updates, recommendations, and information to the HS Leadership when appropriate. Ensures ongoing audit readiness for Population Health deliverables. This professional must have a Bachelor's degree, an RN license is preferred, with a minimum of five (5) years health care operations experience and three (3) years in a management role.

~~Manager of Population Health~~

~~The Manager of Population Health gives day-to-day direction and has management responsibility for the implementation of member-facing outreach campaigns, member wellness coaching, and other member and community-facing activities designed to keep members healthy and support them in managing their emerging health risks. The Manager provides day-to-day direction for supervisors, manages escalated concerns, and ensures ongoing audit readiness for Population Health deliverables within the scope of their assigned unit. Required education includes a Bachelor's degree in Business, Communication, Healthcare Administration, Social Work, or a related field, and a minimum of five (5) years of experience working in a healthcare setting or equivalent combination of education and experience.~~

Supervisor

Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best expertise and sound judgment (and in consultation with clinical leaders, providers, and staff), provides daily oversight, leadership, support, training, and direction of Population Health staff.

Supports and assists the Manager and other Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics. Required education includes a Bachelor's degree in Business, Communication, Healthcare Administration, a related field, or 3-5

years of managed care experience, or equivalent combination of education and experience.

Senior Health Educator

A public health masters-prepared (or MCHES-certified) professional who ensures the delivery of approved health education and member informing resources for both members and primary care providers. Develops trainings for contracted providers ~~and~~, internal Partnership staff, Partnership members, and community members as appropriate and to promote cultural competency, health equity, and member wellness. ~~Responsible for preparation of the PNA and implementation of the C&L Action Plan.~~ Monitors and oversees all regulatory requirements related to Health Education, Cultural & Linguistics programs. The Senior Health Educator may also perform supervisor responsibilities.

Health Educator(s)

Trained and competent to actively participate in the design and implementation of the Health Education Program. Assesses the health education needs of internal staff, leads on specific member education projects, monitors health education materials, and evaluates member grievances. Serves as a resource to internal staff and providers to ensure compliance with state requirements for educational member materials. Required education includes a Bachelor's Degree in Health Education, Public Health, Community Health or related field; experience in Public Health Education. A minimum two (2) years of health education experience is preferred.

Criteria and Authorization Requirements for Interpreting Services

Telephonic or Video Remote Interpreter Services

a. Member or patient (non-member) is being seen at a PHC contracted provider site.
b. Member or patient does not have other health coverage (OHC) that covers the requested/required interpreting service.
c. Telephonic or Video Remote Interpreter Services do not require prior authorization through PHC's Member Services.

Sign Language Interpreters

a. Member is enrolled in PHC at the point the service is required.
b. Member does not have OHC that is primary to PHC, that covers the requested/required interpreting service.
c. Appointment is for a service that is covered by PHC.
d. Member has hearing and/or speech impairment.
e. Sign Language Interpretation services require prior authorization through PHC's Member Services department. Requests can be made by calling Member Services in advance at (800) 863-4155.

Face-to-Face Interpreter Services

a. Member is enrolled in PHC at the point the service is required.
b. Member does not have OHC that is primary to PHC, that covers the requested/required interpreting service.
c. The appointment is for a service that is covered by PHC.
f. Face-to-face interpretation services require prior authorization through PHC's Member Services department. Requests can be made by calling Member Services in advance at (800) 863-4155.
d. Behavioral Health Treatment (BHT) services for members under 21 years of age, such as evaluations and Applied Behavior Analysis, in a therapeutic and/or home setting are a PHC benefit and fall under PHC responsibility to arrange and schedule face-to-face interpreter services.
e. If face-to-face interpreter services are being requested at a hospital, PHC staff contacts the Patient Services department at the hospital for these services. If the hospital refuses to provide these services, PHC arranges the service. The Provider Relations department is notified of the hospital's refusal to provide service.
f. If face-to-face interpreter services are being requested for PHC Medi-Cal covered mental health services, the caller is referred to Carelon Behavioral Health (formerly Beacon Health Options) at (855) 765-9703. Carelon is responsible to provide face-to-face interpreting services. Members are advised to contact Carelon three (3) business days in advance of their appointment to arrange the service.

Providing Auxiliary Aids and Services for Persons with Disabilities

1. Identification and Assessment of Need:
    a. PHC provides notice of the availability of and procedure for requesting auxiliary aids and services through our language assistance taglines and non-discrimination notices.
    b. When a member, their authorized representative (AR), or someone with whom it is appropriate for PHC to communicate (hereafter called "companion") identifies as having a disability affecting the ability to communicate, access, or manipulate written materials, or requests an auxiliary aid or service:
        i. The member/AR/companion can fill out and submit PHC's Auxiliary Aid Request Form
            1. PHC staff will notate this request and reach out to the member/AR/companion to determine what aids or services are necessary to provide effective communication, based on their identified disability.
        ii. The member/AR/companion can tell PHC staff over the phone about their auxiliary aids or services request.
            1. PHC staff will notate this request at time of call.
            2. PHC staff will then work with the member/AR to determine what aids or services are necessary to provide effective communication based on their identified disability.

2. Provision of Auxiliary Aids and Services:
    a. PHC staff will determine and provide the appropriate aid and/or service necessary for members/ARs/companions with impaired sensory, manual, or speaking skills in a timely manner. MCND9002 lists the auxiliary aids and services PHC provides.

Threshold and Concentration Languages

For All Counties as of *July 2021*

County / # of Languages that meet T/CS (Inc. English)	Arabic	Armenian	Cambodian	*Chinese	English	Farsi	**Hindi	Hmong	**Japanese	Korean	**Laotian	**Mien	**Punjabi	Russian	Spanish	Tagalog	**Thai	Vietnamese
Alameda (5)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	Y	N	Y
Alpine (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Amador (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Butte (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Calaveras (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Colusa (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Contra Costa (3)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Del Norte (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
El Dorado (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Fresno (3)	N	N	N	N	Y	N	N	Y	N	N	N	N	N	N	Y	N	N	N
Glenn (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Humboldt (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Imperial (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Inyo (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Kern (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N

County / # of Languages that meet T/CS (Inc. English)	Arabic	Armenian	Cambodian	*Chinese	English	Farsi	**Hindi	Hmong	**Japanese	Korean	**Laotian	**Mien	**Punjabi	Russian	Spanish	Tagalog	**Thai	Vietnamese
Kings (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Lake (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Lassen (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Los Angeles (11)	Y	Y	Y	Y	Y	Y	N	N	N	Y	N	N	N	Y	Y	Y	N	Y
Madera (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Marin (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Mariposa (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Mendocino (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Merced (3)	N	N	N	N	Y	N	N	Y[2]	N	N	N	N	N	N	Y	N	N	N
Modoc (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Mono (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Monterey (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Napa (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Nevada (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Orange (7)	Y	N	N	Y	Y	Y	N	N	N	Y	N	N	N	N	Y	N	N	Y
Placer (3)	N	N	N	N	Y	N	N	N	N	N	N	N	N	Y[2]	Y	N	N	N
Plumas (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Riverside (3)	N	N	N	Y[2]	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N

County / # of Languages that meet T/CS (Inc. English)	Arabic	Armenian	Cambodian	*Chinese	English	Farsi	**Hindi	Hmong	**Japanese	Korean	**Laotian	**Mien	**Punjabi	Russian	Spanish	Tagalog	**Thai	Vietnamese
Sacramento (8)	Y	N	N	Y	Y	Y	N	Y	N	N	N	N	N	Y	Y	N	N	Y
San Benito (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
San Bernardino (4)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	N	N	Y
San Diego (7)	Y	N	N	Y	Y	Y	N	N	N	N	N	N	N	N	Y	Y	N	Y
San Francisco (6)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	Y	Y	Y[2]	N	Y
San Joaquin (3)	N	N	N	Y[2]	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
San Luis Obispo (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
San Mateo (4)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	Y[2]	N	N
Santa Barbara (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Santa Clara (5)	N	N	N	Y	Y	N	N	N	N	N	N	N	N	N	Y	Y	N	Y
Santa Cruz (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Shasta (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Sierra (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Siskiyou (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Solano (3)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	Y[2]	N	N
Sonoma (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Stanislaus (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Sutter (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N

County / # of Languages that meet T/CS (Inc. English)	Arabic	Armenian	Cambodian	*Chinese	English	Farsi	**Hindi	Hmong	**Japanese	Korean	**Laotian	**Mien	**Punjabi	Russian	Spanish	Tagalog	**Thai	Vietnamese
Tehama (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Trinity (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Tulare (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Tuolumne (1)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	N	N	N	N
Ventura (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N
Yolo (3)	N	N	N	N	Y	N	N	N	N	N	N	N	N	Y^2	Y	N	N	N
Yuba (2)	N	N	N	N	Y	N	N	N	N	N	N	N	N	N	Y	N	N	N

Notes:

Chinese is the combination of Cantonese, Mandarin, and Other Chinese Language. Where Chinese has been identified as a threshold or concentration language and the member has requested to receive translated written information in either traditional or simplified Chinese characters, the Medi-Cal Managed Care Health Plan (MCP) must provide written information in the member's preferred characters. However, if the member has not indicated a preference for simplified or traditional Chinese characters, and the MCP does not yet have a process in place to provide written translations in Chinese, the MCP must provide translations in traditional Chinese characters. Only upon member request will the MCP be required to provide translated written information in simplified Chinese characters.*

**Hindi, Japanese, Laotian, Mien, Punjabi, Thai, and Ukrainian are new languages added per APL-21-004. As of July 2021, there is no data available for Ukrainian language.

1) Threshold Standard Languages (Y) ≥3,000 per language or ≥5% of the Medi-Cal Population that speak the language per county.

2) Concentration Standard Languages (Y^2) ≥1,000 per zip code or ≥1,500 per two contiguous – **Hmong** in Merced County, **Tagalog** in San Francisco, San Mateo, and Solano counties, **Russian** in Placer and Yolo counties, & **Chinese** in Riverside and San Joaquin counties.

UNITED LANGUAGE GROUP®

United Language Group: Quality and Culturally and Linguistically Appropriate Translation Services

September 27, 2023

UNITED LANGUAGE GROUP

ULG: Written Translation Quality Processes and Overview

United Language Group has nearly four decades of experience providing qualified written translation and localization services for the U.S. healthcare, health insurance and medical industries in over 235 languages. We approach language access with evidence-based solutions, proactive measures and culturally-sensitive communication to ensure equitable, meaningful access for all diverse communities and populations

From health education and vital documents to member outreach and enrollment materials, ULG delivers high service standards with every translation project, delivering language translation with quality, service and speed. Our ISO-certified quality assurance processes, rigorous linguist assessment and qualification requirements, and metric-driven reporting ensure that all translated materials meet the high level of accuracy that is required while still resonating on a cultural level.

1. **Translator Qualifications and Language Proficiency Assessments**

   ULG has adopted a rigorous screening and training process to assess, evaluate, and qualify our healthcare translators. All translators must be native speakers of the language into which they translate, and most average ten or more years of experience in most languages, hold language certification and/or advanced degrees, and all must pass a variety of tests and questionnaires to measure each applicant's language skill and proficiency in source and target languages, as well as healthcare terminology and cultural appropriateness. The results, combined with the applicant's background and experience, indicate whether a linguist is skilled and proficient enough to work with ULG. We further continue this with training, rating, and assigning the most appropriate translators to work on any given project. Please see below for requirements for our translators in our linguist qualification policy:

   - Must pass a rigorous translation test for accuracy and regional nuance.
   - Most hold a verifiable language certification and at least one advanced degree from a recognized university. Additional degree(s) in industry subject matter are preferred and prioritized
   - Must be a native and primary speaker of their target language(s).
   - Must have >5 years of professional translations experience. >10 years is preferred and prioritized.
   - Must provide 3+ contactable references from clients and samples of previous work to be assessed.
   - Ongoing assessment: In addition to these entry criteria, ULG linguists are continuously assessed at the project level as part of the QA step.

   Additionally, ULG looks to ensure the following:

   - ATA Accreditation: Many of our translators are certified by the American Translators Association (ATA). However, ATA certification is not available in many of the language pairs of the U.S. LEP populations. Due to our high standards of linguist proficiency requirements, we rely on our multi-step qualification process and translator's background, assessment results, education and references to determine their skill level.
   - Technical capabilities: We require translators have appropriate electronic tools, working

knowledge of translation memory, automated term lists and other software programs.

- Onboarding: Once a translator is qualified and approved through the recruitment and qualification process mentioned above, an on-boarding process is in place that includes contract signing, confidentiality agreements, portal training and customer-specific training as well as process and policy review.
- Ongoing monitoring: Work completed by our active translators undergoes our internal quality assessment audits on a regular sample of translation projects. All linguists must maintain high quality scores on these audits to continue working with us.

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2. Metrics and KPI's For Consistent Service Delivery

ULG's Quality/Information Security Management System (QMS/ISMS) guides our policies, principles, processes and procedures which describe how ULG manages organizational goals, meets applicable customer and regulatory requirements and complies with our ISO certifications (see attached)

Our quality process enables us to optimize our services and deliver consistent quality, and timely language services. This approach also facilitates achieving consistent results by measuring KPI's such as turnaround time, accuracy and more, thereby helping to ensure timely, accurate and reliable translations that meet client requirements. Metrics and KPIs tracked include:

- On-time deliveries: ULG maintains a 99% on-time delivery (OTD) rating. On-time delivery is automatically tracked through our secure portal and Translation Management System. ULG translation services and timelines are aligned to meet customer-specific or product-specific timelines, such as rapid-turn Grievance and Appeals, annual enrollment materials, and more.
- Translation Quality: Measuring translation quality is vital to understanding and evaluating final deliverables. Regular quality-level audits help to identify any potential issues with processes/resources and allow us to identify trends that require immediate corrective action.
- Customer Satisfaction: Gathering feedback directly from our clients allows us to identify potential issues which are not visible/identifiable from other reports/KPIs. As well, it indicates where improvements and innovations may be needed.
- TM leveraging analysis: By analyzing TM (translation memory) we identify content trends and savings to maximize the TM leveraging.
- Utilization: Comparing translation volumes against utilization numbers is a great way to identify ULG's capacity for scalability planning for account growth and managing volume projects.

3. Language Quality Control and Quality Assessment Process

Language quality control is at the heart of ULG's ability to help ensure accurate, effective and culturally appropriate translations. Our documented quality-driven policies, procedures, evaluation

standards, and multi-step translation processes, help ensure consistently high quality for every translation in every language.

ULG knows the importance of ensuring linguistic accuracy, readability, and cultural appropriateness in written translations. Our teams take special care to ensure cultural nuance and appropriate literacy levels are applied to each delivery. We also follow industry-leading best practices from healthcare-focused institutes such as Centers for Medicare & Medicaid Services, Department of Health and Human Services, American Medical Association and more. Some examples include:

- Utilizing qualified, subject-matter professional translators who have the appropriate cultural knowledge, translation and writing skills needed to for high-quality, culturally appropriate translations.
- A requirement for using multiple, separate and qualified professionals listed above for every translation.
- Providing linguists with training, reference/ background information, target audience insight, and any specific requirements to better result in a translation that resonates with the intended recipient.
- Ensuring translations preserve the content and meaning of the original text, easy to understand, and translated with cultural and linguistic sensitivity as needed.
- Multiple QA steps to ensure translated text is reviewed for accuracy, cultural and linguistic appropriateness, and literacy level consistency.

Quality Control is measured across the process. Separate, experienced, native-speaking linguists translate, edit and proofread each translation as well as perform an auto check to ensure content matches any approved term lists/glossaries. Separate, qualified proofreaders are utilized with every language pair and service we offer. Proofreaders check for any errors in the grammar, syntax, punctuation, sentence structure and more. They also can check to ensure that the translated text is contextually correct and culturally appropriate. Translated and formatted documents can also go through an additional multi-step Third-Party Quality Assurance (QA) process that includes tasks such as checking sizing and placement of text or headers/footers, text and graphic formatting, function of hyperlinks, updating/ formatting of tables of contents and indices, formatting/placement of bullets and margins and column and page breaks. Quality e assurance representative sign off on the process once complete and is saved for tracking purposes.

Leslie Iburg

Leslie Iburg
Director of Healthcare Accounts
United Language Group,
September 27, 2023

Certificate of Registration

This certifies that the Information Security Management System of

United Language Group, Inc.

1550 Utica Avenue
Suite 420
Minneapolis, Minnesota, 55416, United States

has been assessed by NSF-ISR and found to be in conformance to the following standard(s):

ISO 27001:2013

Scope of Certification:

The ULG Information Security Management System will provide the framework of processes and best practices for the protection of client and employee information and the management of risk to information security in accordance with the Statement of Applicability version 7.0 27th Jan 2020

Statement of Applicability (SOA): January 27, 2020 V 7.0

Sameer Vachani
Senior Director, NSF-ISR

Certificate Number:	C0748976-IM3
Certificate Decision Date:	17-MAR-2023
Certificate Issue Date:	24-MAR-2023
Cycle Effective Date:	11-APR-2023
Certificate Expiration Date*:	10-APR-2026

Issued by:
NSF International Strategic Registrations (NSF-ISR)
789 N. Dixboro Road, Ann Arbor, MI 48105 USA

Authorized Certification and/or Accreditation Marks. This certificate is property of NSF-ISR and must be returned upon request.

***Company is audited for conformance at regular intervals. To verify certification call (888) NSF-9000 or visit our web site at www.nsf-isr.org**

ANAB ANSI National Accreditation Board ACCREDITED ISO/IEC 17021-1 MANAGEMENT SYSTEMS CERTIFICATION BODY

MEMBER OF MULTILATERAL RECOGNITION ARRANGEMENT IAF

Certificate of Registration

ANNEX PAGE FOR CERTIFICATE NUMBER: C0748976-IM3

This Annex is only Valid in connection with the above-mentioned certificate issued by NSF-ISR

CERTIFICATE ISSUE DATE:
24-MAR-2023
CERTIFICATE EXPIRATION DATE:
10-APR-2026

United Language Group, Inc.
1550 Utica Avenue
Suite 420
Minneapolis, Minnesota, 55416, United States

Location:	Scope:
United Language Group, Inc. - 67852 **Unit 27** **Glenrock Business Park** **Ballybane, Galway, H91 AE12,** **Ireland**	**The ULG Information Security Management System will provide the framework of processes and best practices for the protection of client and employee information and the management of risk to information security in accordance with the Statement of Applicability version 7.0 27th Jan 2020**
Location:	**Scope:**
United Language Group, Inc.- C0359514 **Office No. 713- 714, Neelkanth Corporate IT Park** **Neelkanth Corporate IT Park** **Kirol Road, Vidyavihar (West)** **Mumbai, 400086, India**	**The ULG Information Security Management System will provide the framework of processes and best practices for the protection of client and employee information and the management of risk to information security in accordance with the Statement of Applicability version 7.0 27th Jan 2020**

Issued by:
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Consumer Advisory Committee
Guiding Principles

I. Purpose & Overview

The purpose of the Consumer Advisory Committee (CAC) is to act as a liaison between Partnership HealthPlan of California (Partnership) and our members. The CAC provides Partnership members with a forum to discuss common issues of interest and importance, while creating a supportive and informative environment. Partnership's CAC is primarily composed of members, advocates, and stakeholders. The CAC may also include participation from select providers within the service area. Partnership values the input received through the CAC and considers the feedback during annual reviews and policy/procedural updates that affect quality and Health Equity. Additionally, Partnership provides relevant updates to the CAC on how their input is incorporated.

The CAC also advocates for Partnership members by ensuring that the health plan is responsive to the diversity of health care needs of all members. Partnership will make a good faith effort to ensure that CAC members feel supported in their role and may provide resources to help educate CAC members so they can effectively participate in CAC meetings.

The CAC is responsible for and shall carry out the duties listed below:

- Identifying and advocating for preventative care practices utilized by Partnership
- Participate in the development and updating of cultural and linguistic policy and procedure decisions related to quality improvement, member education, and operational and cultural competency issues that may affect groups who speak a primary language other than English
- Provide input on necessary member/provider targeted services, programs, and trainings
- Make recommendations regarding the cultural appropriateness of communications, partnerships, and/or services
- Review Population Needs Assessment findings and discuss improvement opportunities related to Health Equity and Social Drivers of Health
- Identify member concerns that may influence Partnership policies and practices
- Ensure that the concerns of members of all cultures are respected and addressed, including members that speak a primary language other than English
- Serve as advocates for members of Partnership, promote self-advocacy, and cultural competency, thereby improving health outcomes
- Review and provide input regarding Member Rights and Responsibilities and other member materials
- Annually review grievance and appeal data

Consumer Advisory Committee Guiding Principles

- Review and make recommendations regarding Member Services' Quality Improvement activities, including but not limited to the Member Satisfaction Survey results
- Provide feedback and input on Partnership's health education and community focused activities

To manage the operations of this committee, Partnership has a designated CAC Facilitator and Coordinator. The CAC Coordinator, in partnership with the Facilitator is responsible for managing the operations of the CAC. Together, they ensure compliance with all statutory, rule, and DHCS contractual requirements.

These Guiding Principles, may be updated or amended as needed to comply with regulatory or accreditation body requirements, or as proposed by CAC members and/or Partnership staff.

II. Membership

Member Selection

All Partnership members are eligible to become a CAC member if seats are available by completing a CAC application and meeting the requirements below:

- They are an eligible Partnership member, legal parent of a minor (under age 18), or a legal guardian or conservator of an eligible Partnership member
- Will regularly attend and actively participate in meetings

Partnership's CAC Selection Committee is tasked with selecting and appointing all CAC members. The purpose of the CAC Selection Committee is to ensure that the committee is composed of representatives that bring different perspectives, ideas, and views to the committee. These representatives may reflect Partnership's population and serve the following:

- Members of hard-to-reach populations
- Members of diverse racial and ethnic backgrounds, genders, gender identity, sexual orientation, physical disabilities, age backgrounds (including parents/caregivers of adolescents/foster youth), IHS Provider representatives)
- Limited English Proficient (LEP) Members

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Partnership conducts an annual review to ensure that CAC membership is representative of its membership base. Partnership may modify the CAC membership base to reflect changes in member demographics.

Each county within Partnership's service area is allocated a set amount of CAC seats available to members. To determine this allocation, Partnership established a ratio based on the number of Partnership Board of Commissioner seats that each county holds. The ratio selected for each county is defined as 1.5 times the number of Partnership Board of Commissioner seats per county.

The CAC Selection Committee will ensure that all CAC members are selected by June 29, 2024.

Member Responsibilities

- Regularly attend scheduled meetings
- Arrive in a timely manner
- Participate in CAC meetings
- Provide opinions and feedback to improve Partnership services
- Provide updated contact information to the CAC Facilitator and/or Coordinator for the purpose of meeting notices
- Notify the CAC Facilitator and/or Coordinator in advance if you cannot attend a meeting

Membership Term

CAC members may serve for a term of up to four (4) years. At the end of the four (4) year term, CAC members may continue their role as long as there is not a replacement CAC member available.

A CAC member who is absent for three (3) consecutive CAC meetings shall lose voting privileges at the subsequent meeting and will forfeit their membership. The individual may reapply for a seat on the CAC.

CAC members may lose their membership seat and privileges by a quorum of the CAC. CAC members may terminate their position at any time by resigning. The member may resign by calling, emailing, or sending a letter to the CAC Facilitator and/or Coordinator. The CAC Selection Committee

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will make a good faith effort to replace any vacant seats due to member resignation (voluntary or involuntary) within 60 calendar days.

Compensation

A CAC member may receive a stipend for travel and childcare expenses that allows them to attend CAC meetings during their membership term. No CAC member shall receive any profit from the operations of Partnership. This provision shall not prevent reasonable compensation to a CAC member for services performed for Partnership, if such compensation is not in conflict with Partnership policies or procedures, is permitted by these Guiding Principles, and is approved by the Chief Executive Officer of Partnership.

Member Demographic Report

Partnership prepares an annual Member Demographic Report that highlights the composition of the CAC. The Member Demographic Report is submitted to DHCS no later than April 1 of each calendar year. Partnership strives to ensure that the CAC is representative of Partnerships' member demographic. The CAC Member Demographic Report will also identify the following:

- Description of the CAC's ongoing role and impact in decision-making about Health Equity, health-related initiatives, cultural and linguistic services, resource allocation, and other community-based initiatives, including examples of how CAC input impacted and shaped Contractor initiatives and/or policies
- Barriers/challenges in meeting or increasing alignment between CAC's membership with the demographics of the members within Partnership's service area
- Ongoing, updated, and new efforts and strategies undertaken in CAC membership recruitment to address the barriers and challenges to achieving alignment between CAC membership with the demographics of the members within Partnership's service area

Board of Commissioners

The CAC reports directly to Partnership's Board of Commissioners. A consumer representative from Partnership's Northern and Southern Regions will be selected every two years to represent the CAC on the Board of Commissioners. Selection will then rotate from region to region within the larger region.

Consumer Advisory Committee Guiding Principles

Department of Healthcare Services (DHCS) Statewide Consumer Advisory Committee
The CAC shall select and appoint one member of the CAC, or another Partnership member, to serve as the Partnership representative to the DHCS' Statewide Consumer Advisory Committee. Partnership shall compensate the representative for time and participation within the Statewide CAC, including transportation expenses to appear in-person.

Non-Liability of Members
CAC members shall not be personally liable for the debts, liabilities, or other obligations of Partnership.

III. Committee Meetings

Meeting Schedule
CAC meetings are held four times a year (quarterly) and at times and in formats, that foster and facilitate CAC member participation. The CAC meeting schedule is published at the beginning of each year and posted on Partnership's website. Partnership may conduct additional CAC meetings to discuss and take action on matters of urgency.

The principal offices of Partnership's CAC for the transactions of its business for all regions are located at the following meeting locations:

Address	County
4665 Business Center Drive, Fairfield, CA 94534	Solano
495 Tesconi Circle, Santa Rosa, CA 95401	Sonoma
3688 Avtech Parkway, Redding, CA 96002	Shasta
1036 5th St., Suite E, Eureka, CA 95501	Humboldt

CAC meetings are open to the public and we welcome and encourage attendance. Meetings may also be held at additional sites, which will be listed on the meeting notice. Meeting notices are posted in a centralized location on Partnership's website up to 30 days, and no later than 72 hours prior to the meeting. Video conferencing equipment is used when members from multiple locations participate.

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Facilitation of Meetings

CAC meetings are conducted in compliance with the Ralph M. Brown Act. The CAC Facilitator(s) is responsible for the facilitation of all CAC meetings. The CAC Coordinator acts as secretary or may appoint a member/designee to act as secretary of the meeting, for the purpose of taking meeting minutes. Meeting minutes are posted on Partnership's website and distributed to members before the next quarterly meeting. Partnership will also submit meeting minutes to DHCS within 45 calendar days.

Quorum

For the purpose of the CAC, a quorum is defined as the minimum number of members in attendance required to conduct the business of the committee. The CAC quorum shall consist of at least ½ (one half) of the CAC membership seats held. Every act or decision done or made by a quorum is an act of the CAC as a whole.

CAC Records

Partnership shall maintain CAC records, for no less than 10 years. CAC records shall include the following:

- Minutes of all meetings of the CAC, indicating the time and place of holding such meetings, whether regular or special, and the names of those present
- A copy of the Guiding Principles and any modifications to date, which shall be open to inspection

Partnership HealthPlan of California's Whole Child Model Family Advisory Committee (FAC) Charter

Purpose:

The Whole Child Model FAC is a Member Advisory Group to the Chief Executive Officer (CEO) and staff of Partnership HealthPlan of California (Partnership), providing input, review and recommendations on policies and issues that affect children and their families served through the Whole Child Model (WCM) program.

The WCM FAC is intended to promote open communication between families with children who have special health care needs, health plan leadership, California Children's Services (CCS) agencies, and local family support providers. It serves as a mutual learning forum for committee members and health plan staff to make a positive difference in the care the health plan provides to CCS beneficiaries.

Authority and Responsibility:

SB 586 (Hernandez, 2016) established a ~~Whole Child Model~~WCM program, under which managed care plans served by a county organized health system or Regional Health Authority in designated counties would provide CCS services to Medi-Cal eligible CCS children and youth. This legislation also required each Medi-Cal managed care plan participating in the ~~Whole Child Model~~WCM program to establish a family advisory group for CCS families (WIC 14094.17(b)(1)).

The WCM FAC may make recommendations to the CEO, based on member and community input and feedback.

As this is an Advisory Committee to the CEO, the Brown Act does not apply.

Membership:

Membership status is reviewed and approved by a committee of Partnership~~HC~~ leadership.

Membership includes:

- WCM CCS M~~m~~ember and/or family member – Family representatives from each PHC county (Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, ~~and~~ Trinity, ~~and~~ Yolo, and Yuba). Equal representation (two representatives) from each county is sought but not required.[1]
- Local Consumer Advocate – maximum of one (1) local consumer advocate representing CCS families.

[1] Please note, if there are not enough CCS family members to fill both positions on the WCM FAC, Partnership~~HC~~ will allow a county representative from that county to fill that position.

- Local Providers - maximum of one (1) representative from each Partnership~~HC~~ region, including CCS County staff, Parent Advocacy groups or CCS paneled providers. This provider must be serving Partnership~~HC~~ Members in Butte, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Marin, Mendocino, Modoc, Napa, Nevada, Placer, Plumas, Shasta, Sierra, Siskiyou, Solano, Sonoma, Sutter, Tehama, Trinity, ~~or~~ Yolo, or Yuba County.

Committee Staff

- Partnership~~HC~~ employees will serve as support staff to the WCM FAC.

Terms:

WCM CCS M~~m~~ember and/or family member will be appointed to a two-year term. At the end of the term the member may be reappointed to a subsequent two-year term.

Local Consumer Advocate will be appointed to a two -year term. At the end of the term this position will be open to other applicants in the region. If there is no other applicant the advocate may be reappointed to a subsequent term.

Local CCS County Representative will be appointed to a two -year term. At the end of the term, this position will be open to other applicants from other counties in the region. If there is no other applicant the county representative may be reappointed to a subsequent term.

FAC Chair and Vice Chair:

The FAC shall select a Chair and Vice Chair. ~~-~~The Chair and Vice Chair shall be a CCS Member or family representative selected by the voting members of the FAC.

The role of the Chair is to provide meeting facilitation and direct the meeting process through the agenda. The Chair will guide and lead discussion to ensure all participants are provided equal opportunity for participation.

The role of the Vice Chair is to preside at the meetings of the FAC in the absence of the Chair.
If both Chair and Vice Chair are absent, the WCM FAC members present will select one member to act as Chair for the meeting.

The FAC shall elect a Chair and Vice Chair for a two-year term.

Meetings:

The WCM FAC shall meet four (4) times per year (i.e., quarterly).

These meetings will be on the 3rd Tuesday of every third month. This time can be changed at any time by a vote of the Committee.

These meetings will be located at PartnershipHC offices, and remotely. PartnershipHC will provide technical support for remote meeting access. When feasible, meetings could be held at alternative locations with prior approval by the organizers.

Meeting Compensation:

Appointed Members are eligible to receive a stipend for meeting attendance.

Agendas, Minutes, Reports:

PartnershipHC staff will work in collaboration with the Committee, to develop the agenda for each meeting.

PartnershipHC staff are responsible for agenda and meeting material production and distribution.

PartnershipHC staff will record minutes of meetings which will be approved by the FAC members at each subsequent meeting.

Review of Charter:

The FAC shall review this charter as needed. Any proposed changes shall be submitted to the CEO for approval.

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Cultural & Linguistic Program Description

MCND9002

November 13, 2024

Original Date:

Previously Applied to MPLD7001 02/19/14 to 09/09/20

Revision Dates: MCND9002 09/09/20; 09/08/21; 09/14/22; 11/8/23

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Program Purpose

To demonstrate the commitment of Partnership HealthPlan of California (Partnership) to deliver culturally and linguistically appropriate health care services to a culturally and linguistically diverse population of members and potential members in a way that promotes Health Equity for all members.

Introduction

This Cultural and Linguistic (C&L) Program description defines how Partnership uses its resources to achieve the goals and commitments to delivering culturally and linguistically competent health care services to all Partnership members, including members with Limited English Proficiency (LEP) or sensory impairment. This program description also describes how Partnership offers care and services in a way that is effective, health equity-driven, understandable, and respectful and responds to diverse cultural health beliefs and practices and linguistic/communication needs.[1]

Partnership also works to ensure there is equal access to the provision of high quality interpreter and linguistic services for LEP members and potential members, and for members and potential members with disabilities, in compliance with federal and state law, and APL 21-004.[2] Partnership makes this commitment to the availability and accessibility of these C&L services, along with a commitment to nondiscriminatory treatment of members, regardless of sex, race, color, national origin, religion, ancestry, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other persons or group as defined in Title VI of the Civil Rights Act of 1964 or Section 1557 of the Affordable Care Act of 2010. Partnership maintains, continually monitors, improves, and evaluates cultural and linguistic services that support covered services for all members, including members less than 21 years of age.[3]

All covered services, member-facing programs, member facing (including health education) and/or outreach material are provided in a culturally and linguistically appropriate manner that promotes health equity for all members. Member facing materials are routinely distributed in all of Partnerships threshold languages, meet the

[1] National Culturally and Linguistically Appropriate Services Standards
[2] APL 21-004 and Threshold and Concentration Languages
[3] Penal Code 422.56

requirements of APL 18-016 Readability and Suitability of Written Health Education Materials,[4] and are available in accessible formats upon member request. Partnership also ensures that members receive all Member Information in a language or alternative format of their choice.

Objectives

Partnership's C&L Program objectives are accomplished through interdepartmental collaboration and include:

- Collecting and updating data on the race/ethnicity, language, sexual orientation and gender identity of Partnership members and sharing this information with providers. This effort is part of Partnership's goal to monitor and evaluate how CLAS may impact health equity and outcomes, which can better inform service delivery. Members will be advised of the intent to share their data and will be given the right to opt out of data sharing in accordance with their privacy rights.
- Ensuring Partnership's staff, providers' and delegates' Cultural and Linguistic services comply with the Department of Health Care Services (DHCS) and Federal regulations without limitations, particularly relating to communication assistance requirements and access for members with disabilities.[5,6,7,8,9]
- Continually assessing, monitoring, improving and evaluating Partnership's C&L services that support covered services for members, including members under the age of 21.
- Addressing deficiencies and gaps in Partnership's C&L services
- Communicating Partnership's C&L Services and Standards to staff, providers, delegates, and community members

Measurable objectives can be found later in this document and in the joint Quality Improvement Health Equity Transformation Program (QIHETP) and Cultural and Linguistics (C&L) annual work plan.

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[4] APL 18-016 Readability and Suitability of Written Health Education Materials
[5] 22 CCR 53876; 21202.5; 51202.5; 51309.5(a)
[6] 28 CCR 1300.67.04(c)(2)(A)-(B); 1300.67.04(c)(2)(G)(v)-(c)(4)
[7] 42 CFR 438.206(c)(2); 438.10; 438.404
[8] W&I Code 14029.91
[9] Medi-Cal Managed Care Plans, Exhibit A, Scope of Work 5.2.10

Programs and Services

Partnership's C&L programs and services outlined below encompass the services directly provided to members and potential members, as well as the support provided to Partnership staff, providers', and delegates' capacity in understanding the C&L needs of our member population. Partnership will take immediate action to improve its culturally and linguistically appropriate services when deficiencies are noted.

Language Data Collection

At least every three years, DHCS gathers language information for individuals enrolled in Medi-Cal and shares this information with Managed Care Plans (MCPs) to address potential changes to threshold and concentration standard languages (see MCND9002 attachment C for threshold languages) as well as any changes in state and/or federal law. Partnership reviews overall language prevalence per state-published data every three years in order to identify emerging language patterns that may impact Partnership members or potential members. This data is also used to assess languages in a way that aligns with DHCS requirements as outlined in APL 21-004 as well as aligns with NCQA requirements for threshold languages of five (5) percent or 1,000 individuals), as well as languages spoken by one (1) percent or 200 individuals (whichever is less). According to APL 21-004 and its attachments, MCPs must provide translated written member information to specific groups in the MCP's service area as identified by DHCS in the Threshold and Concentration Language dataset.[10] Partnership also routinely collects and maintains records of member language preferences spoken by one (1) percent of the member population or less.

In addition to DHCS's language data collection and analysis process for Partnerships' member population, Partnership will conduct its own data analysis at the community and/or census level to determine and report out on the languages spoken by five (5) percent or 1,000 individuals, whichever is less, and by 1% of the population or 200 individuals, whichever is less. For more details on this process, please refer to the Community Language Assessment report.

At the time of the writing of this document, Partnership's concentration standard and/or threshold languages are Russian, Tagalog, and Spanish, as determined by DHCS. For information on threshold languages as determined by Partnership, please refer to the Community Language Assessment report.

[10] APL 21-004 and Threshold and Concentration Languages

These practices help to address potential changes to threshold and concentration standard languages, as well as any changes in state and/or federal law. This information is used as part of the assessment of language services for members to improve the Cultural and Linguistics program offerings, and when possible, to guide network development. Partnership will retain a list of the DHCS- provided, and Partnership-determined threshold and concentration standard languages. Adjustments to the list will be based on findings from the Community Language Assessment report and DHCS's triennial timeline.

Partnership distributes a written notice in English and up to 18 languages spoken by 1 percent of the members served by the organization or by 200 individuals (whichever is less), informing members that the organization provides language assistance services and how they can obtain it at no cost to the member. Non-speaking or Limited English Proficient (LEP) members can also request language and/or interpretation services, or even refuse interpreter services; this request is then documented in Partnership's member record.[11]. Partnership may use or disclose the member's preferred language with Partnership network practitioners/providers, subcontractors, or other covered entities for the purposes of ensuring communication and care delivery in a culturally sensitive and linguistically appropriate manner. Members are informed when language information is directly collected that their language preferences may be shared.

Partnership also assesses and collects data on the cultural and linguistic needs of the member population through the written Population Needs Assessment (PNA). Each year, Partnership assesses the overall environment, specific community needs, and the factors that influence the health and well-being of the assigned member population. This information is collected from its member population data and integrated into the PNA, which drives the goals of Partnership's Population Health Management Strategy, the Cultural & Linguistics Program, and their associated work plans. Both of these work plans are the driving force by which Partnership responds to the cultural and linguistic diversity and needs of Partnership's member population. The report is written in accordance with the requirements of the National Committee for Quality Assurance (NCQA) Health Plan Accreditation Standards for an annual Population Needs Assessment (PNA).

Finally, in alignment with DHCS's Population Health Management Policy Guide, Partnership collects information on language needs as part of its collaboration with each Local Health Jurisdiction in its service area.[12] This collaborative work is referred to as the Community Health Assessment (CHA) and Community Health Improvement Plan

[11] APL 22-017 and APL 22-017 MMR Standards

[12] DHCS Basic Population Health Management Policy Guide

(CHIP) process. Based on this collaborative work, and input from various stakeholders, Partnership annually reviews and updates its strategies and work streams related to the DHCS goals, health equity, health education materials, wellness and prevention programs, and cultural and linguistic and quality improvement strategies to address identified health and social needs in accordance with the population-level needs and the DHCS Comprehensive Quality Strategy.[13] Findings from both the PNA and CHA/CHIP work are shared with our providers and other stakeholders as needed on a regular basis.

Language Assistance Services

Partnership members are entitled to interpretation services and written translation of critical and vital informing materials in their preferred threshold language, including oral interpretation and American Sign Language, as well as their preferred alternate format. Partnership members can request Interpreting and/or translation services by contacting the Member Services Department or any other member-facing department (Utilization Management, Population Health, Care Coordination, Grievance & Appeals, and Transportation). Members can also call a toll-free number with TTY/TDD.

Language Assistance Taglines, Nondiscrimination Notices, and Member Information

In alignment with APL 21-004[14] and other DHCS requirements, Partnership publishes nondiscrimination notices and language assistance taglines. They are sent with all member correspondences as well. Language assistance taglines are published in a conspicuously visible font size in English and California's top 18 non-English languages spoken by Limited English Proficient (LEP) individuals in the state; they inform members of all available language assistance services and how to access them (including written translation and interpretation). These taglines and nondiscrimination notices are in a font size no smaller than 12-point and are available in all Threshold Languages/Concentration Standard Languages and alternative formats (including Braille, large-size print font that is no smaller than 20-point, accessible electronic format, or audio format), and Auxiliary Aids at no cost to the member, and upon request. Consideration is also given for the special needs of members with disabilities or LEP members. Vital member correspondences include, but are not limited to:

- Partnership Member Handbook/Evidence of Coverage (EOC)
- Partnership Provider Directory

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[13] DHCS Comprehensive Quality Strategy

[14] All Plan Letter 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services

- Form letters and notices critical to obtaining services
- Notices of Action
- Notice of Appeal Resolution Letters
- Notices of Adverse Benefit Determination
- Grievance and Appeals letters
- Welcome Packets
- Marketing Information
- Preventive health reminders
- Member surveys
- Notices advising of the availability of free language assistance services
- Newsletters
- All member information, informational notices, and materials critical to obtaining services targeted to members, potential enrollees, applicants, and members of the public

The nondiscrimination notice and the notice with taglines includes Partnership's toll-free and Telephone Typewriters (TTY)/Telecommunication Devices for the Deaf (TDD) telephone number for obtaining these services, and are posted:[15]

a) In a conspicuous place in all physical locations where Partnership interacts with the public;
b) In a location on Partnership's website that is accessible on the home page, and in a manner that allows Members, Potential Members, and members of the public to easily locate the information; and
c) In the Member Handbook/EOC, and in all Member Information, informational notices, and materials critical to obtaining services targeted to Members, Potential Members, applicants, and the public at large, in accordance with APL 21-004 and APL 22-002, 42 CFR section 438.10(d)(2)-(3), and W&I section 14029.91(a)(3) and (f).

In alignment with DHCS requirements, all member facing material and correspondences are created using simple language, are culturally and linguistically appropriate, are provided at a 6th grade reading level, are in a format that is easily understood, in a font size no smaller than 12-point, are translated and sent in the member's preferred language (including Partnership's threshold languages) and format, and are approved by DHCS before distribution. Health education materials are approved by a Qualified

[15] All Plan Letter 21-004 Standards for Determining Threshold Languages, Nondiscrimination Requirements, and Language Assistance Services

Health educator as defined by APL 18-016.[16] Translation of member facing materials are provided to members at no cost to them.

Partnership also provides members with requested information in their preferred format in a timely fashion. Preferred formats includes Braille, large-size print font no smaller than 20-point, accessible electronic format, audio compact disc (CD) format, or data CD format), and through Auxiliary Aids at no cost and upon member request. Partnership maintains a library of all member facing materials in all Partnership threshold languages, including the major correspondence, health education materials, and other benefit-related, member informing materials. Any mailed correspondence is sent according to the member's preferred threshold language or format. Other documents, such as letters or utilization review determinations are translated within 2 business days. Members may also request translation of other documents. Translated materials are completed within 2 business days of the request and members receive their fully translated materials in a timely manner.

Translation Service

Partnership utilizes United Language Group (ULG) as the certified translation service of all member-facing materials (including vital written materials) for LEP Members and Potential Members who speak Threshold or Concentration Standard Languages. Members can inform Partnership of their preferred language to receive written translations of member materials in the identified Threshold Language, at no cost to the member.

Member requests are fulfilled in a timely manner. ULG services are provided at no cost to the member. Partnership aims to have written member information translated within 2-5 business days depending on the complexity and rarity of the language requested; threshold and concentration languages are defined by DHCS APL 21-004. All translations are verified by separate, additional ULG translators to ensure cultural and linguistic accuracy as well as appropriate grammar and context (see attachment MCND9002 D Process for Culturally and Linguistically Appropriate Translations for further translation explanation).

Partnership has adopted the definition of a qualified translator/vendor as delineated in APL 21-004.[12] Per this APL, a translator interpreting for Partnership member must:

- Adhere to generally accepted translator ethics principles, including client confidentiality,

[16] APL 18-016 Readability and Suitability of Written Health Education Materials

- Have demonstrated proficiency in writing and understanding both written English and the written non-English language(s) in need of translation; and,
- Be able to translate effectively, accurately, and impartially to and from such language(s) and English, using any necessary specialized vocabulary, terminology, and phraseology.

Partnership has requirements for their translator certification process, as set forth by ULG Services in MCND9002 D Process for Culturally and Linguistically Appropriate Translations.

Interpreter Services

Partnership provides equal and timely access to high quality, oral and non-oral interpretation services to members who are monolingual, non-English-speaking, or LEP from a qualified interpreter on a 24-hour, 7 days a week basis at all key points of contact and at no cost to all members and potential members. Oral interpreter services are available for any language spoken by the member (see MCND9002 attachment A for criteria and authorization requirements for interpreting services). Key points of contact include the medical care setting, such as telephone, advice, Urgent Care, and other outpatient encounters with providers; and non-medical care settings, such as a member services, orientations, and appointment scheduling. Interpreter services are available in all of Partnership's threshold languages, and over 200 additional languages are available upon member request through Partnership's contracted language service provider. Member's preferred language (if other than English) is also prominently noted in their medical record, as well as the request or refusal of language/interpretation services in accordance with Title VI of the Civil Rights Act of 1964[17]. Any Partnership staff member who provides interpreter services to members in a non-English language is tested for proficiency through Human Resources before engaging members in that language.

Partnership has contracted with AMN HealthCare as their language interpretation service provider. Sight translation (oral interpretation) of written information can also be provided upon member request. Partnership ensures that timely access to care will not be delayed due to lack of interpretation services. Language services through AMN Healthcare are available for any member in need of an interpreter, member facing staff, and providers working with Partnership members. Member-facing delegates are also

[17] Title VI of the Civil Rights Act of 1964

required to provide interpreter services for members, however, workflows vary per delegate.

Partnership uses the definition provided by APL 21-004 in vendor selection and to define a qualified interpreter as an interpreter who:[9]

- Has demonstrated proficiency in speaking and understanding both spoken English and the non-English language in need of interpretation,
- Is able to interpret effectively, accurately, and impartially, both receptively and expressively, to and from such language(s) and English, using any necessary specialized vocabulary and phraseology; and,
- Adheres to generally accepted interpreter ethics principles, including client confidentiality.

When providing high quality interpretive services for an individual with disabilities, Partnership uses qualified non-oral interpretation services either through a remote interpreting service or an onsite appearance per the requirements stated in APL 21-004. This definition asserts that an interpreter who provides interpretive services for an individual with disabilities is an interpreter who:

- Adheres to generally accepted interpreter ethics principals, including client confidentiality; and
- Is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary, terminology, and phraseology.

For an individual with a disability, qualified interpreters can include sign language interpreters, oral transliterators (individuals who represent or spell in the characters of another alphabet), and cued language transliterators (individuals who represent or spell by using a small number of handshapes). When providing Video Remote Interpreter (VRI) services, Partnership provides real-time, full-motion video and audio over a dedicated high-speed, wide-bandwidth video connection or wireless connection. The connection is delivered through high-quality video images that do not produce lags, choppy, blurry, or grainy images, or irregular pauses in communication; and provide a sharply delineated image that is large enough to display the interpreter's face, arms, hands, and fingers, and the participating individual's face, arms, hands, and fingers, regardless of body position. Partnership provides clear, audible transmission of voices, and adequate training to users of the technology and other involved individuals so that they may quickly and efficiently set up and operate the VRI.

Partnership does not allow for the use of adult friends, family, or minor accompanying a member to interpret. The exceptions to this rule are as follows:

- In the middle of an emergency where a qualified interpreter is not available, or
- If the member explicitly requests the accompanying person to interpret, the accompanying person agrees to help, and it is appropriate for the situation.

Auxiliary Aids and Services

In accordance with APL 21-004 and APL 22-022, Partnership provides the following auxiliary aids and services to members, their authorized representative (AR) or someone with whom it is appropriate for Partnership to communicate with ("companion") by request or as needed, and at no cost to the member:

- Qualified oral and sign language interpreters on-site or through VRI services; note takers; real-time computer-aided transcription services; written materials; exchange of written notes; telephone handset amplifiers; assistive listening devices; assistive listening systems; telephones compatible with hearing aids; closed caption decoders; open and closed captioning, including real-time captioning; voice, text, and video-based telecommunication products and systems, text telephones/telephone typewriters (TTYs) or Telecommunication Devices for the Deaf (TDD), videophones, captioned telephones, or equally effective telecommunications devices; videotext displays; accessible information and communication technology; or other effective methods of making aurally delivered information available to individuals who are deaf or hard of hearing.
- Qualified readers; taped texts; audio recordings; Braille materials and displays; screen reader software; magnification software; optical readers; secondary auditory programs; large print materials (no less than 20-point font); accessible information and communication technology; or other effective methods of making visually delivered materials available to individuals who are blind or have low vision.

Please see MCND 9002 attachment B to learn how Partnership provides auxiliary aids and services for persons with disabilities.

Alternate Formats

In accordance with APL 21-004 and APL 22-002, Partnership provides member information to members and potential members in alternate formats to meet the cultural and linguistic needs of members, including Braille, large print text (20 point font or larger), audio, and electronic formats, at no cost. Partnership maintains record of member's linguistic capability upon member enrollment, and as reported thereafter, using data provided by DHCS or reported to Partnership by the member and/or their

AR, or by Subcontractors. Partnership members, their ARs, or someone with whom it is appropriate for Partnership to communicate with ("companion"), are encouraged to call Partnership or report their format preference via the DHCS AFS application system; this information is then passed on to Partnership for incorporation into the member record and implemented as appropriate.

In alignment with APL 22-002, when a member contacts Partnership about electronic alternative formats, Partnership also informs the member that, unless they request a password-protected format, the requested member information will be provided in an electronic format that is not password protected, which may make the information more vulnerable to loss or misuse. Partnership then communicates to the member that they may request an encrypted electronic format with unencrypted instructions on how the Member can access the encrypted information.[18]

Trainings

In alignment with APL 23-025 Diversity, Equity, And Inclusion Training Program Requirements, Partnership educates and trains all contracted network providers on diversity, equity and inclusion (including sensitivity, communication skills, cultural competency/humility training, health equity, and related trainings), as well as Partnership-specific culturally and linguistically appropriate policies and practices. Providers also separately receive a review of Partnership's policies and procedures for language assistance services and how to access them. Partnership provides trainings for contracted-Network Providers within 90 days of their start date, with retraining as needed during re-credentialing cycles.[19]

Also in alignment with APL 23-025, Partnership's Director of Health Equity reviews and oversees the evidence-based DEI trainings and program. The training content will be delivered as training modules via an electronic Learning Management System (LMS) to allow asynchronous training delivery throughout Partnership's 24 counties of service. It will review 3 major themes to ensure coverage of Partnership member demographics including, but not limited to, members' sex, race, color, religion, ancestry, national origin, creed, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, health status, marital status, gender, gender identity, sexual orientation, or identification with any other person or groups defined in Penal Code section 422.56 within specific regions. For details on the 3 themes

[18] APL 22-002 Alternative Format Selection for Members with Visual Impairments

[19] APL 23-025 Diversity, Equity, and Inclusion Training Program Requirements

described in the training, see the forthcoming policy Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.

The training program will be region specific and include consideration of health-related social needs that are specific to Partnership's servicing counties. Practitioners from different regions will receive different course recommendations that are specific to their region. Practitioners will also acknowledge review of their region's respective disparity report during the completion of the training. For more information on this training, please see the forthcoming policy on Diversity, Equity, and Inclusion Training Program Requirements for External Practitioners.

Partnership has two mandatory trainings required for Partnership staff. Permanent and temporary staff receive the cultural and linguistic program trainings upon hire. Upon hire and then annually, permanent, temporary, and contracted employees receive a diversity basics training with topics such as diversity, equity, and inclusion.

The Cultural and Linguistic unit audits DHCS-identified delegates' annual trainings to ensure that they are in compliance with required elements.

Partnership's State Hearing Representative is expected to become a certified ADA Coordinator, who advises Partnership on how and when accommodation requests should be honored. Partnership staff training records are maintained by Human Resources while the Provider training records are maintained by Provider Relations.

Beyond offering training to promote Cultural and Linguistic related topics, Partnership works to identify and act on at least one area of opportunity to improve the diversity, equity, inclusion (DEI) and cultural humility within the following groups per the findings of the Health Equity Accreditation workforce analyses:

- Staff
- Leadership
- Governing bodies
- Committees
- Providers

Assessment and Evaluation

Linguistic Capacity Assessments

Partnership identifies and tracks the language capabilities of clinicians and other provider office staff during the credentialing process. When available, Partnership contracts with qualified bilingual providers as a linguistic service to members and potential members at no cost and, when possible, to reflect the linguistic needs of

Partnership's members. Using the results from an annual, self-reported survey of our primary care sites, as well as documentation of staff changes, Partnership publishes updates to the Provider Directory to best reflect the linguistic capabilities at provider offices. Annually, Partnership performs an audit of its contracted translation and linguistic services providers (including employees, contracted staff, and other individuals who provide linguistic service) to ensure their services meet the needs of our members, including members under 21 years of age as well as their parents, guardians, and authorized representatives. Identified gaps are addressed as needed.

In accordance with Partnership's Policy HR509 Bilingual Standards, Partnership assesses the linguistic capabilities of bilingual staff members from member-facing departments to ensure they meet the necessary linguistic requirements to serve as qualified interpreters. Partnership's Human Resources Department maintains a record of staff members deemed as qualified interpreters, and their evaluation results.

Member-facing Departments include:

- Member Services
- Utilization Management
- Population Health Management
- Care Coordination
- Grievance & Appeals
- Transportation

Administrative Oversight & Compliance Monitoring

Internal Oversight

Within Partnership's Population Health department, the Senior Health Educator (a masters-prepared or MCHES-certified professional) monitors and oversees all regulatory requirements related to Cultural & Linguistics services program and requirements for compliance purposes and to ensure the delivery of culturally and linguistically appropriate health care services. Partnership recently created the Population Needs Assessment Committee to review findings and strategies to address C&L needs identified in the collaborative work referred to as the CHA and CHIP (please refer to MCND9001 for more detail). To protect the privacy of members, Partnership treats race/ethnicity, language, sexual orientation and gender identity as protected health information (PHI). Member PHI data cannot be used for denial of services, nor for coverage and benefits.

The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system. The goal of this system to address improvements in the quality

of care delivered by all of its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to members. The Partnership QIHETP serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time and in an equitable manner

As part of the QIHETP, and in accordance with MCND9001, the Quality Improvement Health Equity Committee (QIHEC) is comprised of various stakeholders including community based organizations, academic institutions, clinical staff, and Partnership members. The Partnership QIHEC serves as an organized framework to:

- Review and develop equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services. This is done by engaging with a member and using a family-centric approach
- Review activities and identify opportunities to improve health equity throughout Partnership, with oversight and participation of the governing Board of Commissioners and the QIHEC.
- Promote participation from a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers for QIHETP development and performance reviews.
- Review health equity-related training activities and validate that the trainings review the impact of structural and institutional racism, and health inequities on members, staff, subcontractors, and downstream subcontractors per DHCS's published DEI training All Provider Letters (APLs).

This committee meets quarterly to align interdepartmental efforts promoting health equity through both member-facing and systemic interventions outlined in the C&L/QIHETP Work plan (see figure below). As described in MCEP6002, the QIHEC is responsible for analyzing and evaluating the results of quality improvement and health equity activities including annual review of the results of performance measures, utilization data, consumer satisfaction surveys, and findings and activities of internal Partnership-specific committees. This committee is also responsible for developing actions to address performance deficiencies and ensuring appropriate follow-up of identified performance deficiencies. The QIHEC provides recommendations to the Quality/Utilization Advisory Committee (Q/UAC) (see policy MPQP1002).

QIHEC also makes a good faith effort to recruit individuals representing the racial/ethnic, linguistic, gender identity that are represented in our 24 counties. Ideally, the committee is looking to include individuals representing such groups in our network – especially groups that constitute at least 5% of the population at a minimum. Annually, the Health Equity Officer reviews the composition of the committee and will work with committee members to make a good faith effort to meet such thresholds.

Quality Improvement Health Equity Committee

HEALTH SERVICES TEAM

Chief Health Services Officer

Director(s)

Associate Director

Manager(s)

HEALTH EQUITY

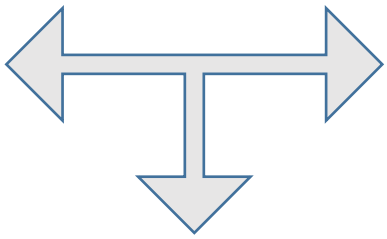
Director/Officer of Health Equity

Tribal Liaison

EXECUTIVE LEADERSHIP

Chief Operations Officer

Chief Medical Officer



REGIONAL ENGAGEMENT

Regional Representatives

Regional Medical Directors

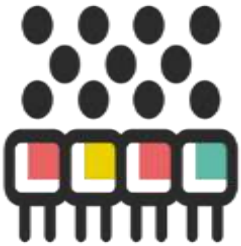
DEPARTMENTAL REPRESENTATION

Quality

Improvement

Health Equity

Human Resources



Provider Relations

Behavioral Health

OpEx/PMO

Transportation Services

Community Engagement

Partnership's Consumer Advisory Committee (CAC) and Whole Child Model Family Advisory Committee (FAC) serves as a linkage between Partnership and the community see attachment MCND9002-E CAC Guiding Principles and attachment MCND9002-F FAC Charter for additional details. The CAC and FAC consists of culturally and linguistically diverse Partnership members and community advocates. The advisory committee seeks to include individuals representing the racial/ethnic and linguistic groups that constitute at least 5% of the population at a minimum. When possible, Partnership works to include Seniors and Persons with Disabilities (SPD), persons with chronic conditions, Limited English Proficient (LEP) Members, and Members from diverse cultural and ethnic backgrounds or their representatives, to participate in establishing public policy.

One role of the CAC and FAC is to advise Partnership on the development and implementation of its C&L services program. The CAC and FAC also work to identify and help prioritize opportunities for improvement. The CAC can also provide input and advice, including, but not limited to, the following:

- Culturally and linguistically appropriate service or program design, including culturally and linguistically appropriate health education;
- Priorities for health education and outreach program;
- Member satisfaction survey results;
- Plan marketing materials and campaigns.
- Communication of needs for Network development and assessment;
- Community resources and information;
- Population Health Management (including wellness and prevention strategies) and Quality Interventions;
- Health Delivery Systems Reforms to improve health outcomes;
- Carved Out Services;
- Coordination of Care;
- Health Equity;
- Accessibility of Services;
- Health related initiatives;
- Resource allocation; and
- Other community-based initiatives

Delegate/Vendor Audits

In alignment with DHCS requirements, Partnership delegates some C&L services to subcontractors, including interpreter services, translator services and the coordination of

auxiliary aids and services in a culturally and linguistically and linguistically appropriate way. A formal agreement is maintained and inclusive of all delegate functions. Partnership's Health Education unit conducts an audit no less than annually on these delegated bodies. This audit helps to ensure that delegates have appropriate policies and procedures in place to meet compliance with state and federal language and communication assistance requirements as well as civil rights laws requiring access to members with disabilities and other C&L service requirements. The annual audits also help to ensure Subcontractors and Downstream Subcontractors deliver culturally and linguistically competent care, including offering interpreter services when a Limited English Proficient (LEP) Member accesses a Provider who does not speak the Member's language. Any unmet requirements result in the delegate receiving preliminary CAPs. Any preliminary CAPs that were not closed within the timeframe given by the Audit team are deemed final CAPs. Any final CAPs will go to Delegation Oversight Review Sub-committee (DORS) for additional review and direction, even if the delegate submits appropriate documentation before the DORS meeting.

Partnership acknowledges the type of relationship described above is known to the National Committee for Quality Assurance (NCQA) as a vendor relationship. Partnership has no known entities acting upon its behalf that would constitute a delegate as defined by the NCQA Health Equity Accreditation standards.

Goals and Work Plan

Partnership has measurable, culturally and linguistically appropriate goals for the improvement of CLAS standards and for the reduction of health care inequities that are presented annually in the QIHEC/C&L Work Plan. Partnership has an annual work plan that described the planned work for the coming year, along with the strategy and rubrics for monitoring against the measurable goals for the improvement of CLAS and reduction of health care inequities; this annual plan is approved by various committees, including:

- The Quality Improvement and Health Equity Committee (QIHEC), and
- The Internal Quality Improvement (IQI) Committee
- The Quality Utilization Advisory Committee (Q/UAC)
- The Physician's Advisory Committee (PAC) as final approval.

Partnership communicates its progress in implementing and sustaining CLAS standards by way of the C&L work plan to all stakeholders, constituents, and the general public.

2024-2025 Goals

Partnership identified multiple goals for 2024-2025. Goals 1-5 will carry over from 2024; goals 6-10 are new goals. These goals are listed below. Additional goal details can found in the C&L/QIHETP Work Plan:

- Goal 1: By December 31, 2024 90% of members requesting an alternate format will receive at least one mailing in their preferred format.
    - This goal was chosen to ensure members are receiving information in a way that they can understand.
- Goal 2: By August 31, 2024, define the framework and processes by which the QIHETP Program Description, C&L/QIHETP Work Plan, and QIHETP Evaluation will be initiated in 2024 and maintained through approval of corresponding 2025 versions needed for HEA Initial Survey in June 2025.
    - This goal was chosen to strategize and streamline required initiatives to advance Health Equity.
- Goal 3: By September 30, 2024, submit DEI training to DHCS for review to fulfill Phase I APL-23-025 deliverables.
    - This goal was chosen due in part to new regulatory requirements around DEI trainings and to ensure all member facing individuals are equipped to provide appropriate care.
- Goal 4: By December 31, 2024, increase the number of bilingual Member Service Representative (MSR) staff hired by 1% to move closer to organizational goal of 75% of bilingual MSR staff.
    - This goal was chosen in order to align with an existing organizational goal to have 75% of the Member Services staff possess bilingual skills.
- Goal 5: By December 31, 2024, improve controlled blood pressure rate among American Indian/Alaska Native members by 5%.
    - This goal was chosen due in part to the fact that American Indian/Alaska Native members are a current Population of Focus at Partnership.
- Goal 6: By December 2025, improve the rate of timely translations in the Utilization Management and/or Care Coordination department to achieve the threshold of at least 90%.
    - Goal 6 was chosen due to the recognized need for quality translation services and an overall positive member experience.
- Goal 7: By December 31, 2025, improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 22% in the next 5 years.
- Goal 8: By December 31, 2025, improve Well Care Visits rate among Black, White, and/or American Indian/Alaska native members by 5% overall or in at least 1.25% in at least one region.

- Goals 7 and 8 were chosen due to the recognized disparities in each goal's respective clinical measure and population of focus.

Partnership will continue to monitor these goals through the annual C&L Work Plan to ensure the goals are met. Progress toward this goal will be reviewed on a quarterly basis. Progress toward this goal will be also be reviewed no less than annually by the committees described above.

Population Health Department Structure

Population Health operations are supported by a leadership team and administrative staff that recruits, promotes, and supports a culturally and linguistically diverse structural and organizational environment that is responsive to Partnership members.

Partnership's Population Health department is responsible for developing, maintaining, and overseeing implementation of Partnership's overall PHM strategy (MCND9001), and identifying the health disparities, wellness needs, and health education needs of Partnership's members. These efforts include making referrals to culturally and linguistically appropriate community service programs, and aligning organizational and community efforts to meet these needs, in accordance with DHCS and NCQA requirements. In order to accomplish these objectives, Population Health departmental resources are leveraged to engage internal stakeholders, external stakeholders, and members aligning existing projects and efforts to promote health equity for Partnership's population, including the provision of cultural and linguistic services. Population Health department staff are allocated to develop and share member education materials, ensure all member subpopulations have resources specific to their needs, identify and refer to culturally and linguistically appropriate community service programs when available, engage with the community, educate community partners on Partnership programs and interventions, learn about resources available within communities, and promote collaboration of effort and reduce duplication of services.

Team Roles and Responsibilities

Chief Medical Officer:

As the principal manager of medical care, the Chief Medical Officer is responsible for the appropriateness and quality of medical care delivered through Partnership HealthPlan of California (Partnership) and for the cost-effectiveness of the utilization of services. This position provides overall direction to multiple departments, including the Population Health Management Team and has the ultimate responsibility of ensuring that departmental programs and services are consistent and meet all regulatory requirements in every office location. Required education includes an MD/DO degree from an accredited program preferably in a primary care specialty required; minimum two (2) years' experience in a managed care plan preferred with duties comparable to those listed above, and experience administering medical programs. This role also requires board certification in a specialty and a minimum of seven (7) years clinical/medical practice experience.

Director of Population Health

Provides oversight of Population Health strategy, programs and services to improve the health of Partnership members. Reports to the Chief Medical Officer. Works with the Senior Director of Quality and Performance Improvement and other department leaders to meet organization and department goals and objectives while developing and tracking the measurable outcomes of department services. This professional must have training in Public Health and Population Health processes. This role also requires at least five (5) years of experience in a leadership/management role.

Associate Director of Population Health

Assists the Director of Population Health in the development, implementation and evaluation of Partnership's population health interventions and program oversight. The Associate Director oversees the Managers of Population Health and the operational workings of the Population Health department. The Associate Director reviews and submits issues, updates, recommendations, and information to the HS Leadership when appropriate. Ensures ongoing audit readiness for Population Health deliverables. This professional must have a Bachelor's degree, an RN license is preferred, with a minimum of five (5) years health care operations experience and three (3) years in a management role.

Supervisor

Provides supervisory oversight during daily department operations for assigned team members through sustained leadership and support. Using best expertise and sound

judgment (and in consultation with clinical leaders, providers, and staff), provides daily oversight, leadership, support, training, and direction of Population Health staff.

Supports and assists the Manager and other Supervisors in developing and maintaining a cohesive team with a high level of productivity and accuracy to achieve the department's overall performance metrics. Required education includes a Bachelor's degree in Business, Communication, Healthcare Administration, a related field, or 3-5 years of managed care experience, or equivalent combination of education and experience.

Senior Health Educator

A public health masters-prepared (or MCHES-certified) professional who ensures the delivery of approved health education and member informing resources for both members and primary care providers. Develops trainings for contracted providers, internal Partnership staff, Partnership members, and community members as appropriate and to promote cultural competency, health equity, and member wellness. Monitors and oversees all regulatory requirements related to Health Education, Cultural & Linguistics programs. The Senior Health Educator may also perform supervisor responsibilities.

Health Educator(s)

Trained and competent to actively participate in the design and implementation of the Health Education Program. Assesses the health education needs of internal staff, leads on specific member education projects, monitors health education materials, and evaluates member grievances. Serves as a resource to internal staff and providers to ensure compliance with state requirements for educational member materials. Required education includes a Bachelor's Degree in Health Education, Public Health, Community Health or related field; experience in Public Health Education. A minimum two (2) years of health education experience is preferred.

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QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHETP) PROGRAM DESCRIPTION

MCED6001

November 13, 2024~~3~~

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Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description

PROGRAM PURPOSE AND GOALS

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

The mission of Partnership HealthPlan of California is "To help our Members, and the Communities we serve, be healthy." Our vision is to be "the most highly regarded health plan in California." Partnership believes in fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes; focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners; and promoting diversity by accepting, respecting, and valuing individual differences and capitalizing on the diverse backgrounds and experiences of our members, community partners, and staff.

Partnership's defining focus is ensuring the highest quality of care, positive health outcomes, and timely access to care for all diverse members (i.e., Quality, Access, and Equity). Therefore, Partnership has developed program descriptions and policies to describe the structures needed to promote health equity. Specifically, Partnership has implemented the Partnership Quality Improvement and Health Equity Transformation Program (QIHETP).

The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system to address improvements in the quality of care delivered by all of its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to members. The Partnership QIHETP serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time and in an equitable manner

The Partnership QIHETP provides a reliable and credible mechanism to review, monitor, evaluate, recommend, and implement actions that acknowledge health equity.

The Partnership QIHETP serves as an organized framework to:

- Review and develop equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services by engaging with a member and family-centric approach
- Review activities and identify opportunities to improve health equity throughout Partnership with oversight and participation of the governing Board of Commissioners and the Quality Improvement and Health Equity Committee (QIHEC)
- Promote participation from a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers for QIHETP development and performance reviews
- Review health equity-related training activities and validate that the trainings review the impact of structural and institutional racism and health inequities on members, staff, network providers, subcontractors, and downstream subcontractors per Department of Health Care Services (DHCS) published All Plan Letters (APLs) regarding diversity, equity and inclusion (DEI) training.

PROGRAM OBJECTIVES

The Partnership QIHETP serves to ensure that appropriate, high quality cost-effective utilization of health care resources is available to all members while being cognizant of health care disparities and inequities. This is accomplished through the systematic and consistent application of management processes based on current health equity review literature and expert opinion when needed. The scope of the QIHETP includes the quality of clinical care and services for all members receiving Medi-Cal healthcare services from Partnership. The monitoring and evaluation of clinical issues reflects the population served by Partnership without regard to social drivers of health (SDOH), age group, disease category, or risk status. In alignment with other Partnership departments, the QIHETP encompasses all aspects of medical and behavioral healthcare including:

- Identifying and addressing racial/ethnic and other disparities in health care delivery or outcomes
- Identifying overuse, misuse, and underuse of health care services and prescription medications
- Evaluating clinical quality of physical health care
- Evaluating clinical quality of behavioral health care focusing on prevention, recovery, resiliency, and rehabilitation
- Identifying and addressing equitable access or quality issues related to behavioral health services through delegated contracts
- Ensuring access to primary and specialty health care providers and services
- Ensuring availability and regular engagement with primary care providers (PCPs)
- Evaluating continuity and care coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent provider-patient relationships
- Evaluating member experience with respect to clinical quality, access, and availability and culturally and linguistically competent health care and services, and continuity and care coordination
- Promoting cultural and linguistic competence of Partnership staff and network practice sites and providers

The QIHETP program accomplishes these goals by:

- Systematically monitoring and evaluating services and care provided by conducting quantitative and qualitative data collection. Using this data and various statistical analyses, Partnership will make data-driven decisions
- Identifying, evaluating, and reducing health disparities utilizing internal reports, reflecting utilization management, quality improvement, member satisfaction (Consumer Assessment of Healthcare Providers and Systems [CAHPS®]), care coordination, grievance and appeals, and population health activities to ensure services are provided equitably.
- Actively conducting systematic searches for tertiary and primary medical literature to ensure decisions are based upon up-to-date evidence in the health equity discipline
- Actively pursuing opportunities for improvement in areas that are relevant and important to Partnership members' health
- Implementing strong and sustainable interventions when opportunities for improvement are identified for addressing a health disparity

PROGRAM STRUCTURE

This section outlines the individual program staff and their assigned activities and responsibilities.

PROGRAM STAFF

Chief Medical Officer (CMO)

The Chief Medical Officer is responsible for working with the Health Equity Officer (HEO) to assist with the implementation, supervision, oversight and evaluation of the QIHETP. This position provides guidance and overall direction of QIHETP activities and has the authority to make decisions based on Quality Improvement and 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 Health Equity Officer (HEO); oversees QIHETP operations and assists in the development and coordination of QIHETP policies and procedures
- Serves as the Committee Chair for the Quality/Utilization Advisory Committee (Q/UAC) and Co-Chair of the Quality Improvement and Health Equity Committee (QIHEC)
- Guides and assists in the development and revision of QIHETP policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for Q/UAC review

Chief Health Services Officer (CHSO)

Responsible for the day-to-day implementation of ~~the PHC~~ Partnership's Utilization Management, Care Coordination, Population Health Management (PHM) and Health Equity (HE) p~~P~~rograms. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Collaborates with the Chief Medical Officer and the Q/UAC on Care Coordination, Population Health, Health Equity, and Utilization Management activities
- Provides oversight and guidance for Partnership's Health Equity program across all regions
- Monitors and analyzes health services and health equity data to inform decision making
- Develops recommendations based on data analysis and strategic planning
- Collaborates with the Chief Medical Officer, the Health Equity Officer and the Q/UAC on QIHETP activities
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC) as a standing member
- Evaluates and uses provider and member experience data when evaluating the QIHETP program in collaboration with the Health Equity Officer and the Chief Medical Officer
- Serves as Chairperson of the Benefit Review Evaluation Workgroup (BREW)
- Reviews the QIHETP Annual Program Evaluation and Program Description before presentation to Q/UAC and PAC

Director of Health Equity (Health Equity Officer)

The Director of Health Equity serves as the Health Equity Officer (HEO) for Partnership and is responsible for the co-implementation, co-supervision, co-oversight and evaluation of the QIHETP. This position provides guidance and overall direction of QIHETP activities through the Quality Improvement and Health Equity annual work 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
- Coordinates departmental Health Equity and Quality Performance and Improvement efforts

- Serves as a Co-Chair for the Quality Improvement and Health Equity Committee (QIHEC) and regularly attends the Quality/Utilization Advisory Committee (Q/UAC) as a standing member
- Guides and assists in reviewing Partnership policies and program goals against QIHETP guidelines and under the purview of the QIHEC
- Other duties as assigned by the Executive Committee and/or Chief Executive Officer (CEO)
- Reports to executive team and Board of Commissioners on program goals, activities, and results
- Provides guidance to staff through trainings and on-site continuing education regarding diversity, equity, and inclusion (DEI) and health equity

Medical Director for Quality

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 Member Safety Quality Investigations and Clinical Quality Inspection teams, ~~Assurance & Patient Safety, Clinical Quality & Patient Safet~~y and the Quality Measurement ~~–~~HEDIS team~~s~~. 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)
- Regularly attends the Credentialing Committee
- Regularly attends the Physician Advisory Committee (PAC)
- Regularly attends the Internal Quality Improvement (IQI) Committee
- Serves as the Chair for the Peer Review Committee
- 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 and Performance Improvement or by the Chief Medical Officer

Senior Director of Quality and Performance Improvement

Responsible for day-to-day leadership, strategic direction, and implementation of Partnership's Quality and Performance Improvement programs across all regions. Assigned activities include:

- Provide oversight and guidance for Partnership's Quality Measurement, Quality Management and Quality Improvement Analysis programs
- Collaborate with the Chief Medical Officer, the Sr. Health Services Director, the Sr. Provider Relations Director, the Health Equity Officer and other department leaders to support the delivery of high-quality clinical care
- Engage with the Health Equity Officer and Chief Medical Officer to identify and prioritize QIHETP actions. Participate in the QIHEC to identify community priorities and implement action plans.
- Strengthen a culture of continuous quality improvement within Partnership's network of providers leveraging pay-for-performance initiatives along with other provider support programs
- Work collaboratively with other organizational leaders to maximize use of data to generate information, knowledge and wisdom to improve health outcomes, optimize utilization of resources, and enhance the member experience of care

Director of Population Health

Provides oversight of Population Health strategy, programs and services to improve the health of Partnership members.

- Oversees DHCS compliance and National Committee for Quality Assurance (NCQA) survey readiness for assigned areas of responsibility
- ~~Serves as Co-Chair for the Population Health Management and Health Equity (PHM&HE) committee with the HEO~~
- Works with the Chief Medical Officer, Chief Health Services Officer, Senior Director of Quality and Performance Improvement, Health Equity Officer and other department leaders to meet organization and department goals and objectives while developing and tracking the measurable outcomes of department services.
- Other duties as assigned by the Eexecutive Ceommittee or the Chief ~~Health~~ Medical ~~Services~~ Officer

Behavioral Health Clinical Director

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
- Serves on Q/UAC; Pharmacy and Therapeutics Committee; Credentials Committee and Internal Quality Improvement Committee including the Substance Use Internal Quality Improvement Subcommittee.

Program Coordinator

Under the direction of the Health Equity Officer (HEO) or other designated leadership, provides administrative support to the Health Equity Officer Director and/or other QIHETP Leadership. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

- Tracks project deliverables and resources using appropriate internal tools to ensure deadlines are met
- Coordinates the QIHEC meetings
- Coordinates with Regulatory Affairs and Compliance (RAC) to conduct research on regulations, statutes, laws, administrative health equity-related policies and procedures

COMMITTEES

Board of Commissioners

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

Quality/Utilization Advisory Committee (Q/UAC)

The Q/UAC is responsible to assure that quality, comprehensive health care, and services are provided to Partnership members through an ongoing, systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external providers who are contracted primary care providers (PCPs) and board certified specialists in the areas of internal medicine, family medicine, pediatrics, OB/GYN, neonatology, behavioral health, and representatives from other high volume specialties. The Partnership Chief Medical Officer (CMO) (chair of the committee), Clinical Director of Behavioral Health, Health Equity Officer, Medical Director for Quality, Associate and Regional Medical Directors and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, Care Coordination, Population Health, Health Equity, Pharmacy, and Grievance dDepartments 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 QIHEC by functioning as the expert reviewing panel as follows:

- Reviewing, making recommendations to, and approving the *QIHETP Program Description* annually
- Analyzing summary data and making recommendations for action
- Reviewing action plans for quality improvements of QIHETP activities and providing ongoing monitoring and evaluation

Quality Improvement and Health Equity Committee (QIHEC)

Partnership's QIHEC is overseen by the Quality/Utilization Advisory Committee (Q/UAC) and the Physicians Advisory Committee (PAC), which subsequently reports to our governing Board of Commissioners. The QIHEC analyzes and evaluates the results of Health Equity-related Quality Improvement activities. Specifically, QIHEC will conduct an annual review of the results of key health equity-related data to provide plan-wide recommendations (e.g., generate policy recommendations) to address health-equity performance deficiencies. The QIHEC ensures appropriate assessment of interventions, measurement, and follow-up of identified performance deficiencies. The QIHEC responsibilities include the following:

- Analyze and evaluate the results of clinical quality performance measures related to Health Plan Ratings (HPR), as specified by NCQA Health Equity Accreditation (HEA) standards, as mandated by DHCS, or due to poor performance trending on the DHCS Managed Care Accountability Set (MCAS) (with stratification by race/ethnicity and language):
  - Assigned Health Effectiveness Data & Information Set (HEDIS®) Measures
  - Consumer Assessment of Healthcare Providers and Systems [CAHPS®]
- Analyze utilization data (tTypes of services, denials, deferrals, modifications) with stratification by race/ethnicity and language
- Analyze utilization data of language services and experience with language services with stratification by language.

- Analyze and evaluate the results of member satisfaction surveys, Grievance and Appeal surveys, and care coordination-based surveys with stratification by race/ethnicity and language
- Analyze and evaluate the strategy and work plans presented by internal committees to ensure that clinical quality performance measures (with stratification by race/ethnicity and language) and member satisfaction are evaluated and attended to in prospective work plans
- Analyze and evaluate feedback from member representative committees (e.g., Consumer Advisory Committee~~AC~~, Family Advisory Committee~~FAC~~)
- Recommend Managed Care Plan (MCP)-related interventions (e.g., education, programs, etc.) for various departments to address key clinical quality performance deficiencies (e.g., HEDIS, CAHPS, etc.) per the scope of work of managed care plans. ~~(MCPs).~~

Partnership's QIHEC membership will consist of the following key members, who subsequently will report directly to Q/UAC:

- Chief Medical Officer or CMO Designee (e.g., Medical Director)
- Health Equity Officer
- Chief Operating Officer
- Internal Leadership from following departments: Health Analytics, QI/PI, Provider Relations, Utilization Management, Member Services, Care Coordination, and Population Health

In addition, the Partnership's QIHEC membership will be composed of representatives from our Providers, health plan subcontractors, and health plan downstream subcontractors, who provide health care services to members affected by health disparities, members who are considered to have Limited English Proficiency (LEP), members with children with special health care needs (CSHCN), members who are considered to be Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions. Example entities from which representatives will be drawn include, but are not limited to, h~~H~~ospitals, c~~C~~linics, c~~C~~ounty p~~P~~artners, p~~P~~hysicians, s~~S~~ubcontractors, d~~D~~ownstream s~~S~~ubcontractors, n~~N~~etwork p~~P~~roviders, and Partnership m~~M~~embers. The QIHEC ~~Committee~~ meeting minutes, findings and recommendations will be reported directly to the Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC), and Partnership's Board of Commissioners. Also the QIHEC will report findings to our various other internal committees (e.g., CAC, ~~Consumer Advisory Committee (CAC) and/or Family Advisory Committee (~~FAC~~)~~, etc). ~~The PHCs~~Partnership's Confidentiality Policy (CMP-10) provides guidance to ensure avoidance of conflict of interest among committee members and ensure that member confidentiality is maintained throughout QIHEC-related meetings.

Population Health Needs Assessment (PNA) Committee

The Population Health Needs Assessment Committee (PNA) is an internal committee and serves as a multi-departmental body whose goal is to support the advancement, growth, and execution of population health and health equity interventions at Partnership. The committee consists of Partnership staff representing member, community, regional, and provider~~-~~-facing departments; it also incorporates representatives from Human Resources, Regulatory Affairs, IT, and Health Analytics. The committee meets ~~quarterly~~every other month to align interdepartmental efforts promoting health equity through member and systemic interventions outlined in the relevant Needs Assessment (PNA) Action Plans. The PNA Committee activities and recommendations will be shared with the, Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), QIHEC, Physician Advisory Committee (PAC) and Partnership's Board of Commissioners.~~*Population Health Management & Health Equity Committee (PHM&HE)*~~

~~The Population Health Management & Health Equity Committee (PHM&HE) is an internal committee and serves as a multi-departmental body whose goal is to support the advancement, growth, and execution of population health and health equity interventions at Partnership. The committee consists of Partnership staff representing member, community, regional, and provider facing departments; it also incorporates representatives from Human Resources, Regulatory Affairs, IT, and Health Analytics. The committee meets quarterly to align~~

~~interdepartmental efforts promoting health equity through member and systemic interventions outlined in the relevant Needs Assessment Action Plans. PHM&HE ensures Partnership is meeting specifically assigned state and NCQA requirements for health equity, culturally and linguistically appropriate services (including appropriate language access services at all points of contact), health education, and population health management to meet the individual needs of members The PHM&HE Committee activities and recommendations will be shared with the, Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), QIHEC, Physician Advisory Committee (PAC) and Partnership's Board of Commissioners~~.

Family Advisory Committee (FAC)

The Family Advisory Committee (FAC) is a member advisory group to the CEO and staff of Partnership. The FAC provides a forum for parents, guardians and caregivers of children with California Children Services (CCS) conditions to discuss common issues of interest and importance, to create a supportive and informative networking environment and to advocate for members by ensuring that Partnership is responsive to the diversity of health care needs for all members. Minutes from FAC meetings are reviewed by the Pediatric Quality Committee (PQC). The FAC membership is comprised of representatives from throughout Partnership's geographic service areas who advocate for CCS-eligible children of diverse cultures, ethnicities, genders, ages and disabilities. Meetings are held at least four (4) times per year with the option for additional meetings as needed

Consumer Advisory Committee (CAC)

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

QUALITY AND PERFORMANCE IMPROVEMENT COLLABORATION

The ~~QIHETP team~~Health Equity department works collaboratively with the Quality and Performance Improvement (QI/PI) d~~D~~epartment to enhance the care provided to our members through venues such as the Internal Quality Improvement Committee (IQI), the Quality/ Utilization Advisory Committee (Q/UAC) and daily QIHETP activities.

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

- Reviewing, making recommendations to, and approving the *QIHETP Program Description* annually
- Analyzing summary data and making recommendations for action
- Reviewing the recommendations of QI's Performance Improvement Teams to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. The QI/PI department is often the lead for many improvement efforts, particularly those that are mandated or due to poor performance on the Managed Care Accountability Set (MCAS), which ~~are~~ is

the set of measures that ~~Department of Health Care Services (~~DHCS~~)~~ selects for annual reporting by Medi-Cal managed care health plans. This can include mandated improvement efforts to meet disparity reduction targets for specific populations and/or measures as identified by DHCS. The QI/PI department also takes the lead on mandated Performance Improvement Projects (PIPs) that are assigned by DHCS. PIPs are led by the QI/PI program based on criteria defined by DHCS and overseen by the California External Quality Review Organization (EQRO), and include at least annual status reports to DHCS

- Recommending improvements to enhance health equity language in Partnership policies and protocol according to QIHETP standards

For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the ~~QIHETP team~~Health Equity department supports ongoing quality improvement efforts in the identification of potential quality or equity of care issues, improvement of HEDIS quality measures in context with social drivers of health. For member-facing improvement efforts, CAC and other member focus groups are often consulted.

~~The QI/PI department is often the lead for many improvement efforts, particularly those that are mandated or due to poor performance on the Managed Care Accountability Set (MCAS), which are the set of measures that Department of Health Care Services (DHCS) selects for annual reporting by Medi-Cal managed care health plans. This can include mandated improvement efforts to meet disparity reduction targets for specific populations and/or measures as identified by DHCS. The QI/PI department also takes the lead on mandated Performance Improvement Projects (PIPs) that are assigned by DHCS. PIPs are led by the QI/PI program based on criteria defined by DHCS and overseen by the EQRO, and include at least annual status reports to DHCS."~~

NCQA Accreditation Program Management

Partnership strives to improve the health status of members and their care experience to become one of the highest quality health plans in California. NCQA Health Plan Accreditation supports Partnership's vision, mission, and strategic goals byproviding a rigorous and comprehensive framework for essential quality improvement, operational excellence, and measurement of clinical performance (HEDIS) and member experience (CAHPS).

Per the 2024 DHCS contract, all managed care plans (MCPs), including Partnership, are mandated to achieve both NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation (HEA) by Jan. 1, 2026. Partnership successfully achieved HPA reaccreditation on Dec. 18, 2023.~~Partnership officially obtained NCQA First Survey Accreditation Status as of January 26, 2021~~. In order to maintain NCQA Health Plan Accreditation, Partnership was~~is~~ required to report annual results starting in June 2022. Partnership ~~will~~ earned a Health Plan Rating (HPR) of 3.5~~0 5~~ stars in June 2023 based on HEDIS/CAHPS performance from MY 2022/RY 2023.~~June 2023. In addition,~~ NCQA released Partnership's current HPR of 3.5 stars in September 2024.~~will undergo the Renewal Survey in October 2023. '~~

Partnership's defining focus is ensuring the highest quality of care, positive health outcomes, and timely access to care for all diverse members (i.e., Quality, Access, and Equity). NCQA Health Equity Accreditation (HEA) complements Partnership's overall mission by encouraging managed care organizations to establish a foundation of health equity work. Specifically, the HEA encourages the focus on building an internal culture that complements external health equity work with our population health management department; collecting relevant data that provides insight on how to ensure appropriate representation in language services and providers; identifying and categorizing inequities to guide future population health-based interventions

Partnership will be submitting first survey documentation, to obtain the NCQA Health Equity Accreditation (HEA),

by June~~,~~ 2025.

DATA SOURCES

DHCS Bold Goals
To have a context of Health Equity and align internal quality and health equity efforts with DHCS, Partnership will review the DHCS's Health Disparities Report and Bold Goals of 2025. Currently, The Bold Goals of 2025 are as follows:

- Close racial/ethnic disparities in well child visits by 50%
- Close racial/ethnic disparities in immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow up for mental health and substance use disorder by 50%

Partnership uses several methods to identify and evaluate member needs, and strategize how to address such needs by reducing health disparities.

Step 1: Sample Selection to Evaluate Disparities

Partnership initially utilized Measurement Year 2023 (MY 2023) MCAS final sample measures ~~measure samples~~ (n=186 to 167,450 members) to evaluate each of the clinical measures of focus. The rates for each measure are comprised of the members included in each measure's audit for Partnership's Health Plan Accreditation Plan-wide summary of performance report. The random member sample that was generated for each hybrid measure and full member denominator along with member race/ethnicity demographic information, was provided by Partnership's HEDIS vendor, Inovalon. Inovalon has been classified a~~i~~s a direct data source.

Step 2: Statistical Analysis to Identify Key Disparities

After receiving the data from Inovalon, members from Partnership's Health Analytics team conducted various statistical analyses. The Chi-Square and Fisher's Exact statistical tests were utilized, based upon sample size, to determine if there were significant differences for the various categorical measure outcomes.

When analyzing disparities based upon race/ethnicity, Partnership conducted various statistical analyses using the White group as the key comparator group. When analyzing disparities based upon language, Partnership conducted various statistical analyses using the English language group as the key comparator group. Finally, when analyzing disparities based upon gender, Partnership conducted various statistical analyses using the Male gender identity group as the key comparator group. A statistically significant difference was classified as a p value less than 0.05 when comparing the categorical outcomes of one group versus the key comparator group, respectively (i.e., White, English-speaking, Male). These comparators were identified based upon various literature suggesting that such groups, respectively, have had significantly more political, economic, and/or social advantages within the United States (Malat et al., 2018). Data, that were excluded from the evaluation, were findings from patients who reported "Unknown" in race, language, and gender identity.

Step 3: Analysis of Measures

Partnership also reviewed the performance of each race/gender identity/linguistic group in comparison to the MCAS benchmarks to assess not only how each group performed statistically in comparison to the White/Male/English speaking group, but also in comparison to the national Medicaid benchmarks. In MY 2023, DHCS is holding managed care plans (MCPs) accountable and imposing sanctions on selected Hybrid and Administrative measures performing below the minimum performance level (MPL) (50th national Medicaid

percentile) by reporting region, and as a result, Partnership thought it valuable to assess how each group is performing in comparison to that benchmark to assess whether group performance could also have an impact on accountable measures.

Step 4: Prioritization of Disparities
The HEO, CMO, and members of the QI/PI team reviewed the information supplied about health disparities and draft a preliminary report of disparity metrics to prioritize based upon clinical measure stratification, statistical or clinical findings, size of the disparity, strength of evidence, feasibility, and return of investment. An established baseline will be developed for each group to follow for the next 3 to 5 years to evaluate long-term impact. The team will identify the key disparity priorities per region and per population of key racial/ethnic, gender, or linguistic groups.

Step 5: Distribution of Disparity Data for Community Feedback

The preliminary report will be shared with relevant internal committees (e.g., CAC, FAC ~~Consumer Advisory Committee (CAC), Family Advisory Committee (FAC),~~ etc), corresponding providers, health plan subcontractors, and health plan downstream subcontractors, via their corresponding QIHEC representative or newsletter. The goal will be to solicit feedback to ensure we have identified disparities that may not have been captured during our internal data analysis and identify strategies to address the disparities in respective communities. The Health Equity department will review internally submitted community needs assessment information to increase the likelihood of receiving credible information from community leaders and CAC/FAC/QIHEC members. Also, the Health Equity department will review feedback from members, parents, and/or caregivers to ensure that the community is given an opportunity to engage in the development of quality improvement and health equity activities and suggest interventions that will likely work in their respective communities. The advisory feedback will be transcribed and shared with the Health Equity department.

The Health Equity department will review the solicited findings from QIHEC, CAC, FAC, providers, health plan subcontractors, and health plan downstream subcontractors and share the results to the QIHEC for final approval of the key ~~PHC~~Partnership health equity priorities to share with the overall organization to serve as guidance for various departments and activities (e.g. PNA, QIP, etc.).

Step 6: Distribution of Disparity Data into Department Activities

Quality Improvement

For internal QI/PI related activities, t~~T~~he ~~QIHETP team~~Health Equity department, in collaboration with the QI/PI team, will ~~collaborate to~~ ensure that HEDIS/CAHPS–associated disparities (e.g. racial, ethnic, linguistic, disability, SOGI, etc.) are specifically being addressed in QI/PI programs (e.g., value-based payment programs, provider improvement plans, Corrective Action Plans (CAPS) etc.). Specifically, the QIHETP and QI/PI teams will review the internal value based payment programs (e.g., primary care provider quality improvement program (PCP QIP), hospital quality improvement program, (HQIP) etc.) and performance improvement projects to assess whether adjustments need to be made to ensure the projects can address HEDIS/ CAHPS –associated disparities. For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the ~~QIHETP team~~Health Equity department supports ongoing QI/PI efforts in the identification of potential quality or equity of care issues, improvement of HEDIS quality measures in context with social determinants of health. The QIHETP and QI/PI teams will collaborate to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. Finally, the QIHETP and QI/PI teams will share data with NCQA team members to validate that disparity reduction goals/targets are ~~complicit~~compliant with NCQA HEA standards.

The QIHEC will review, among other reports, the updated QI/PI Program Evaluation to ensure that one or more HEDIS/CAHPSs-associated racial disparity, HEDIS/CAHPSs-associated linguistic disparity, or a mandated disparity reduction target for specific populations and/or measures as identified by DHCS has been addressed in response to findings from Partnership's annual QI Work Plan.

Population Health

For internal population-health department-specific activities, tThe QIHETP and Population Health teams will collaborate to generate a finalized report to help refine the various population health reports and analyses. (The PHM Strategy provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population served in the program. Specifically, teams will review tertiary and primary medical literature and health indices, review findings from other managed care organizations, collaborate with community key opinion leaders or subject matter experts, and survey members of the CAC and FAC to find credible interventions that can be executed by a managed care organization based upon the synthesized findings of the preliminary report. The QIHETP and Population Health and Health Equity teams will review and assess corresponding social drivers of health metrics. to ensure they are assessed. Social determinants or drivers of health have been classified as conditions in various environments that affect health and overall quality-of-life outcomes

The QIHEC will review, among other reports, relevant Community Health Assessment (CHA) information, Population Health and Cultural and Linguistics (C&L)-associated wWork pPlans to ensure that one or more HEDIS-associated racial/ethnic disparity(ies), and one or more HEDIS-associated disparity(ies) related to one additional category of stratification (e.g., disability, geographical representation, etc.) is addressed based on the findings -from the assessed reports. The QIHEC will also review reports regarding the utilization of language services, individual experience with language services, staff experience with language services, and member experience with language services during health care encounters to ensure that one or more interventions is identified and incorporated into work plan(s) to address one or more culturally and linguistically appropriate services (CLAS) disparity or HEDIS-associated linguistic disparity. The QIHEC will review these elements to ensure they correlate appropriately with Partnership's annual QI Work Plan.

Human Resources

For internal Human Resources (HR) related activities, the Health Equity department, in collaboration with the HR department, will review submitted data for annual DEI-related training for employees, network providers, etc. to ensure review of completion. Specifically, the QIHETP and HR team will review the annual training on culturally and linguistically appropriate practices to ensure they are teaching principles to reduce bias and promote inclusion. Also, QIHETP and HR team will review the annual training to validate that it meets all the criteria to be considered appropriate per any related APL set forth by DHCS. The QIHETP and HR team will also review internal recruiting and hiring processes to ensure they support diversity in staff leadership, committees, and governance bodies. Also, the Health Equity department will conduct an annual survey of the DEI satisfaction from staff, leadership, governance bodies, and committees and solicit recommendations to improve the DEI or cultural humility of each.

The QIHEC will review, among other reports, the annual results of such DEI surveys to ensure that Partnership has acted on at least one opportunity identified to improve DEI for at least one group (staff, leadership, committees, or governance bodies). Also, the QIHEC will review annual employee demographic data to ensure that our internal recruiting and hiring process continues to support diversity in staff leadership, committees, and governance bodies.

For grievance and appeals-related activities, the Health Equity department, in collaboration with leadership from the Population Health and Grievance and Appeals departments, will review for any patterns of disparities in reported grievances. The QIHEC will review, among other reports, the updated PNA, Cultural and Linguistics

(C&L) Program Description and Work Plan, and/or Grievance and Appeals-associated Work Plans to ensure that one or more CAHPS-associated racial disparity(ies) or CAHPS-associated linguistic disparity(ies) is addressed with a Work Plan action item.

Miscellaneous Departments

For any subcontractors' and downstream subcontractors' QI and Health Equity activities, QIHEC will review report findings and actions on a quarterly basis during each QIHEC meeting. A summation of the ~~quarterly~~ results will be evaluated in the annual program evaluation.

~~To identify and evaluate health disparities, the QIHETP team will review performance of clinical quality performance measures (i.e. HEDIS®) as specified by NCQA HEA standards, as mandated by DHCS, or due to poor performance trending on the DHCS Managed Care Accountability Set (MCAS). The QI/PI team collects data under both the DHCS MCAS and NCQA Accreditation clinical quality performance measures. The Health Analytics team provides analysis of data collected under HEDIS measures stratified by race/ethnicity and language. Measure performance will be evaluated to clarify if there is a statistically significant ($p<0.05$) worse performance of each race/ethnicity at the MCP aggregate level when compared to the Caucasian population (i.e. historically dominant population within the US). Also, measures will be evaluated to clarify if there is a statistically significant worse performance of other languages when compared to the English speaking population. Also, Measure performance will be evaluated to clarify if there is a statistically significant ($p<0.05$) worse performance of each race/ethnicity/language group at the MCP aggregate level when compared to the most probable limit of detection (MPL) set by DHCS.~~

~~The HEO, CMO, and members of the QI/PI team will manually review the information supplied about health disparities and draft a preliminary report of disparity metrics to prioritize based upon statistical findings, clinical judgement, and requirements per NCQA HEA and MCAS.~~

~~The preliminary report will be shared with relevant internal committees (e.g. , Consumer Advisory Committee (CAC), Family Advisory Committee (FAC), etc), corresponding providers, health plan subcontractors, and health plan downstream subcontractors, via their corresponding QIHEC representative or newsletter. The goal will be to solicit feedback to ensure we have identified disparities that may not have been captured during our internal data analysis and identify strategies to address the disparities in respective communities. The QIHETP team~~Health Equity department ~~will review internally submitted community needs assessment information to increase the likelihood of receiving credible information from community leaders and CAC/FAC/QIHEC members. Also, the QIHETP team~~Health Equity department ~~will review feedback from members, parents, and/or caregivers to ensure that the community is given an opportunity to engage in the development of quality improvement and health equity activities and suggest interventions that will likely work in their respective communities. The advisory feedback will be transcribed and shared with the QIHETP team~~Health Equity department~~.~~

~~The QIHETP team will review the solicited findings from QIHEC, CAC, FAC, providers, health plan subcontractors, and health plan downstream subcontractors and share the results to the QIHEC for final approval of the key PHC health equity priorities to share with the overall organization to serve as guidance for various departments and activities (e.g. PNA, QIP, etc.).~~

~~For internal QI/PI related activities, The QIHETP team, in collaboration with the QI/PI team, will collaborate to ensure that HEDIS/CAHPS -associated disparities (e.g. racial, ethnic, linguistic, disability, SOGI, etc.) are specifically being addressed in QI/PI programs (e.g. value-based payment programs, provider improvement plans, Corrective Action Plans (CAPS) etc.). Specifically, the QIHETP and QI/PI teams will review the internal value based payment programs (e.g. primary care provider quality improvement program, hospital quality improvement program, etc.) and performance improvement projects to assess whether adjustments need to be made to ensure~~

the projects can address HEDIS/ CAHPS –associated disparities. For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the QIHETP team supports ongoing QI/PI efforts in the identification of potential quality or equity of care issues, improvement of HEDIS quality measures in context with social determinants of health. The QIHETP and QI/PI teams will collaborate to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. Finally, the QIHETP and QI/PI teams will share data with NCQA team members to validate that disparity reduction goals/targets are complicit with NCQA HEA standards.

The QIHEC will review, among other reports, the updated QI/PI Program Evaluation to ensure that one or more HEDIS/CAHPs-associated racial disparity, HEDIS/CAHPs-associated linguistic disparity, or a mandated disparity reduction target for specific populations and/or measures as identified by DHCS has been addressed in response to findings from Partnership's annual QI Work Plan.

For internal population health department specific activities, The QIHETP and Population Health teams will collaborate to generate a finalized report to help refine the various population health reports and analyses. (The PHM Strategy provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population served in the program. Specifically, teams will review tertiary and primary medical literature and health indices, review findings from other managed care organizations, collaborate with community key opinion leaders or subject matter experts, and survey members of the CAC and FAC to find credible interventions that can be executed by a managed care organization based upon the synthesized findings of the preliminary report. The QIHETP and Population Health and Health Equity teams will review corresponding social drivers of health metrics to ensure they are assessed. Social determinants or drivers of health have been classified as conditions in various environments that affect health and overall quality-of-life outcomes. Specifically, Partnership will evaluate the following social drivers of health (including but not limited to):

- Economic Stability (e.g. Median Income Per Zip Code, Job Growth Rate)
- Education Access and Quality (e.g. Highest Level of Education Attainment)
- Health Care Access and Quality (e.g. Number of Primary Care Visits, Physicians per Capita, Health Cost Index, etc.)
- Neighborhood Environment (e.g. Number of Grocery Stores throughout Zip Code, number of outdoor parks per capita, healthy places index, air quality index, health cost index, water quality index, walkability score, etc.)
- Social and Community Context (e.g. Local Crime Rate, Rates of discrimination grievance reports, etc.)

The QIHEC will review, among other reports, relevant Community Health Assessment (CHA) information, Population Health and Cultural and Linguistics (C&L) associated Work Plans to ensure that one or more HEDIS-associated racial/ethnic disparity(ies), and one or more HEDIS-associated disparity(ies) related to one additional category of stratification (e.g. disability, geographical representation, etc.) is addressed based on the findings from the assessed reports. The QIHEC will also review reports regarding the utilization of language services, individual experience with language services, staff experience with language services, and member experience with language services during health care encounters to ensure that one or more interventions is identified and incorporated into work plan(s) to address one or more culturally and linguistically appropriate services (CLAS) disparity or HEDIS-associated linguistic disparity. The QIHEC will review these elements to ensure they correlate appropriately with Partnership's annual QI Work Plan.

For internal Human Resources (HR) related activities, the QIHETP team, in collaboration with the HR department, will review submitted data for annual DEI-related training for employees, network providers, etc. to ensure review of completion. Specifically, the QIHETP and HR team will review the annual training on culturally and linguistically appropriate practices to ensure they are teaching principles to reduce bias and promote inclusion. Also, QIHETP and HR team will review the annual training to validate that it meets all the criteria to be

~~considered appropriate per any related APL set forth by DHCS. The QIHETP and HR team will also review internal recruiting and hiring processes to ensure they support diversity in staff leadership, committees, and governance bodies. Also, the QIHETP team will conduct an annual survey of the DEI satisfaction from staff, leadership, governance bodies, and committees and solicit recommendations to improve the DEI or cultural humility of each.~~

~~The QIHEC will review, among other reports, the annual results of such DEI surveys to ensure that Partnership has acted on at least one opportunity identified to improve DEI for at least one group (staff, leadership, committees, or governance bodies). Also, the QIHEC will review annual employee demographic data to ensure that our internal recruiting and hiring process continues to support diversity in staff leadership, committees, and governance bodies.~~

~~For grievance and appeals-related activities, the QIHETP team, in collaboration with leadership from the Population Health and Grievance and Appeals departments, will review for any patterns of disparities in reported grievances. The QIHEC will review, among other reports, the updated PNA, Cultural and Linguistics (C&L) Program Description and Work Plan, and/or Grievance and Appeals-associated Work Plans to ensure that one or more CAHPS-associated racial disparity(ies) or CAHPS-associated linguistic disparity(ies) is addressed with a Work Plan action item.~~

~~For any subcontractors' and downstream subcontractors' QI and Health Equity activities, QIHEC will review report findings and actions on a quarterly basis during each QIHEC meeting. A summation of the quarterly results will be evaluated in the annual program evaluation.~~

CULTURALLY & LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

Partnership is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible beneficiaries. Partnership's Health Education team regularly assesses and documents member cultural and linguistic needs in the C&L Program Description to determine whether covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. The Health Education team also ensures that all culturally and linguistics services are provided in an appropriate manner through the C&L Program Description.

The Population Health department is responsible for the operation and implementation of the C&L Program Description and associated work plan. Additionally, key internal committees with community members (e.g., CAC, QIHEC, FAC) provide feedback on the development and implementation of culturally and linguistically accessible services.

Partnership monitors and evaluates the effectiveness of cultural and linguistic services by reviewing and responding to: CAHPS, member grievances and appeals, reports of utilization of interpreter services by language, provider assessments, and facility site reviews.

QUALITY IMPROVEMENT AND HEALTH EQUITY ANNUAL WORK PLAN

The QI and Health Equity Annual Work Plan will be used to strategize, prioritize, and track progress on equity-related initiatives throughout the year. Specifically, the QI and Health Equity Annual Work Plan will provide a comprehensive assessment of the QI and Health Equity activities, undertaken by Partnership, to evaluate effectiveness of Health Equity-related QI interventions.

The QI and Health Equity Annual Work Plan describes population-based HE measured objectives, timelines, and accountable Partnership employees for each activity. It includes progress updates on planned activities and objectives for achieving internal measures of equity in context of clinical care, safety of clinical care, quality of service, and member experience. Forms for providing status updates are sent to staff one month in advance of the semi-annual and annualupdate deadlines to be completed by work plan contributors. Finally, the Work Plan will be reviewed annually by Q/UAC and approved by PAC and the Board of Commissioners.

The QI and Health Equity Annual Work Plan will also evaluate delegated subcontractors' and downstream fully delegated subcontractors' performance measure results and evaluate actions to mitigate any identified deficiencies.

ANNUAL PROGRAM EVALUATION

The overall effectiveness of the Quality Improvement and Health Equity Transformation Pprogram is annually evaluated and approved ~~in writing annually by IQI/ and reviewed by Q/UAC; it is then approved by~~ at Q/UAC, PAC, and the Commission. The annual QIHETP~~PT~~ Program Evaluation includes:

- Clinical Quality of Physical and Behavioral Health
  - Annual assessment of key HEDIS MCAS measures with stratification to race/ethnicity, primary language, gender identify, and/or age
- Member Experience
  - Annual assessment of key CAHPS measures with stratification to race/ethnicity and primary language
  - Analysis of CAC findings and strategy to increase member listening session-like activities
- Access and Engagement of Providers and DEI Training
  - Review submitted data of annual diversity, health equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) for staff via internal human resources department~~.~~
  - Review submitted data of annual diversity, health equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) for network providers from the provider relations department per DEI training APL. Per internal Credential and Re-credential decision making process policy, a negative response on a provider attestation regarding completion of training, on credentialing criteria for practitioners, will trigger a file review
- Continuity and Coordination Across Settings and all levels of care
  - Analysis and evaluation of interventions to address both over- and under-utilizations of services and interventions
- Health Equity Promotion in Quality Improvement and Population Health
  - Analysis and evaluation of equity-related programs, initiatives and QI-related work as well as the overall effectiveness of the QI/PI program and of its progress toward influencing network-wide safe clinicalpractices~~.~~
  - Analysis of county and region specific population needs assessment data
  - Analysis of community partnerships with local health departments, community based organizations, nonprofit organizations, etc.
  - Analysis of community reinvestments
- Regional Quality and Health Equity Team Compositions
  - Names and Roles of Partnership Team Members per region for quality and health equity
  - Identity of key network providers, county behavioral health plans, local health departments, community-based organizations, local government agencies, First 5 programs, etc. per disparity priority
- Administrative
  - The annual QI and Health Equity Work Plan goals and associated deliverables are informed by the QIHEC. If there are opportunities for improvement identified in the evaluation of prior year initiatives and work conducted to support the goals of the quality improvement program, these opportunities are translated into goals with actionable deliverables for the next year's work plan. The results in the annual QI and Health Equity Program Evaluation, particularly those tied to the need to revisit allocated resources, for committees, standing programs and other related activity

are assessedand if changes are deemed necessary, they are reflected in the program in the subsequent year.
    - Strategy of sharing annual program evaluation with various subcontractors, downstream subcontractors, and network providers
    - Analysis of actions taken to address any recommendations in the annual external quality review technical report
    - Analysis of annual reports of any subcontractors' and downstream subcontractors' performance of delegated health equity activities. Each subcontractor's health equity officer/liaison will be required to submit an annual performance report to Partnership ~~by their respective health equity officer/liaison.~~
    - NCQA Health Equity Accreditation Status
    - Annual Summary of QIHEC activities

- ~~Current status of relevant NCQA Health Equity Accreditations~~
- ~~A description of completed and ongoing QI and Health Equity activities that Partnership is directly undertaking~~
- ~~Baseline and trending data on key measures to assess equity in the quality and safety of clinical care and quality of service (e.g. comparison of racial subgroups of various HEDIS/ CAHPS measures)~~
- ~~Analysis and evaluation of equity-related programs, initiatives and QI-related work as well as the overall effectiveness of the QI/PI program and of its progress toward influencing network-wide safe clinicalpractices.~~
- ~~Analysis and evaluation of health-equity related components of PHM activities~~
- ~~The annual QI and Health Equity Work Plan goals and associated deliverables are informed by the QIHEC. If there are opportunities for improvement identified in the evaluation of prior year initiatives and work conducted to support the goals of the quality improvement program, these opportunities are translated into goals with actionable deliverables for the next year's work plan. The results in the annual QI and Health Equity Program Evaluation, particularly those tied to the need to revisit allocated resources, for committees, standing programs and other related activity are assessedand if changes are deemed necessary, they are reflected in the program in the subsequent year.~~
- ~~Strategy of sharing annual program evaluation with various subcontractors, downstream subcontractors, and network providers~~
- ~~Analysis and evaluation of interventions to address both over- and under-utilizations of services and interventions~~
- ~~Analysis of actions taken to address any recommendations in the annual external quality review technical report~~
- ~~Analysis of CAC findings and strategy to increase member listening session-like activities~~
- ~~Analysis of annual reports of any subcontractors' and downstream subcontractors' performance of delegated health equity activities. Each subcontractor will be required to submit an annual performance by their respective health equity officer/liaison.~~
- ~~Review submitted data of annual diversity, health equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) for staff via internal human resources department.~~
- ~~Review submitted data of annual diversity, health equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) for network providers from the provider relations department per DEI training APL. This includes, but not limited to, Continued Medical Education (CME) credit monitoring on cultural competency and implicit bias. Per internal Credential~~

~~and Re-credential decision making process policy, a negative response on a provider attestation regarding completion of training, on credentialing criteria for practitioners, will trigger a file review.~~

The following are separate evaluations and not included in the QI and Health Equity Annual Work Plan Evaluation:

- Evaluation of cultural and linguistic competency work plan activities
- Evaluation of Utilization Management and Care Coordination activities
- Evaluation of Member grievance and appeals

Preparation for the Annual Program Evaluation involves participation by all QIHETP leadership including but not limited to:

- Chief Medical Officer
- Chief Health Services Officer
- Health Equity Officer
- Senior Director of Quality and Performance Improvement

The QI and Health Equity Plan will be made available on the Partnership website on an annual basis

NON-DISCRIMINATION STATEMENT

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

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
- Written information in other formats (large print, audio, 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 sign language interpreters
- Information written in other languages
- Use of California Relay Services for hearing impaired

REFERENCES

1. Department of Health Care Services (DHCS) standards

2. National Committee for Quality Assurance (NCQA) Guidelines (Effective ~~July 1, 2023~~2024) HEA Standards 1 to 7
3. **Original Date:** 11/08/2023 Effective Date: 03/03/2023

QIHETP PROGRAM DESCRIPTION APPROVAL

	~~**10/18/2023**~~**10/16/2024**

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

	~~**11/08/2023**~~**11/13/2024**

Steve Gwiazdowski, MD, FAAP *Date Approved*
Physician Advisory Committee Chairperson

	~~**12/06/2023**~~**12/04/2024**

~~*Alicia Hardy, LCSW*~~*Kim Tangermann*
~~*Date Approved*~~
Board of Commissioners Chairperson

QUALITY IMPROVEMENT AND HEALTH EQUITY TRANSFORMATION PROGRAM (QIHETP) PROGRAM DESCRIPTION

MCED6001

November 13, 2024

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Quality Improvement and Health Equity Transformation Program (QIHETP) Program Description

PROGRAM PURPOSE AND GOALS

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

The mission of Partnership HealthPlan of California is "To help our Members, and the Communities we serve, be healthy." Our vision is to be "the most highly regarded health plan in California." Partnership believes in fostering strong partnerships with members, providers, and community leaders to collectively improve health outcomes; focusing on continuous quality improvement in every aspect of the organization and in collaboration with our partners; and promoting diversity by accepting, respecting, and valuing individual differences and capitalizing on the diverse backgrounds and experiences of our members, community partners, and staff.

Partnership's defining focus is ensuring the highest quality of care, positive health outcomes, and timely access to care for all diverse members (i.e., Quality, Access, and Equity). Therefore, Partnership has developed program descriptions and policies to describe the structures needed to promote health equity. Specifically, Partnership has implemented the Partnership Quality Improvement and Health Equity Transformation Program (QIHETP).

The QIHETP is designed to develop, implement, monitor, and maintain a health equity transformation system to address improvements in the quality of care delivered by all of its providers in any setting, and take appropriate action to improve upon the health equity and health care delivered to members. The Partnership QIHETP serves to accomplish the following:

- Ensure that members receive the appropriate quality and quantity of healthcare services
- Ensure that healthcare service is delivered at the appropriate time and in an equitable manner

The Partnership QIHETP provides a reliable and credible mechanism to review, monitor, evaluate, recommend, and implement actions that acknowledge health equity.

The Partnership QIHETP serves as an organized framework to:

- Review and develop equity-focused interventions intended to address disparities in the utilization and outcomes of physical and behavioral health care services by engaging with a member and family-centric approach
- Review activities and identify opportunities to improve health equity throughout Partnership with oversight and participation of the governing Board of Commissioners and the Quality Improvement and Health Equity Committee (QIHEC)
- Promote participation from a broad range of network providers, including but not limited to hospitals, clinics, county partners, physicians, community health workers, and other non-clinical providers for QIHETP development and performance reviews
- Review health equity-related training activities and validate that the trainings review the impact of structural and institutional racism and health inequities on members, staff, network providers, subcontractors, and downstream subcontractors per Department of Health Care Services (DHCS) published All Plan Letters (APLs) regarding diversity, equity and inclusion (DEI) training.

PROGRAM OBJECTIVES

The Partnership QIHETP serves to ensure that appropriate, high quality cost-effective utilization of health care resources is available to all members while being cognizant of health care disparities and inequities. This is accomplished through the systematic and consistent application of management processes based on current health equity review literature and expert opinion when needed. The scope of the QIHETP includes the quality of clinical care and services for all members receiving Medi-Cal healthcare services from Partnership. The monitoring and evaluation of clinical issues reflects the population served by Partnership without regard to social drivers of health (SDOH), age group, disease category, or risk status. In alignment with other Partnership departments, the QIHETP encompasses all aspects of medical and behavioral healthcare including:

- Identifying and addressing racial/ethnic and other disparities in health care delivery or outcomes
- Identifying overuse, misuse, and underuse of health care services and prescription medications
- Evaluating clinical quality of physical health care
- Evaluating clinical quality of behavioral health care focusing on prevention, recovery, resiliency, and rehabilitation
- Identifying and addressing equitable access or quality issues related to behavioral health services through delegated contracts
- Ensuring access to primary and specialty health care providers and services
- Ensuring availability and regular engagement with primary care providers (PCPs)
- Evaluating continuity and care coordination across settings and at all levels of care, including transitions in care, with the goal of establishing consistent provider-patient relationships
- Evaluating member experience with respect to clinical quality, access, and availability and culturally and linguistically competent health care and services, and continuity and care coordination
- Promoting cultural and linguistic competence of Partnership staff and network practice sites and providers

The QIHETP program accomplishes these goals by:

- Systematically monitoring and evaluating services and care provided by conducting quantitative and qualitative data collection. Using this data and various statistical analyses, Partnership will make data-driven decisions
- Identifying, evaluating, and reducing health disparities utilizing internal reports, reflecting utilization management, quality improvement, member satisfaction (Consumer Assessment of Healthcare Providers and Systems [CAHPS®]), care coordination, grievance and appeals, and population health activities to ensure services are provided equitably.
- Actively conducting systematic searches for tertiary and primary medical literature to ensure decisions are based upon up-to-date evidence in the health equity discipline
- Actively pursuing opportunities for improvement in areas that are relevant and important to Partnership members' health
- Implementing strong and sustainable interventions when opportunities for improvement are identified for addressing a health disparity

PROGRAM STRUCTURE

This section outlines the individual program staff and their assigned activities and responsibilities.

PROGRAM STAFF

Chief Medical Officer (CMO)

The Chief Medical Officer is responsible for working with the Health Equity Officer (HEO) to assist with the implementation, supervision, oversight and evaluation of the QIHETP. This position provides guidance and overall direction of QIHETP activities and has the authority to make decisions based on Quality Improvement and 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 Health Equity Officer (HEO); oversees QIHETP operations and assists in the development and coordination of QIHETP policies and procedures
- Serves as the Committee Chair for the Quality/Utilization Advisory Committee (Q/UAC) and Co-Chair of the Quality Improvement and Health Equity Committee (QIHEC)
- Guides and assists in the development and revision of QIHETP policy, criteria, clinical practice guidelines, new technology assessments, and performance standards for Q/UAC review

Chief Health Services Officer (CHSO)

Responsible for the day-to-day implementation of Partnership's Utilization Management, Care Coordination, Population Health Management (PHM) and Health Equity (HE) programs. This position has the authority to make decisions on coverage not relating to medical necessity. The assigned activities include:

- Collaborates with the Chief Medical Officer and the Q/UAC on Care Coordination, Population Health, Health Equity, and Utilization Management activities
- Provides oversight and guidance for Partnership's Health Equity program across all regions
- Monitors and analyzes health services and health equity data to inform decision making
- Develops recommendations based on data analysis and strategic planning
- Collaborates with the Chief Medical Officer, the Health Equity Officer and the Q/UAC on QIHETP activities
- Regularly attends the Quality Improvement and Health Equity Committee (QIHEC) as a standing member
- Evaluates and uses provider and member experience data when evaluating the QIHETP program in collaboration with the Health Equity Officer and the Chief Medical Officer
- Serves as Chairperson of the Benefit Review Evaluation Workgroup (BREW)
- Reviews the QIHETP Annual Program Evaluation and Program Description before presentation to Q/UAC and PAC

Director of Health Equity (Health Equity Officer)

The Director of Health Equity serves as the Health Equity Officer (HEO) for Partnership and is responsible for the co-implementation, co-supervision, co-oversight and evaluation of the QIHETP. This position provides guidance and overall direction of QIHETP activities through the Quality Improvement and Health Equity annual work 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
- Coordinates departmental Health Equity and Quality Performance and Improvement efforts

- Serves as a Co-Chair for the Quality Improvement and Health Equity Committee (QIHEC) and regularly attends the Quality/Utilization Advisory Committee (Q/UAC) as a standing member
- Guides and assists in reviewing Partnership policies and program goals against QIHETP guidelines and under the purview of the QIHEC
- Other duties as assigned by the Executive Committee and/or Chief Executive Officer (CEO)
- Reports to executive team and Board of Commissioners on program goals, activities, and results
- Provides guidance to staff through trainings and on-site continuing education regarding diversity, equity, and inclusion (DEI) and health equity

Medical Director for Quality

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 Member Safety Quality Investigations and Clinical Quality Inspection teams, y and the Quality Measurement–HEDIS team. 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)
- Regularly attends the Credentialing Committee
- Regularly attends the Physician Advisory Committee (PAC)
- Regularly attends the Internal Quality Improvement (IQI) Committee
- Serves as the Chair for the Peer Review Committee
- 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 and Performance Improvement or by the Chief Medical Officer

Senior Director of Quality and Performance Improvement

Responsible for day-to-day leadership, strategic direction, and implementation of Partnership's Quality and Performance Improvement programs across all regions. Assigned activities include:

- Provide oversight and guidance for Partnership's Quality Measurement, Quality Management and Quality Improvement Analysis programs
- Collaborate with the Chief Medical Officer, the Sr. Health Services Director, the Sr. Provider Relations Director, the Health Equity Officer and other department leaders to support the delivery of high-quality clinical care
- Engage with the Health Equity Officer and Chief Medical Officer to identify and prioritize QIHETP actions. Participate in the QIHEC to identify community priorities and implement action plans.
- Strengthen a culture of continuous quality improvement within Partnership's network of providers leveraging pay-for-performance initiatives along with other provider support programs
- Work collaboratively with other organizational leaders to maximize use of data to generate information, knowledge and wisdom to improve health outcomes, optimize utilization of resources, and enhance the member experience of care

Director of Population Health

Provides oversight of Population Health strategy, programs and services to improve the health of Partnership members.

- Oversees DHCS compliance and National Committee for Quality Assurance (NCQA) survey readiness for assigned areas of responsibility
- Works with the Chief Medical Officer, Chief Health Services Officer, Senior Director of Quality and Performance Improvement, Health Equity Officer and other department leaders to meet organization and department goals and objectives while developing and tracking the measurable outcomes of department services.
- Other duties as assigned by the Executive Committee or the Chief Medical Officer

Behavioral Health Clinical Director

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
- Serves on Q/UAC; Pharmacy and Therapeutics Committee; Credentials Committee and Internal Quality Improvement Committee including the Substance Use Internal Quality Improvement Subcommittee.

Program Coordinator

Under the direction of the Health Equity Officer (HEO) or other designated leadership, provides administrative support to the Health Equity Officer Director and/or other QIHETP Leadership. Responsible for maintaining and updating online policy and procedure manuals and managing appointment calendars. Coordinates setup and executes minutes for designated meetings.

- Tracks project deliverables and resources using appropriate internal tools to ensure deadlines are met
- Coordinates the QIHEC meetings
- Coordinates with Regulatory Affairs and Compliance (RAC) to conduct research on regulations, statutes, laws, administrative health equity-related policies and procedures

COMMITTEES

Board of Commissioners

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

Quality/Utilization Advisory Committee (Q/UAC)

The Q/UAC is responsible to assure that quality, comprehensive health care and services are provided to Partnership members through an ongoing systematic evaluation and monitoring process that facilitates continuous quality improvement. Q/UAC voting membership includes consumer representative(s) and external providers who are contracted primary care providers (PCPs) and board certified specialists in the areas of internal medicine, family medicine, pediatrics, OB/GYN, neonatology, behavioral health, and representatives from other high volume specialties. The Partnership Chief Medical Officer (CMO) (chair of the committee), Clinical Director of Behavioral Health, Health Equity Officer, Medical Director for Quality, Associate and Regional Medical Directors and leadership from the Quality and Performance Improvement, Provider Relations, Utilization Management, Care Coordination, Population Health, Health Equity, Pharmacy, and Grievance departments attend the Q/UAC meetings regularly. Other Partnership staff attend on an ad hoc basis to provide expertise on specific agenda items. The committee meets monthly at least ten (10) times per year, with the option to add additional meetings if needed. Q/UAC activities and recommendations are reported to the PAC and at least quarterly to the Commission. The Q/UAC provides guidance and direction to the QIHEC by functioning as the expert reviewing panel as follows:

- Reviewing, making recommendations to, and approving the *QIHETP Program Description* annually
- Analyzing summary data and making recommendations for action
- Reviewing action plans for quality improvements of QIHETP activities and providing ongoing monitoring and evaluation

Quality Improvement and Health Equity Committee (QIHEC)

Partnership's QIHEC is overseen by the Quality/Utilization Advisory Committee (Q/UAC) and the Physicians Advisory Committee (PAC), which subsequently reports to our governing Board of Commissioners. The QIHEC analyzes and evaluates the results of Health Equity-related Quality Improvement activities. Specifically, QIHEC will conduct an annual review of the results of key health equity-related data to provide plan-wide recommendations (e.g., generate policy recommendations) to address health-equity performance deficiencies. The QIHEC ensures appropriate assessment of interventions, measurement, and follow-up of identified performance deficiencies. The QIHEC responsibilities include the following:

- Analyze and evaluate the results of clinical quality performance measures related to Health Plan Ratings (HPR), as specified by NCQA Health Equity Accreditation (HEA) standards, as mandated by DHCS, or due to poor performance trending on the DHCS Managed Care Accountability Set (MCAS) (with stratification by race/ethnicity and language):
  - Assigned Health Effectiveness Data & Information Set (HEDIS®) Measures
  - Consumer Assessment of Healthcare Providers and Systems [CAHPS®]
- Analyze utilization data (types of services, denials, deferrals, modifications) with stratification by race/ethnicity and language
- Analyze utilization data of language services and experience with language services with stratification by language.

- Analyze and evaluate the results of member satisfaction surveys, Grievance and Appeal surveys, and care coordination-based surveys with stratification by race/ethnicity and language
- Analyze and evaluate the strategy and work plans presented by internal committees to ensure that clinical quality performance measures (with stratification by race/ethnicity and language) and member satisfaction are evaluated and attended to in prospective work plans
- Analyze and evaluate feedback from member representative committees (e.g., Consumer Advisory Committee, Family Advisory Committee)
- Recommend Managed Care Plan (MCP)-related interventions (e.g., education, programs, etc.) for various departments to address key clinical quality performance deficiencies (e.g., HEDIS, CAHPS, etc.) per the scope of work of managed care plans.

Partnership's QIHEC membership will consist of the following key members, who subsequently will report directly to Q/UAC:

- Chief Medical Officer or CMO Designee (e.g., Medical Director)
- Health Equity Officer
- Chief Operating Officer
- Internal Leadership from following departments: Health Analytics, QI/PI, Provider Relations, Utilization Management, Member Services, Care Coordination, and Population Health

In addition, the Partnership's QIHEC membership will be composed of representatives from our Providers, health plan subcontractors, and health plan downstream subcontractors, who provide health care services to members affected by health disparities, members who are considered to have Limited English Proficiency (LEP), members with children with special health care needs (CSHCN), members who are considered to be Seniors and Persons with Disabilities (SPDs), and persons with chronic conditions. Example entities from which representatives will be drawn include, but are not limited to, hospitals, clinics, county partners, physicians, subcontractors, downstream subcontractors, network providers, and Partnership members. The QIHEC meeting minutes, findings and recommendations will be reported directly to the Quality/Utilization Advisory Committee (Q/UAC), Physician Advisory Committee (PAC), and Partnership's Board of Commissioners. Also the QIHEC will report findings to our various other internal committees (e.g., CAC,FAC, etc). Partnership's Confidentiality Policy (CMP-10) provides guidance to ensure avoidance of conflict of interest among committee members and ensure that member confidentiality is maintained throughout QIHEC-related meetings.

Population Health Needs Assessment (PNA) Committee

The Population Health Needs Assessment Committee (PNA) is an internal committee and serves as a multi-departmental body whose goal is to support the advancement, growth, and execution of population health and health equity interventions at Partnership. The committee consists of Partnership staff representing member, community, regional, and provider-facing departments; it also incorporates representatives from Human Resources, Regulatory Affairs, IT, and Health Analytics. The committee meets every other month to align interdepartmental efforts promoting health equity through member and systemic interventions outlined in the relevant Needs Assessment (PNA) Action Plans. The PNA Committee activities and recommendations will be shared with the, Internal Quality Committee (IQI), Quality/Utilization Advisory Committee (Q/UAC), QIHEC, Physician Advisory Committee (PAC) and Partnership's Board of Commissioners..

Family Advisory Committee (FAC)

The Family Advisory Committee (FAC) is a member advisory group to the CEO and staff of Partnership. The FAC provides a forum for parents, guardians and caregivers of children with California Children Services (CCS) conditions to discuss common issues of interest and importance, to create a supportive and informative networking environment and to advocate for members by ensuring that Partnership is responsive to the diversity of health care needs for all members. Minutes from FAC meetings are reviewed by the Pediatric Quality

Committee (PQC). The FAC membership is comprised of representatives from throughout Partnership's geographic service areas who advocate for CCS-eligible children of diverse cultures, ethnicities, genders, ages and disabilities. Meetings are held at least four (4) times per year with the option for additional meetings as needed

Consumer Advisory Committee (CAC)

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

QUALITY AND PERFORMANCE IMPROVEMENT COLLABORATION

The Health Equity department works collaboratively with the Quality and Performance Improvement (QI/PI) department to enhance the care provided to our members through venues such as the Internal Quality Improvement Committee (IQI), the Quality/ Utilization Advisory Committee (Q/UAC) and daily QIHETP activities.

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

- Reviewing, making recommendations to, and approving the *QIHETP Program Description* annually
- Analyzing summary data and making recommendations for action
- Reviewing the recommendations of QI's Performance Improvement Teams to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. The QI/PI department is often the lead for many improvement efforts, particularly those that are mandated or due to poor performance on the Managed Care Accountability Set (MCAS), which is the set of measures that DHCS selects for annual reporting by Medi-Cal managed care health plans. This can include mandated improvement efforts to meet disparity reduction targets for specific populations and/or measures as identified by DHCS. The QI/PI department also takes the lead on mandated Performance Improvement Projects (PIPs) that are assigned by DHCS. PIPs are led by the QI/PI program based on criteria defined by DHCS and overseen by the California External Quality Review Organization (EQRO), and include at least annual status reports to DHCS
- Recommending improvements to enhance health equity language in Partnership policies and protocol according to QIHETP standards

For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the Health Equity department supports ongoing quality improvement efforts in the identification of potential quality or equity of care issues, improvement of HEDIS quality measures in context with social drivers of health. For member-facing improvement efforts, CAC and other member focus

groups are often consulted.

NCQA Accreditation Program Management

Partnership strives to improve the health status of members and their care experience to become one of the highest quality health plans in California. NCQA Health Plan Accreditation supports Partnership's vision, mission, and strategic goals byproviding a rigorous and comprehensive framework for essential quality improvement, operational excellence, and measurement of clinical performance (HEDIS) and member experience (CAHPS).

Per the 2024 DHCS contract, all managed care plans (MCPs), including Partnership, are mandated to achieve both NCQA Health Plan Accreditation (HPA) and NCQA Health Equity Accreditation (HEA) by Jan. 1, 2026. Partnership successfully achieved HPA reaccreditation on Dec. 18, 2023.. In order to maintain NCQA Health Plan Accreditation, Partnership was required to report annual results starting in June 2022. Partnership earned a Health Plan Rating (HPR) of 3.5 stars in June 2023 based on HEDIS/CAHPS performance from MY 2022/RY 2023. NCQA released Partnership's current HPR of 3.5 stars in September 2024.

Partnership's defining focus is ensuring the highest quality of care, positive health outcomes, and timely access to care for all diverse members (i.e., Quality, Access, and Equity). NCQA Health Equity Accreditation (HEA) complements Partnership's overall mission by encouraging managed care organizations to establish a foundation of health equity work. Specifically, the HEA encourages the focus on building an internal culture that complements external health equity work with our population health management department; collecting relevant data that provides insight on how to ensure appropriate representation in language services and providers; identifying and categorizing inequities to guide future population health-based interventions

Partnership will be submitting first survey documentation, to obtain the NCQA Health Equity Accreditation (HEA), by June 2025.

Data Sources

DHCS Bold Goals

To have a context of Health Equity and align internal quality and health equity efforts with DHCS, Partnership will review the DHCS's Health Disparities Report and Bold Goals of 2025. Currently, The Bold Goals of 2025 are as follows:

- Close racial/ethnic disparities in well child visits by 50%
- Close racial/ethnic disparities in immunizations by 50%
- Close maternity care disparity for Black and Native American persons by 50%
- Improve maternal and adolescent depression screening by 50%
- Improve follow up for mental health and substance use disorder by 50%

Partnership uses several methods to identify and evaluate member needs, and strategize how to address such needs by reducing health disparities.

Step 1: Sample Selection to Evaluate Disparities

Partnership initially utilized Measurement Year 2023 (MY 2023) MCAS final sample measures (n=186 to 167,450 members) to evaluate each of the clinical measures of focus. The rates for each measure are comprised of the members included in each measure's audit for Partnership's Health Plan Accreditation Plan-wide summary of performance report. The random member sample that was generated for each hybrid measure and full member

denominator along with member race/ethnicity demographic information, was provided by Partnership's HEDIS vendor, Inovalon. Inovalon has been classified as a direct data source.

Step 2: Statistical Analysis to Identify Key Disparities

After receiving the data from Inovalon, members from Partnership's Health Analytics team conducted various statistical analyses. The Chi-Square and Fisher's Exact statistical tests were utilized, based upon sample size, to determine if there were significant differences for the various categorical measure outcomes.

When analyzing disparities based upon race/ethnicity, Partnership conducted various statistical analyses using the White group as the key comparator group. When analyzing disparities based upon language, Partnership conducted various statistical analyses using the English language group as the key comparator group. Finally, when analyzing disparities based upon gender, Partnership conducted various statistical analyses using the Male gender identity group as the key comparator group. A statistically significant difference was classified as a p value less than 0.05 when comparing the categorical outcomes of one group versus the key comparator group, respectively (i.e., White, English-speaking, Male). These comparators were identified based upon various literature suggesting that such groups, respectively, have had significantly more political, economic, and/or social advantages within the United States (Malat et al., 2018). Data, that were excluded from the evaluation, were findings from patients who reported "Unknown" in race, language, and gender identity.

Step 3: Analysis of Measures

Partnership also reviewed the performance of each race/gender identity/linguistic group in comparison to the MCAS benchmarks to assess not only how each group performed statistically in comparison to the White/Male/English speaking group, but also in comparison to the national Medicaid benchmarks. In MY 2023, DHCS is holding managed care plans (MCPs) accountable and imposing sanctions on selected Hybrid and Administrative measures performing below the minimum performance level (MPL) (50^{th} national Medicaid percentile) by reporting region, and as a result, Partnership thought it valuable to assess how each group is performing in comparison to that benchmark to assess whether group performance could also have an impact on accountable measures.

Step 4: Prioritization of Disparities

The HEO, CMO, and members of the QI/PI team reviewed the information supplied about health disparities and draft a preliminary report of disparity metrics to prioritize based upon clinical measure stratification, statistical or clinical findings, size of the disparity, strength of evidence, feasibility, and return of investment. An established baseline will be developed for each group to follow for the next 3 to 5 years to evaluate long-term impact. The team will identify the key disparity priorities per region and per population of key racial/ethnic, gender, or linguistic groups.

Step 5: Distribution of Disparity Data for Community Feedback

The preliminary report will be shared with relevant internal committees (e.g., CAC, FAC etc), corresponding providers, health plan subcontractors, and health plan downstream subcontractors, via their corresponding QIHEC representative or newsletter. The goal will be to solicit feedback to ensure we have identified disparities that may not have been captured during our internal data analysis and identify strategies to address the disparities in respective communities. The Health Equity department will review internally submitted community needs assessment information to increase the likelihood of receiving credible information from community leaders and CAC/FAC/QIHEC members. Also, the Health Equity department will review feedback from members, parents, and/or caregivers to ensure that the community is given an opportunity to engage in the development of quality improvement and health equity activities and suggest interventions that will likely work in their respective communities. The advisory feedback will be transcribed and shared with the Health Equity department.

The Health Equity department will review the solicited findings from QIHEC, CAC, FAC, providers, health plan subcontractors, and health plan downstream subcontractors and share the results to the QIHEC for final approval of the key Partnership health equity priorities to share with the overall organization to serve as guidance for various departments and activities (e.g. PNA, QIP, etc.).

Step 6: Distribution of Disparity Data into Department Activities

Quality Improvement

For internal QI/PI related activities, the Health Equity department, in collaboration with the QI/PI team, will ensure that HEDIS/CAHPS–associated disparities (e.g. racial, ethnic, linguistic, disability, SOGI, etc.) are specifically being addressed in QI/PI programs (e.g., value-based payment programs, provider improvement plans, Corrective Action Plans (CAPS) etc.). Specifically, the QIHETP and QI/PI teams will review the internal value based payment programs (e.g., primary care provider quality improvement program (PCP QIP), hospital quality improvement program, (HQIP) etc.) and performance improvement projects to assess whether adjustments need to be made to ensure the projects can address HEDIS/ CAHPS –associated disparities. For improvement efforts focused on reducing health disparities, the QIHEC ensures appropriate follow-ups on equity-focused interventions and related activities Partnership commits itself to in addressing quality measure performance deficiencies. Additionally, the Health Equity department supports ongoing QI/PI efforts in the identification of potential quality or equity of care issues, improvement of HEDIS quality measures in context with social determinants of health. The QIHETP and QI/PI teams will collaborate to develop QIHETP improvement action plans specific to clinical quality measure performance with on-going monitoring and evaluation. Finally, the QIHETP and QI/PI teams will share data with NCQA team members to validate that disparity reduction goals/targets are compliant with NCQA HEA standards.

The QIHEC will review, among other reports, the updated QI/PI Program Evaluation to ensure that one or more HEDIS/CAHPS-associated racial disparity, HEDIS/CAHPS-associated linguistic disparity, or a mandated disparity reduction target for specific populations and/or measures as identified by DHCS has been addressed in response to findings from Partnership's annual QI Work Plan.

Population Health
For internal population-health specific activities, the QIHETP and Population Health teams will collaborate to generate a finalized report to help refine the various population health reports and analyses. (The PHM Strategy provides a high-level overview of Partnership's approach to improving the health and wellbeing of the population served in the program. Specifically, teams will review tertiary and primary medical literature and health indices, review findings from other managed care organizations, collaborate with community key opinion leaders or subject matter experts, and survey members of the CAC and FAC to find credible interventions that can be executed by a managed care organization based upon the synthesized findings of the preliminary report. The QIHETP and Population Health and Health Equity teams will review and assess corresponding social drivers of health metrics. t. Social determinants or drivers of health have been classified as conditions in various environments that affect health and overall quality-of-life outcomes

The QIHEC will review, among other reports, relevant Community Health Assessment (CHA) information, Population Health and Cultural and Linguistics (C&L)-associated work plans to ensure that one or more HEDIS-associated racial/ethnic disparity(ies), and one or more HEDIS-associated disparity(ies) related to one additional category of stratification (e.g., disability, geographical representation, etc.) is addressed based on the findings from the assessed reports. The QIHEC will also review reports regarding the utilization of language services, individual experience with language services, staff experience with language services, and member experience with language services during health care encounters to ensure that one or more interventions is identified and incorporated into work plan(s) to address one or more culturally and linguistically appropriate services (CLAS) disparity or HEDIS-associated linguistic disparity. The QIHEC will review these elements to ensure they correlate

appropriately with Partnership's annual QI Work Plan.

Human Resources

For internal Human Resources (HR) related activities, the Health Equity department in collaboration with the HR department, will review submitted data for annual DEI-related training for employees, network providers, etc. to ensure review of completion. Specifically, the QIHETP and HR team will review the annual training on culturally and linguistically appropriate practices to ensure they are teaching principles to reduce bias and promote inclusion. Also, QIHETP and HR team will review the annual training to validate that it meets all the criteria to be considered appropriate per any related APL set forth by DHCS. The QIHETP and HR team will also review internal recruiting and hiring processes to ensure they support diversity in staff leadership, committees, and governance bodies. Also, the Health Equity department will conduct an annual survey of the DEI satisfaction from staff, leadership, governance bodies, and committees and solicit recommendations to improve the DEI or cultural humility of each.

The QIHEC will review, among other reports, the annual results of such DEI surveys to ensure that Partnership has acted on at least one opportunity identified to improve DEI for at least one group (staff, leadership, committees, or governance bodies). Also, the QIHEC will review annual employee demographic data to ensure that our internal recruiting and hiring process continues to support diversity in staff leadership, committees, and governance bodies.

For grievance and appeals-related activities, the Health Equity department, in collaboration with leadership from the Population Health and Grievance and Appeals departments, will review for any patterns of disparities in reported grievances. The QIHEC will review, among other reports, the updated PNA, Cultural and Linguistics (C&L) Program Description and Work Plan, and/or Grievance and Appeals-associated Work Plans to ensure that one or more CAHPS-associated racial disparity(ies) or CAHPS-associated linguistic disparity(ies) is addressed with a Work Plan action item.

Miscellaneous Departments

For any subcontractors' and downstream subcontractors' QI and Health Equity activities, QIHEC will review report findings and actions on a quarterly basis during each QIHEC meeting. A summation of the results will be evaluated in the annual program evaluation.

Health Equity departmentHealth Equity departmentHealth Equity department

CULTURALLY & LINGUISTICALLY APPROPRIATE SERVICES (CLAS)

Partnership is committed to delivering culturally and linguistically appropriate services (CLAS) to all eligible beneficiaries. Partnership's Health Education team regularly assesses and documents member cultural and linguistic needs in the C&L Program Description to determine whether covered services are available and accessible to all members regardless of race, color, national origin, creed, ancestry, religion, language, age, gender, marital status, sexual orientation, health status or disability. The Health Education team also ensures that all culturally and linguistics services are provided in an appropriate manner through the C&L Program

Description.

The Population Health department is responsible for the operation and implementation of the C&L Program Description and associated work plan. Additionally, key internal committees with community members (e.g., CAC, QIHEC, FAC) provide feedback on the development and implementation of culturally and linguistically accessible services.

Partnership monitors and evaluates the effectiveness of cultural and linguistic services by reviewing and responding to: CAHPS, member grievances and appeals, reports of utilization of interpreter services by language, provider assessments, and facility site reviews.

QUALITY IMPROVEMENT AND HEALTH EQUITY ANNUAL WORK PLAN

The QI and Health Equity Annual Work Plan will be used to strategize, prioritize, and track progress on equity-related initiatives throughout the year. Specifically, the QI and Health Equity Annual Work Plan will provide a comprehensive assessment of the QI and Health Equity activities, undertaken by Partnership, to evaluate effectiveness of Health Equity-related QI interventions.

The QI and Health Equity Annual Work Plan describes population-based HE measured objectives, timelines, and accountable Partnership employees for each activity. It includes progress updates on planned activities and objectives for achieving internal measures of equity in context of clinical care, safety of clinical care, quality of service, and member experience. Forms for providing status updates are sent to staff one month in advance of the semi-annual and annualupdate deadlines to be completed by work plan contributors. Finally, the Work Plan will be reviewed annually by Q/UAC and approved by PAC and the Board of Commissioners.

The QI and Health Equity Annual Work Plan will also evaluate delegated subcontractors' and downstream fully delegated subcontractors' performance measure results and evaluate actions to mitigate any identified deficiencies.

ANNUAL PROGRAM EVALUATION

The overall effectiveness of the Quality Improvement and Health Equity Transformation Program is annually evaluated and approved at Q/UAC, PAC, and the Commission. The annual QIHETP Program Evaluation includes:

- Clinical Quality of Physical and Behavioral Health
    - Annual assessment of key HEDIS MCAS measures with stratification to race/ethnicity, primary language, gender identify, and/or age
- Member Experience
    - Annual assessment of key CAHPS measures with stratification to race/ethnicity and primary language
    - Analysis of CAC findings and strategy to increase member listening session-like activities
- Access and Engagement of Providers and DEI Training
    - Review submitted data of annual diversity, health equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) for staff via internal human resources department
    - Review submitted data of annual diversity, health equity, and inclusion training (sensitivity, diversity, communication skills, and cultural competency training) for network providers from the provider relations department per DEI training APL. Per internal Credential and Re-credential decision making process policy, a negative response on a provider attestation regarding completion of training, on credentialing criteria for practitioners, will trigger a file review
- Continuity and Coordination Across Settings and all levels of care
    - Analysis and evaluation of interventions to address both over- and under-utilizations of services and interventions
- Health Equity Promotion in Quality Improvement and Population Health
    - Analysis and evaluation of equity-related programs, initiatives and QI-related work as well as the overall effectiveness of the QI/PI program and of its progress toward influencing network-wide safe clinicalpractices
    - Analysis of county and region specific population needs assessment data
    - Analysis of community partnerships with local health departments, community based organizations, nonprofit organizations, etc.
    - Analysis of community reinvestments
- Regional Quality and Health Equity Team Compositions
    - Names and Roles of Partnership Team Members per region for quality and health equity
    - Identity of key network providers, county behavioral health plans, local health departments, community-based organizations, local government agencies, First 5 programs, etc. per disparity priority
- Administrative
    - The annual QI and Health Equity Work Plan goals and associated deliverables are informed by the QIHEC. If there are opportunities for improvement identified in the evaluation of prior year initiatives and work conducted to support the goals of the quality improvement program, these opportunities are translated into goals with actionable deliverables for the next year's work plan. The results in the annual QI and Health Equity Program Evaluation, particularly those tied to the need to revisit allocated resources, for committees, standing programs and other related activity are assessedand if changes are deemed necessary, they are reflected in the program in the

subsequent year.

- Strategy of sharing annual program evaluation with various subcontractors, downstream subcontractors, and network providers
- Analysis of actions taken to address any recommendations in the annual external quality review technical report
- Analysis of annual reports of any subcontractors' and downstream subcontractors' performance of delegated health equity activities. Each subcontractor's health equity officer/liaison will be required to submit an annual performance report to Partnership
- NCQA Health Equity Accreditation Status
- Annual Summary of QIHEC activities

The following are separate evaluations and not included in the QI and Health Equity Annual Work Plan Evaluation:

- Evaluation of cultural and linguistic competency work plan activities
- Evaluation of Utilization Management and Care Coordination activities
- Evaluation of Member grievance and appeals

Preparation for the Annual Program Evaluation involves participation by all QIHETP leadership including but not limited to:

- Chief Medical Officer
- Chief Health Services Officer
- Health Equity Officer
- Senior Director of Quality and Performance Improvement

The QI and Health Equity Plan will be made available on the Partnership website on an annual basis

NON-DISCRIMINATION STATEMENT

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

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
- Written information in other formats (large print, audio, 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 sign language interpreters
- Information written in other languages
- Use of California Relay Services for hearing impaired

REFERENCES

1. Department of Health Care Services (DHCS) standards
2. National Committee for Quality Assurance (NCQA) Guidelines (Effective 2024) HEA Standards 1 to 7
3. **Original Date:** 11/08/2023 Effective Date: 03/03/2023

QIHETP PROGRAM DESCRIPTION APPROVAL

	10/16/2024

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

	11/13/2024

Steve Gwiazdowski, MD, FAAP *Date Approved*
Physician Advisory Committee Chairperson

	12/04/2024

Kim Tangermann *Board of*
Commissioners Chairperson

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="3">Guideline/Procedure Number: MCUG3038 (previously UG100338 and MCUP3105)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="3">Guideline/Procedure Title: Review Guidelines for Member Placement in Long Term Care (LTC) Facilities</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="2">Original Date: 04/25/1994</td><td colspan="4">Next Review Date: ~~06/12/2025~~11/13/2025
Last Review Date: ~~06/12/2024~~11/13/2024</td></tr>
<tr><td>Applies to:</td><td colspan="2">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td>☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td>☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td>☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td>☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="3">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: ~~06/12/2024~~11/13/2024</td></tr>
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I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3051 – Long Term Care SSI Regulation
C. MCUG3058 – Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities
D. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
E. MCCP2016 – Transportation Guidelines for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT)
F. MPQP1016 – Potential Quality Issue Investigation and Resolution
G. MCRP4068 – Medical Benefit Medication TAR Policy
H. MCUP3142 – CalAIM Community Supports
I. MCCP2032 – CalAIM Enhanced Care Management (ECM)
~~I.~~J. MPPRXX – Long Term Support Services Liaison

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

A. Custodial Care: Non-medical care that helps ~~member~~Members with their daily basic care such as eating, bathing, and/or mobility.
B. Intermediate Care Facility~~ies~~ (ICF): A health facility/home that provides inpatient care to ambulatory or non-ambulatory patients who have recurring need for skilled nursing supervision and need supportive care.
C. Long Term Care (LTC) Facility: A health facility that provides rehabilitative, restorative and/or on-going skilled nursing care to patients in need of assistance with activities of daily living (ADLs).
D. Skilled Nursing Facilities (SNFs): A special facility or part of a hospital that provides medically necessary services provided by nurses, therapists, and/or physicians.
E. Sub-acute Care Facilities: Facilities with a level of care that is less intensive than acute care, but is more intensive than skilled nursing care (e.g. ~~ventilator dependent member~~Members who require ventilators, tracheostomies, total parenteral nutrition, tube feeding, complex wound management care, etc.).
~~E.~~F. Subacute Contracting Unit: (SCU)

IV. ATTACHMENTS:

A. Bed Hold & Change of Status Report form

Guideline/Procedure Number: MCUG3038 (previously UG100338 and MCUP3105)		**Lead Department: Health Services**
Guideline/Procedure Title: Review Guidelines for Member Placement in Long Term Care (LTC) Facilities		☒ **External Policy** ☐ **Internal Policy**
Original Date: 04/25/1994	**Next Review Date:** ~~06/12/2025~~11/13/2025 **Last Review Date:** ~~06/12/2024~~11/13/2024	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

V. PURPOSE:

To delineate the medically necessary criteria for admission and continuing care in Long Term Care (LTC) facilities for Partnership HealthPlan of California ~~(Partnership) member~~Members.

VI. GUIDELINE / PROCEDURE:

A. Identifying Members and Selecting Appropriate Long Term Care Facilities

1. Partnership ensures access to licensed long-term care facilities, irrespective of location in or out-of-network, to ~~member~~Members in need of long-term care services. These facilities may include:
   a. Skilled Nursing Facilities (SNF) as defined in III.D
   b. Sub-acute Care Facilities (pediatric and adult) as defined in III.E.
   c. Intermediate Care Facilities (ICF) as defined in III.B.
2. A ~~member~~Member in need of long term care is identified by his/her physician, health care clinician, institution, Nurse Coordinator and/or Care Coordination staff who refers the ~~member~~Member to the appropriate type of facility.
3. The primary care provider (PCP) and/or treating physician, in collaboration with hospital Discharge Planning/Care Management departments, and ~~PHC~~Partnership Utilization Management (UM) team identifies the most appropriate level of care for the ~~member~~Member and assures that the ~~member~~Member is placed in a health care facility that provides the level of care most appropriate to the ~~member~~Member's medical needs. Decisions regarding the appropriate level of care are based on the definitions set forth in Title 22, California Code of Regulations (CCR) Sections 51118, 51120, 51120.5, 51121, 51124, 51124.5, and 51124.6, and the criteria for admission set forth in Sections 51335, 51118, 51120, 51335.5, 51334, 51335.6, and referenced sections of 51003 (e). These Title 22 Medi-Cal guidelines are used to determine the medical necessity for continued placement in a long-term care facility. If care can be delivered at a lower acuity level, an alternative setting will be approved/ recommended. Classification categories include the following:
   a. Subacute Care: The ~~member~~Member requires subacute care, which is more intense than skilled nursing care but less intense than acute hospitalization. Members at this level of care either can be short term, where there is potential for the ~~member~~Member eventually being transferred to a lower level of care; or long term, when there is no potential for improvement in their medical condition. Treatment Authorization Requests (TARs) for these ~~member~~Members are authorized for time intervals based on the characteristics of the ~~member~~Member's medical condition.
   b. Short Term Care: The ~~member~~Member may need a short term stay for a skilled nursing care need or short term rehab services and expected to return to his/her previous living arrangement or alternate level of care.
   c. Long Term Care: When a ~~member~~Member is admitted for custodial care, the TAR submission may be approved for a six (6) month period. Member's condition will be re-evaluated at six (6) month increments.
4. The choice of a long term care facility for a patient is a decision that should include consideration of the following:
   a. If the facility is a licensed Medi-Cal provider
   b. If the facility is contracted with ~~PHC~~Partnership
   c. If there are beds available
   d. If more than one choice is available, the family's choice of facility
   e. Benefit coverage limitations
5. A Long Term Care (LTC) facility must be a licensed institution (other than a hospital).
   a. An LTC facility~~ies~~ must meet all of the following requirements:
      1) It must be qualified as a provider of services under Medi-Cal
      ~~1)~~2)It must maintain on the premises all facilities necessary for medical care and treatment

~~2)~~3)It must provide such services under the supervision of physicians
~~3)~~4)It must provide services given by or supervised by a registered nurse AND
~~4)~~5)It must keep medical records on all patients

b. For Members approved for subacute services, Partnership verifies those services are received from a provider that has a contract with the Department of Health Care Services' (DHCS') Subacute Contracting Unit (SCU) or is actively in the process of applying for a contract with DHCS' SCU.

B. Short Term Skilled Nursing and Rehab Programs
1. Skilled level nursing is a covered level of care for ~~PHC~~Partnership's ~~member~~Members. Usually this level of care is short term and follows hospitalization at an acute care facility during the acute rehabilitation stage of treatment for an illness or injury.
   a. Admission to a skilled nursing facility must be coordinated with a contracted, Medi-Cal licensed facility by the discharge planner. If the ~~member~~Member is not currently confined, or the hospital discharge planner is unavailable, the ~~PHC~~Partnership Nurse Coordinator is the appropriate contact for referral to a skilled nursing level facility.
   b. The attending physician should also be aware that a history and physical are needed by the skilled nursing facility that is accepting the ~~member~~Member. Orders are generally accepted over the telephone for an immediate placement and a written history and physical must then be completed and sent to the accepting facility.
2. Specialized Rehabilitative Services
   a. Specialized rehabilitative services in skilled nursing facilities shall be covered in accordance with the standards of medical necessity. Such service shall include the medically necessary continuation of treatment services initiated in the hospital or short term intensive therapy expected to produce recovery of function leading to either:
      1) A sustained higher level of self-care and discharge to home or
      2) A lower level of care
   b. Specialized rehabilitation service shall be covered contingent upon compliance with the following requirements:
      1) The services shall be ordered by the beneficiary's attending physician.
      2) The physician's signed order, specifying the care to be given, shall be on the beneficiary's chart.
      3) A copy of the order shall be made available for departmental review upon request.
   c. The services require prior authorization by the ~~PHC~~Partnership Nurse Coordinator prior to admission to a skilled nursing facility. The authorization request shall be accompanied by a treatment plan, signed by the attending physician, which shall include the following:
      1) Principal and significant diagnoses
      2) Prognosis
      3) Date of onset of illness or injury
      4) Specific type, number, and frequency of services to be performed by each discipline
      5) Therapeutic goals of the service provided by each discipline and anticipated duration of treatment
      6) Extent of and benefits or improvements demonstrated by any previous provision of physical therapy, occupational therapy, speech pathology or respiratory services
   d. Professional therapy necessary to establish maintenance program services under treatment programs not requiring the skills of a qualified therapist shall not be separately payable or authorized.

C. Admission to a LTC Facility
1. In alignment with Manual of Criteria R-15-98E, an initial Treatment Authorization Request (TAR) is required with each admission. A LTC Treatment Authorization Request (TAR) is required when

the ~~member~~Member:

a. Is a new admission to the facility
b. Has exhausted his/her Medicare benefits
c. Medicare or other insurance denies LTC
d. Is readmitted to LTC from an acute care hospital or did not return to the LTC facility on or before day eight (8) of "bed hold days"
e. Returns to the LTC facility from an approved leave of absence beyond the approved return date
f. Is newly eligible with ~~PHC~~Partnership while residing in the LTC facility
g. Changes level of care (e.g. ICF level to SNF level, SNF to ICF level of care, SNF to Subacute)

2. The physician/ facility submits the TAR to the ~~PHC~~Partnership UM Department with the following documentation:
   a. A completed Pre-admission Screening and/or a Preadmission Screening and Resident Review (PASRR) form indicating appropriateness for placement
   b. The Minimum Data Set (MDS) and relevant medical record documentation supporting the medical necessity for the level of care requested which must have been completed within the last 90 calendar days to request for custodial care or re-authorization
   c. A Medicare or other insurance denial, if applicable
3. A UM Nurse Coordinator reviews the request for medical necessity and level of care.
   a. Cases not meeting criteria for medical necessity are referred to one of the Medical Directors for review and determination.
   b. Upon determination of medical necessity, an approval will be issued to the facility in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6.
   c. ~~PHC~~Partnership reserves the right to modify a request; it is the facility's responsibility to review their request against what ~~PHC~~Partnership actually approves.
   d. The facility is responsible for verifying the ~~member~~Member's eligibility using Partnership's "eEligibilty" on a monthly basis. (For improved accuracy, it is recommended that eligibility be verified after the 5th of the month.) If a ~~PHC~~Partnership ~~member~~Member loses eligibility, the authorization will no longer be valid.
   e. Acute Care to Long Term Care Facility
      The transfer must be coordinated by the hospital discharge planner or case worker to ~~PHC~~Partnership inpatient concurrent review nurse prior to admission to the LTC facility. The hospital discharge planner or case worker will notify the ~~PHC~~Partnership inpatient concurrent review nurse when the ~~member~~Member needs to be transferred to a LTC facility.
      1) The ~~PHC~~Partnership inpatient concurrent review nurse will discuss the case with the ~~PHC~~Partnership Nurse Coordinator. If the transfer meets the ~~PHC~~Partnership guidelines, verbal approval is given for admission to the skilled nursing facility.
      2) If a ~~member~~Member is capped to a hospital, the discharge planner at the hospital will directly notify the ~~PHC~~Partnership Nurse Coordinator to initiate a referral to a skilled facility.
   f. Admission from Home to Long Term Care Facility
      1) A LTC facility is required to notify ~~PHC~~Partnership before any elective admission. Prior authorization is required for all elective admissions from home.
      2) The following information must be submitted with the prior authorization request via TAR:
         a) Primary Care Provider's (PCP's) orders indicating the services needed that require confinement in a long term care facility and the physician's certification that placement in the long term care facility is the appropriate level of care for the ~~member~~Member.
         b) If placement follows an acute hospital stay within the past 30 calendar days, please submit the hospital history and physical and discharge summary.

c) If the ~~member~~Member has not been confined in an acute care hospital within the past 30 calendar days, please submit the Primary Care Provider's progress notes for the past six (6) months.
d) Please Note: If the admission from home occurs without prior approval from ~~PHC~~Partnership and the ~~member~~Member's condition and services do not meet criteria, ~~PHC~~Partnership will issue a denial to the facility.

g. Admissions on Weekends and Outside normal business hours
1) For an admission to LTC facility on the weekend or outside normal business hours, facility is to contact ~~PHC~~Partnership as soon as possible to identify the ~~PHC~~Partnership ~~member~~Member, reason for admission, and name of facility.
2) Upon review, if ~~PHC~~Partnership determines the ~~member~~Member did not meet criteria, the dates of service already provided will be authorized, but subsequent days will be denied.

h. Transfer to an Acute Care Facility
1) The transfer of a ~~member~~Member to an acute care facility must be reported through the Bed Hold & Change of Status Report form (Attachment A) weekly. When appropriate, the ~~PHC~~Partnership Nurse Coordinator places the ~~member~~Member in a "bed hold" status for up to 7 calendar days. (see VI.G.4)
2) The LTC facility must notify ~~PHC~~Partnership when the ~~member~~Member is readmitted to the LTC facility. Claims will not be paid if the readmission is not appropriately reported to ~~PHC~~Partnership.

i. Discharge or Death
1) All discharges or deaths must be reported on a weekly basis. (Attachment A "Bed Hold & Change of Status Report" form is recommended for reporting.)
2) Notification of a ~~member~~Member's death should include whether the death occurred within the LTC or in an acute care facility.

j. Medicare/Medi-Cal Members
1) Members with both Medi-Cal and Medicare coverage become the financial responsibility of ~~PHC~~Partnership when the Member has exhausted their Medicare skilled days benefit.
2) The SNF must submit the Medicare denial letter showing non-coverage of services to ~~PHC~~Partnership along with a completed TAR and required medical documentation for review. ~~PHC~~Partnership's Nurse Coordinator reviews the case to determine the medical necessity of continued authorization.
3) Note: ~~PHC~~Partnership follows Title 22 criteria for admission and continuing care for LTC facilities.

D. Denials and Coordination of Care
1. Cases determined to not meet LTC guidelines based on Title 22 Medi-Cal Guidelines and the information available at the time of review, are managed as follows:
a. If the Nurse Coordinator has concerns regarding a case, the case is discussed with the appropriate facility representative to determine if there is any additional pertinent information available.
b. The Nurse Coordinator contacts the attending physician to discuss concerns regarding patient's acuity, treatment plan or length of stay (LOS), or to obtain any additional pertinent information that might assist with the level of care determination.
c. Denials of medical necessity are determined only by the ~~PHC~~Partnership Chief Medical Officer (CMO) or Physician Designee.
d. UM staff ensures the ~~member~~Member, provider, and facility are notified in writing of a denial for LTC, including the applicable appeal rights.

E. Continuing Care Determinations
1. Extensions of stay in SNF ~~long term care~~ facilities for Medi-Cal ~~member~~Members require re-

authorization by ~~PHC~~Partnership on a case by-case basis and are approved in accordance with the time limitations as outlined in Title 22, CCR, Sections 51334, 51335, 51335.5 and 51335.6 for newly admitted ~~member~~Members who may be eligible to return home.

~~1.~~2. Extensions of stay in subacute care facilities are reviewed in alignment with Manual of Criteria R-15-98E and require reauthorization by Partnership every two months. Prolonged care may be authorized for up to a maximum of four months. Extensions are based on the same criteria as initial authorizations.

~~2.~~3. When a ~~member~~Member is admitted for custodial care, a TAR submission may be approved for a six (6) month period. Member's condition will be re-evaluated at six (6) month increments upon submission of a new TAR within 15 days of the expiration date of the previous TAR.

F. Continuity of Care Requirements

1. Effective January 1, ~~2023~~2024, and through ~~July 1~~June 30, ~~2023~~2024, for Members residing in a ~~SNF~~ Subacute Care Facility and transitioning from Medi-Cal FFS to Medi-Cal managed care, ~~PHC~~ Partnership will automatically provide 12 months of continuity of care for the ~~SNF~~ Subacute Care Facility placement. Automatic continuity of care means that if the ~~member~~Member is currently residing in a ~~SNF~~Subacute Care Facility, they do not have to request continuity of care to continue to reside in that ~~SNF~~facility. While ~~member~~Members must meet medical necessity criteria for ~~SNF~~ adult or pediatric subacute care services, continuity of care must be automatically applied.
   a. Consistent with Health and Safety Code section 1373.96, application of automatic continuity of care allows for the completion of covered services provided by a nonparticipating provider to a newly covered ~~PHC~~ Partnership ~~member~~Member who, at the time that coverage became effective, was receiving services from that provider, irrespective of contracting status with ~~PHC~~Partnership.
   b. Members are allowed to stay in the same Subacute Care Facility~~SNF~~, irrespective of location in or out-of-network, under continuity of care only if all of the following applies:
      1) The facility is contracted or actively in the process of being contracted by DHCS SCU.
      ~~1)~~2)The facility is enrolled and licensed by the California Department of Public Health (CDPH)
      ~~2)~~3)The facility is enrolled as a Medi-Cal P~~p~~rovider ~~in Medi-Cal~~
      ~~3)~~4)The ~~SNF~~ Subacute Care Facility and ~~PHC~~ Partnership agree to payment rates that meet state statutory requirements; and
      ~~4)~~5)The facility meets ~~PHC's~~ Partnership's applicable professional standards and has no disqualifying quality-of-care issues.
   c. ~~PHC~~ Partnership will determine if a ~~member~~Member ~~s are~~is eligible for automatic continuity of care before the transition by identifying the Member's ~~SNF~~ Subacute Care Facility residency and pre-existing relationship through historical utilization data or documentation provided by DHCS, such as Medi-Cal FFS utilization data, or by using information from the ~~member~~Member or provider. A pre-existing relationship means that the Member has resided in the Subacute Care Facility~~SNF~~ at some point during the 12 months prior to the date of the ~~member~~Member's enrollment with ~~PHC~~Partnership.
   d. Following their initial 12-month automatic continuity of care period, a ~~member~~Members~~s~~ may request an additional 12 months of continuity of care, following the process established by APL ~~22-032~~23-022, "Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service~~, and for Medi-Cal Members Who Transition into a New Medi-Cal Managed Care Health Plan~~ On or After January 1, 2023."
   e. A ~~member~~Member newly enrolling with ~~PHC~~ Partnership and residing in a Subacute Care Facility ~~SNF~~ on or after July 1, 2024~~2023~~, does not receive automatic continuity of care and must instead request continuity of care~~,~~ following the process established by APL ~~22-032~~23-022 .

2. A Member residing in a SNF who newly enrolls with Partnership on or after July 1, 2023 does not receive automatic continuity of care and must request continuity of care following the process established by APL 23-022.

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

H. TAR Submission Requirements:
The authorization request shall be initiated by the facility with all required attachments as noted below. TAR should be submitted within 15 business days from the date of service. (Note that the TAR must also be submitted within 60 calendar days from the date that the ~~member~~Member established eligibility with ~~PHC~~Partnership.)
1. Initial TAR must include the following:
   a. Completed new TAR form
   b. MC171 (Medi-Cal Long Term Facility Admission and Discharge notification)
   c. Medicare or other Insurance denial letter (if applicable)
   d. ~~MDS (~~Minimum Data Set~~)~~ (MDS)
2. Continued Care with a new TAR must include the following:
   a. Completed new TAR form
   b. Current MDS (or most recent quarterly MDS)
   c. Social Services notes and evaluation
3. Post-service Retrospective TAR must include the following:
   a. Completed new TAR form
   b. MC171 (Medi-Cal LTC Facility Admission and Discharge Notification form)
   c. PASSR (Preadmission Screening and Resident Review Medicaid form)
   d. Minimum Data Set (MDS)
   e. Medicare or other health coverage denial letter (as applicable)
   f. Social Services notes and evaluation
4. Bed hold TAR (When a ~~member~~Member residing in a nursing facility or subacute care facility is transferred to an acute care hospital or has an approved leave of absence)
   a. Bed hold TARs must include the following:
      1) Doctor's order
      2) Completed new TAR
   b. Maximum bed hold is 7 calendar days per hospitalization. The facility must hold a bed vacant when requested during the entire hold period, except when notified in writing by the attending physician that the patient requires more than seven days of hospital care. The facility is then no longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days.
   c. When a ~~member~~Member returns to the LTC facility on the 8th calendar day, the current TAR is still valid.
   d. If a ~~PHC~~Partnership ~~member~~Member returns to a ~~Long Term Care~~an LTC facility after 8 calendar days, a new TAR and all required attachments must be submitted (see VI.H~~G~~.1.- TAR Submission Requirements, Initial TAR).
5. Short Term TAR (Less than 90 calendar days in a LTC facility) must include the following:
   a. Doctor's order
   b. Completed new TAR form
   c. Medicare or other health coverage denial letter (as applicable)

d. Eligibility must be No Other Insurance

I. Criteria for Ending or Modifying an Existing TAR
With written or electronic (via ~~PHC~~Partnership ePortal) notification, ~~PHC~~Partnership staff will end or modify an existing valid TAR in the system under the following circumstances:
1. Member's death
2. Exhausted 7 calendar day bed hold
3. Discharge to Medicare, Health Maintenance Organization (HMO) or other insurance bed
4. Discharge to hospice care
5. Discharged to home or transfer to other LTC facility

J. Procedures for Discharge from LTC Facilities
1. Discharge summary should be sent to the ~~member~~Member's PCP upon discharge.
2. Day of Discharge or Death Same as Day of Admission Reimbursement Policy
   a. When a patient receiving skilled nursing or intermediate care expires or is discharged from a LTC facility, the facility must notify ~~PHC~~Partnership via the Bed Hold & Change of Status Report form (Attachment A).
   b. If the day of discharge or death is the same day as admission, the day is payable regardless of the hour of discharge or death. If the day of death/discharge is not the same day as admission, the day is not payable.
3. Durable Medical Equipment (DME)
   a. For requests for DME for residents residing in a LTC facility, it is the responsibility of the facility and its staff to meet the patient's needs for activities of daily living including assistance with mobility. (This includes, but is not limited to, mobility components such as rollators, 4 wheel walkers, commodes, etc.) Please refer to Department of Health Care Services (DHCS) All Plan Letter (APL) 15-018 of July 9, 2015, Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components, regarding provision of wheel chairs for patients residing in a skilled nursing facility.
   b. The LTC facility is responsible for providing wheelchairs that are properly maintained at all times unless the ~~member~~Member demonstrates the need for a custom wheelchair [as per Title 22 section 51321(h)] in which case a TAR should be submitted to ~~PHC~~Partnership for consideration.

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

deformities

2. Transportation
   a. For all transportation needs, please refer to ~~PHC~~Partnership's policy MCCP2016 Transportation Guidelines for Non-Medical (NMT) and Non-Emergency Medical Transportation (NEMT).
3. Enhanced Care Management / Community Supports
   a. Members who are currently in a Skilled Nursing Facility may be eligible for the Enhanced Care Management (ECM) benefit. Refer to ~~PHC~~Partnership policy MCCP2032 CalAIM Enhanced Care Management (ECM) for further details.
   b. Community Supports are medically appropriate and cost-effective alternatives to traditional medical services or settings that are designed to address social drivers of health, which are factors in people's lives that influence their health. For ~~member~~Members currently in a LTC setting who may benefit from Community Supports, please refer to ~~PHC~~Partnership policy MCUP3142 CalAIM Community Supports (CS)

VII. REFERENCES:

A. Medi-Cal Guidelines/Provider Manual: ~~including~~ Subacute Care Programs: Level of Care for Adults and Children (*subacut lev*); Subacute Care Programs: Adult *(subacute adu);* Subacute Care Programs: Pediatric (*subacut ped*); Leave of Absence, Bed Hold, and Room and Board (*leave)*

B. InterQual® criteria

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

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

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

F. Welfare and Institutions Code (WIC) §14132.25

~~C.~~G. Health and Safety Code (HSC) § 1373.96

~~D.~~H. DHCS APL 15-018 dated 07/09/2015 Criteria for Coverage of Wheelchairs and Applicable Seating and Positioning Components

~~E.~~I. All County Welfare Director's Letter ACWD 97-07 1997 Statewide Average Private Pay Rate (APPR) for Nursing Facility Services (02/27/1997)

~~F.~~J. Department of Health Care Services (DHCS) All Plan Letter (APL) 23-004 Skilled Nursing Facilities – Long Term Care Benefit Standardization and Transition of Members to Managed Care (03/14/2023)

~~G.~~K. DHCS APL 23-022: Continuity of Care for Medi-Cal Beneficiaries Who Newly Enroll in Medi-Cal Managed Care from Medi-Cal Fee-for-Service On or After January 1, 2023. (08/15/2023)

L. DHCS APL 23-027: Subacute Care Facilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (09/26/2023)

~~H.~~M. DHCS Subacute Care Program and Manual of Criteria R-15-98E

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors
B. ~~PHC~~Partnership Provider Manual

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

X. REVISION DATES:

06/21/00; 04/18/01; 03/20/02; 03/19/03; 04/21/04; 02/16/05; 03/15/06; 08/20/08; 03/21/12; 01/20/16; 09/21/16; 09/20/17; *10/10/18; 09/11/19; 03/11/20; 03/10/21; 05/11/22; 04/12/23; 06/12/24; 11/13/24

*Through 2017, Approval Date reflective of the Quality/Utilization Advisory Committee meeting

date. Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:
MCUP3105 - Coordination of Services for Members Requiring Long Term Care

****

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

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

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

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

<table>
<tr><td colspan="4">Guideline/Procedure Number: MCUG3058 (previously UG100358)</td><td colspan="2">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Guideline/Procedure Title: Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities</td><td colspan="2">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 03/19/2003</td><td colspan="3">Next Review Date: ~~10/09/2025~~11/13/2025
Last Review Date: ~~10/09/2024~~11/13/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="2">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td>☒ IQI</td><td colspan="2">☐ P & T</td><td>☒ QUAC</td><td></td></tr>
<tr><td>☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: ~~10/09/2024~~11/13/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUG3038 - Review Guidelines for Member Placement in Long Term Care (LTC) Facilities

B. MCUP3041 - Treatment Authorization Request (TAR) Review Process

~~B.~~C. MCCP2016 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)

II. IMPACTED DEPTS:

A. Health Services

B. Claims

C. Member Services

III. DEFINITIONS:

A. BH: Bed Hold

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

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

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

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

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

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

~~G.~~H. LOA: Leave of Absence

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

~~H. NF-A: Nursing Facility Level A -Freestanding nursing facilities~~

~~I. NF-B: Nursing Facility Level B -The facilities comprising this category are distinct parts of acute care hospitals~~

~~J. BH: Bed Hold~~

Guideline/Procedure Number: MCUG3058 (previously UG100358)		**Lead Department: Health Services**
Guideline/Procedure Title: Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities		☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/19/2003	**Next Review Date: 10/09/202511/13/2025** **Last Review Date: 10/09/202411/13/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

IV. ATTACHMENTS:

A. Bed hold/TAR Process

V. PURPOSE:

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

VI. GUIDELINE / PROCEDURE:

A. As a Managed Care Plan (MCP), Partnership provides all medically necessary covered services for Members residing in or obtaining care in an ICF/DD facility/home, including home services, professional services, ancillary services, and transportation services. Partnership also provides the appropriate level of care coordination, as outlined in DHCS All Plan Letter (APL) 23-023 *Revised* and in adherence to DHCS contract requirements and the DHCS Population Health Management (PHM) Policy Guide.

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

1. Federal regulations require California to provide a program of independent professional review of Intermediate Care Facilities for the Developmentally Disabled (ICF/DD), Intermediate Care Facilities for the Developmentally Disabled/Habilitative (ICF/DD-H), and Intermediate Care Facilities for the Developmentally Disabled/Nursing (ICF/DD-N) that provide services to Medi-Cal recipients. This process is referred to as utilization review. Its purpose is to control unnecessary utilization of services by evaluating patient needs and the appropriateness, quality and timeliness of service delivery.
2. Patient Placement Requirements
   a. Only individuals with predictable, intermittent skilled nursing needs, which can be arranged for in advance, are appropriate for ICF/DD-H and ICF/DD-N placement. Recipients who require skilled nursing procedures "as needed" are not appropriate for ICF/DD-H and ICF/DD-N placement.
   b. Please refer to policy MCUG3038 Review Guidelines for Member Placement in Long Term Care (LTC) Facilities
3. Federal Requirements for monitoring utilization and quality of care include:
   a. A review of the recipient's plan of care every 90 calendar days by the facility's interdisciplinary team.
   b. A comprehensive medical and social evaluation of the recipient within 12 months prior to admission
   c. A requirement that the recipient be seen by the attending physician at least every 60 calendar days.
4. Per Diem Services
   a. Services covered under the daily rate of an ICF/DD, ICF/DD-H and ICF/DD-N include:
      1) Services of the direct care staff
      2) Services of the facility's interdisciplinary team
      3) Services of qualified intellectual disabilities professional
      4) Case conference reviews
      5) Development of service plans
      6) In-service training of direct care staff and consultation on individual recipient needs
      7) Transportation services (see policy MCCP2016 - Transportation Policy for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)
      8) Equipment and supplies necessary to provide appropriate care
      9) Room and Board

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

~~B.~~C. Leave of Absence

1. Leave of Absence Qualifications
   a. A leave of absence (LOA) may be granted to a recipient in an ICF/DD-N ~~-~~or ICF/DD-H in accordance with the recipient's individual plan of care and for the specific reasons outlined below:
      1) A visit with relatives or friends
      2) Participation by developmentally disabled recipients in an organized summer camp for developmentally disabled persons
2. Leave of Absence Maximum Time Period
   a. If the LOA is an overnight visit (or longer) to the home of relatives or friends, the time period is restricted as follows:
      ~~1) Eighteen days per calendar year for non-developmentally disabled recipients. Up to 12 additional days of leave per year may be approved in increments of no more than two consecutive days when the following conditions are met:~~
      ~~a) The request for additional days of leave shall be in accordance with the individual patient care plan and appropriate to the physical and mental well-being of the patient.~~
      ~~b) At least five days of LTC inpatient care must be provided between each approved LOA.~~
      1) Developmentally disabled recipients can receive a leave of absence for relatives/friend visits or summer camp for up to seventy-three (73) days per calendar year.
         ~~c)~~a) A physician signature is required for an LOA only when a Member is participating in a summer camp for the developmentally disabled.
      3) These limits are in addition to bed hold days ordered by the attending physician for each period of acute hospitalization for which the facility is reimbursed for reserving the patient's bed (bed hold) as described below.

~~C.~~D. Bed Hold (BH) Qualifications

1. Partnership covers the stay w~~W~~hen a recipient residing in a ICF/DD facility/ home is admitted to an acute care hospital setting, a post-acute care setting such as a skilled nursing facility (SNF), or a rehabilitation facility, and then requires a return to an ICF/DD Home. ~~,~~ P~~p~~roviders must bill bed hold (BH) days. Reimbursement for bed hold days is limited to a maximum of seven days per hospitalization, subject to the following:
   a. The attending physician must order the acute hospitalization.
   b. The ICF/DD facility/home must hold a bed vacant when requested during the entire hold period, maximum of 7 days for each bed hold period, except when notified in writing by the attending physician that the patient requires more than seven days of hospital care. The facility is then no

longer required to hold a bed and may not bill Medi-Cal for any remaining bed hold days.

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

VII. REFERENCES:

A. Title 42 Code of Federal Regulations (CFR) Sections 483.400 – 483.480
B. Title 22 California Code of Regulations (CCR) Section 51535
C. California Department of Developmental Services (DDS) Guidelines
D. Medi-Cal Provider Manual/Guidelines: Utilization Review: ICF/DD, ICF/DD-H and ICF/DD-N
~~D.~~E. Facilities (*util review*); Leave of Absence, Bed Hold, and Room and Board (*leave*)
~~E.~~F. Lanterman Developmental Disabilities Services Act
G. DHCS APL 23-023 *Revised* Intermediate Care Facilities for Individuals With Developmental Disabilities - Long Term Care Benefit Standardization and Transition of Members to Managed Care (11/28/2023)
~~F.~~H. DHCS Population Health Management Guide

VIII. DISTRIBUTION:

A. ~~PHC~~Partnership Department Directors
B. ~~PHC~~Partnership Provider Manual

Guideline/Procedure Number: MCUG3058 (previously UG100358)		**Lead Department: Health Services**
Guideline/Procedure Title: Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities		☒ **External Policy** ☐ **Internal Policy**
Original Date: 03/19/2003	**Next Review Date: 10/09/202511/13/2025** **Last Review Date: 10/09/202411/13/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

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

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

PREVIOUSLY APPLIED TO: N/A

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

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

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

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

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: MCUP3049 (previously UP100349)</td><td colspan="3">Lead Department: Health Services</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Pain Management Specialty Services</td><td colspan="3">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 12/20/2000</td><td colspan="4">Next Review Date: <s>11/08/2024</s>11/13/2025
Last Review Date: <s>11/08/2023</s>11/13/2024</td></tr>
<tr><td>Applies to:</td><td colspan="3">☒ Medi-Cal</td><td colspan="3">☐ Employees</td></tr>
<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☒ IQI</td><td colspan="2">☐ P & T</td><td colspan="2">☒ QUAC</td></tr>
<tr><td colspan="2">☐ OPERATIONS</td><td colspan="2">☐ EXECUTIVE</td><td>☐ COMPLIANCE</td><td>☐ DEPARTMENT</td></tr>
<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td>☐ FINANCE</td><td>☒ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="2">☐ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="3">Approval Date: <s>11/08/2023</s>11/13/2024</td></tr>
</table>

I. RELATED POLICIES:

A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
B. MCUP3124 – Referral to Specialists (RAF) Policy
C. MPCR13– Credentialing of Pain Management Specialist

II. IMPACTED DEPTS:

A. Health Services
B. Claims
C. Member Services

III. DEFINITIONS:

N/A

IV. ATTACHMENTS:

~~A. PHC Treatment Authorization Request (TAR) Requirements (see Pain Management CPT's Requiring a TAR)~~
~~B.~~A. ~~PHC~~Partnership Medical Necessity Criteria for Pain Management Procedures

V. PURPOSE:

To describe the specialty of Pain Management, the practitioners eligible to provide services as a Pain Management Specialist, and the reimbursement mechanism for this specialty.

VI. POLICY / PROCEDURE:

A. Partnership HealthPlan of California (~~PHC~~Partnership) recognizes Pain Management as a specialty and will reimburse certain practitioners to perform services to ~~member~~Members as contracted Pain Management Specialists. These specialists are recognized by ~~PHC~~Partnership as experts in the medical management of acute and chronic pain, and may have expertise in the performance of invasive procedures designed to treat such conditions. Pain Management Specialists may also act as care coordinators for ~~PHC~~Partnership ~~member~~Members requiring a multi-disciplinary approach to their condition.
B. In order to be considered as a Pain Management Specialist, the practitioner must be credentialed by the ~~PHC~~Partnership Credentials Committee as a Pain Management Specialist.
C. The Primary Care Provider (PCP) must refer ~~member~~Members by submitting an electronic or hardcopy Referral Authorization Form (RAF). If the Pain Management Specialist wants the ~~member~~Member to see another specialist, the physician must ensure that the ~~member~~Member's PCP completes a referral authorization request (RAF) for the consultation.

D. The specialty of Pain Management is to be reimbursed based on provisions in the specialist's contract. Medications dispensed or provided to ~~PHC~~Partnership ~~member~~Members as part of pain management services are reimbursed at the Medi-Cal rate. Revisions to the reimbursement schedule will be governed by the Specialty Contract of each provider.

E. TAR Requirements

1. The Pain Management Specialist must submit a Treatment Authorization Request (TAR) to ~~PHC~~Partnership for those procedures requiring a TAR.
   a. The Partnership TAR Requirements List can be found in policy MCUP3041 Treatment Authorization Request (TAR) Review Process as Attachment A.
   ~~a.~~b. For Partnership Medical Necessity Criteria for Pain Management Procedures, refer to ~~Please see~~ Attachment A~~-~~ of this policy. ~~for a list of those pain management services that require a TAR.~~

VII. REFERENCES:
InterQual® Criteria

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

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

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

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

PREVIOUSLY APPLIED TO: N/A

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

Policy/Procedure Number: MCUP3049 (previously UP100349)		**Lead Department: Health Services**
Policy/Procedure Title: Pain Management Specialty Services		☒ **External Policy** ☐ **Internal Policy**
Original Date: 12/20/2000	**Next Review Date: 11/08/202411/13/2025** **Last Review Date: 11/08/202311/13/2024**	
Applies to:	☒ **Medi-Cal**	☐ **Employees**

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

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

A. **Acupuncture** *(see policy MCUG3002 Acupuncture Service Guidelines)*
A RAF is required for the first visit, and then members are limited to 2 visits per month. A TAR is required if services exceed two visits per month.

B. **Allergy Injections** – A TAR is required when services exceed Medi-Cal frequency limit of eight (8) allergy injections in any 120-day period for code 95115 or four (4) allergy injections in any 120-day period for code 95117. (For codes 95115 and/or 95117 in any combination, a maximum of eight (8) allergy injections in any 120-day period is reimbursable to any provider for the same recipient without authorization.)

C. **Cardiac Rehabilitation** – Phase II and pediatric *(see policy MCUP3128 Cardiac Rehabilitation)*

D. **Chiropractic Services** *(see policy MCUG3010 Chiropractic Services)*
A RAF is required for the first visit, and then members are limited to 2 visits per month. A TAR is required if services exceed two visits per month.

E. **Community Health Worker (CHW) Services** *(see policy MCCP2033 Community Health Worker (CHW) Services Benefit)* Partnership does not require prior authorization for CHW services as preventive care for the first 12 units. A TAR is required for Members who need multiple CHW services or continued CHW services in excess of 12 units.

F. **Community Supports** A TAR is required for all members receiving a Community Supports service. *[see policies MCUP3142 CalAIM Community Supports (CS) and MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)]*

G. **Dental Anesthesia** *(see policy MPUP3048 Dental Services (including Dental Anesthesia)*

H. **Diagnostic Studies**
1. CT Scans: TARs are required for all CT scans for Members under age 21 years. For adults age 21 years and older, TARs are required for CT scans of the chest, abdomen, and/or pelvis. *No TARs are required for other CT scans of the extremities, head, neck, or spine, for CT angiograms, or for screening CT colonograms - effective 7/1/2024*
2. MRI: TARs are required for all MRIs for Members under age 21 years. For adults age 21 years and older, TARs are required for MRIs of the chest (including Cardiac MRI 05561), abdomen, and/or pelvis. *No TARs are required for other MRI scans of the extremities, head, neck, or spine, for MR elastography, or for breast MRIs - effective 7/1/2024*
3. MRA (MR Angiogram)
4. MSI
5. MEG
6. PET scan *[see policy MPUP3116 Positron Emission Tomography Scans (PET Scans)]*
7. Transcranial Doppler
8. Sleep Studies / Polysomnography: Facility based sleep studies/polysomnography always require a TAR. Home based studies/polysomnography require a TAR when more than 1 per year is requested. *(see policy MCUG3110 Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)*
9. Non-specific radiology codes for X-rays and ultrasound including 76497, 76380, 76506

I. **Doula Services** *(see policy MCNP9006 Doula Services Benefit*) While most doula services are provided with no TAR requirement, please refer to the policy for details on when a TAR may be required for additional visits (beyond eight) during the postpartum period.

J. **Durable Medical Equipment (DME) Supplies** – *(see policy MCUP3013 DME Authorization*)
1. Orthotics – Cumulative costs for repair/maintenance or purchase exceeds $250 / item (*see policy*

MCUG3032 Orthotic and Prosthetic Appliances Guidelines)

2. Prosthetics – Cumulative costs for repair / maintenance or purchase exceeds $500 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines). **Also any unlisted / miscellaneous code and any custom made item that does not have a Medi-Cal rate (by-report or by-invoice)***
3. Hearing Aids and Cochlear Implant Replacement Supplies – (*see policy MCUG3019 Hearing Aid Guidelines*)
4. Repairs or maintenance over $250.00 / item - (Out of guarantee repairs are to be guaranteed for at LEAST three (3) months from the date of repair. Reimbursement will NOT be allowed for parts or labor during a guarantee period if due to a defect in material or workmanship)
5. Oxygen and related supplies
6. Positive Airway Pressure (PAP) devices - No TAR is required for PAP supplies for a PAP machine owned by the member (as per Medi-Cal guidelines for ordering/quantity limits).
7. Purchase items when the cumulative cost of items within a group exceeds $100.00 within the calendar month. Providers may refer to the *Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates* section in the Medi-Cal manual to determine if items are related within a group. Items grouped together under specific headings, such as "Hospital Beds" or "Bathroom Equipment," are considered within the same group. (Vendor to guarantee for a MINIMUM of six (6) months from the date of purchase)
8. Rental items when the cumulative cost of rental for items within the group exceeds $50.00 within a 15-month period. This includes any daily amount that an individual item, or a combination of a similar group of DME items, exceeds the $50 threshold. The 15-month period begins on the date the first item is rented. (Rental rate includes equipment related supplies.)
9. Purchase of any wheelchairs for Medi-Medi members
10. Purchase of knee scooters with appropriate criteria met. Invoice is required and maximum payable benefit amount is $200. *(see policy MCUP3013 DME Authorization*)
9. Incontinence Supplies *(see policy MCUG3022 Incontinence Guidelines*)
    a. Note that codes A4335 for skin wash and A4665 for skin cream for members with incontinence do not require a TAR unless claim quantity exceeds normal frequency limits. However, providers are encouraged to include these items on the incontinence supply TAR as the authorization will be good for one year and the provider will be able to submit claims electronically without attaching the prescription each month. If these items are not included on the incontinence supply TAR, then the provider must submit a paper claim and attach a prescription form with each submission.

K. **Enhanced Care Management (ECM)** A TAR is required for all members receiving the ECM Benefit. *[see policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)]*

L. **EPSDT** (Early and Periodic Screening, Diagnosis and Treatment) Supplemental Services (*see policy MCCP2022 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services)*

M. **Fecal Microbiota Transplant (FMT)** A TAR is required for all procedures related to fecal microbiota transplant. *(see policy MCUP3136 Fecal Microbiota Transplant)*

N. **Gender Dysphoria** – A TAR is required for all procedures related to gender dysphoria. *(see policy MCUP3125 Gender Dysphoria/ Surgical Treatment)*

O. **Genetic Testing and Screening** – A TAR is required for certain genetic testing and screening as outlined in Attachment A of policy *MCUP3131 Genetic Screening and Diagnostics*

P. **Home Health Care** *(see policy MCUG3011 Criteria for Home Health Services)*

Q. **Home Infusion Therapy**

R. **Hysterectomy**

S. **Hospice Care (Inpatient Only)** *(see policy MCUP3020 Hospice Service Guidelines*)

T. **Hospitalization**
1. The hospital must notify Partnership of any admission within 24 hours of the admission.
2. Authorization for elective admission must be requested by the admitting physician prior to the admission.

U. **Hyperbaric Oxygen Pressurization**

V. **Long Term Care**
The LTC facilities must notify Partnership of any admissions, transfer, bed hold/ leave of absence, or change in payor status within one working day. (Examples include Medicare non-coverage or exhaustion of benefits/ hospice election.) *See policy MCUG3038 Review Guidelines for Member Placement in Long Term Care (LTC) Facilities.*

W. **Medical Supplies***
1. Nebulizers – When the billed price including tax is $200 or more *(see policy MPUG3031 Nebulizer Guidelines*)
2. Ostomy Supplies[+] (Note: NU modifier may not be used for "disposable" ostomy supplies)
3. Urological Supplies[+] (Note: NU modifier may not be used for "disposable" urological supplies)
4. Tracheostomy Supplies[+]
5. Wound Care Supplies[+] TAR requirements may vary.
6. Negative Pressure Wound Therapy Devices [*see policy MPUP3059 Negative Pressure Wound Therapy (NPWT) Device/Pump]*
7. Nutritional Supplements - *(see policy MCUP3052 Medical Nutrition Services*) Physician administered nutritional supplements require a TAR to be submitted to Partnership when the item is billed to Partnership's medical benefit and is not included in Partnership's Medical Drug List (MDL) Navigator, or when the Partnership MDL indicates a prior authorization is required. Nutritional supplements provided by a Pharmacy must be submitted through Medi-Cal Rx TAR processes* when not on the Medi-Cal Rx Contract Drugs List (CDL). Enteral formulas require a Medi-Cal Rx TAR when provided by a pharmacy.

***Note:** *Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 Revised. TARs will be operationally denied if submitted to Partnership for supplies which are carved out from managed care reimbursement and are only provided through Medi-Cal Rx as Pharmacy claims. See Medi-Cal Rx Provider Manual for covered medical supplies and limits. Supplies that can only be billed to Medi-Cal Rx include Insulin Syringes, Pen needles, Lancets, Diabetic Test Strips, Peak Flow Meters, and Inhaler Assistive Devices.*
[+] **Note**: *For detailed information regarding Medi-Cal frequency limits and TAR requirements for ostomy, urological, tracheostomy and wound care supplies, please reference Medi-Cal Provider Manual/ Guidelines section Medical Supplies Billing Codes, Units and Quantity Limits*

X. **Medications Provided by a Pharmacy:** Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 *Revised* and all medications (Rx and OTC) which are provided by a pharmacy must be billed to

State Medi-Cal/DHCS contracted pharmacy administrator instead of Partnership.

Y. **Medications Administered in a Medical Setting, and Billed as a Medical Claim [Physician Administered Drugs (PADs) given in an outpatient clinic, office, dialysis center, hospital]:** Partnership requires a TAR for certain prescription drugs, over-the-counter drugs and injectable drugs (including drugs compounded for IV infusion therapy) as outlined in policy *MCRP4068 Medical Benefit Medication TAR Policy*.

Z. **Non-Emergency Medical Transportation:** [*see policy MCCP2016 Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)*]

AA. **Occupational Therapy** *(see policy MCUP3114 Physical, Occupational and Speech Therapies)*

- Partnership Members under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
  Note: *No TAR is required for Members age 21 and over up to 12 visits (limit one visit per day) for OT services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
- A TAR is required for all OT services provided as Home Health or by Non-contracted Providers

BB. **Outpatient Hemo / Peritoneal Dialysis** Initial authorization will be limited to 90 days and a lifetime authorization may be granted with annual certification, only after submission of Medicare determination.)

CC. **Outpatient Surgical Procedures** – see **CPTs Requiring TAR** list (page 5)

DD. **Pain Management** – see **Pain Management CPTs Requiring TAR** list (page 8) and policy *MCUP3049 Pain Management Specialty Services*

EE. **Phototherapy** for dermatological condition

FF. **Physical Therapy** *(see policy MCUP3114 Physical, Occupational and Speech Therapies)*

- Partnership Members under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
  Note: *No TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) for PT services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
- A TAR is required for all PT services provided as Home Health or by Non-contracted Providers

GG. **Pulmonary Rehabilitation** *(see policy MCUP3111 Pulmonary Rehabilitation)*

HH. **Speech Therapy** *(see policy MCUP3114 Physical, Occupational and Speech Therapies)*

- Partnership members age 21 and over can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
  Note: *No TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) for ST services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
- A TAR is required for all ST services provided as Home Health or by Non-contracted Providers

II. **Transplants** (*see policy MCUP3104 Transplant Authorization Process)*

JJ. **ANY UNLISTED OR MISCELLANEOUS CODE**

HCPCS Codes	Description
P9020	Platelet rich plasma unit
V2531	Contact Lens, Scleral, Gas Permeable, Per Lens
C9757	Spine/Lumbar Surgery

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
10040	Acne Surgery
15769	Graft of Autologous Soft Tissue, Other, Direct Excision
15771	Graft of Autologous Fat Harvested by Liposuction; 50cc or less injectate
15772	Graft of Autologous Fat Harvested by Liposuction; each additional 50cc
15773	Graft of Autologous Fat Harvested by Liposuction; 25cc or less injectate
15774	Graft of Autologous Fat Harvested by Liposuction; each additional 25cc
15788 Thru 15793	Chemical Peel, Facial Et Al
15820 Thru 15823	Revision Of Lower Or Upper Eyelid
15845	Skin And Muscle Repair, Face
17360	Skin Peel Therapy
17999	Skin Tissue Procedure
19300	Mastectomy For Gynecomastia
19316	Mastopexy
19318	Reduction Mammoplasty
19324/25	Breast Augment; W/O Prosthetic Implant
19499	Correction Of Inverted Nipples
19380	Revise Breast Reconstruction
19396	Design Custom Breast Implant
19499	Unlisted Procedure, Breast
20999	Musculoskeletal Surgery
21208	Augmentation Of Facial Bones
22899	Spine Surgery Procedure
22999	Abdomen Surgery Procedure
28292, 28296, 28297, 28298, 28299, 28899	Correction Of Bunion
28289	Repair Hallux Rigidus
28300 Thru 28345	Osteotomy / Repair / Reconstruction
30400, 30410, 30420, 30430, 30435, 30450, 30460, 30465, 30468, 30520	Reconstruct Of Nose
30520	Repair Nasal Septum

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
32999	Chest Surgery Procedure
36299	Vessel Injection Procedure
36522	Photopheresis, extracorporeal
37700	Ligation And Division of Long Saphenous Vein at Saphenofemoral Junction, Or Distal Interruptions
37718	Ligation, Division, And Stripping, Short Saphenous Vein
37722	Ligation, Division, And Stripping, Long (Greater) Saphenous Veins from Saphenofemoral Junction to Knee or Below
37735	Ligation And Division And Complete Stripping of Long or Short Saphenous Veins With Radical Excision of Ulcer And Skin Graft And/or Interruption of Communicating Veins Of Lower Leg, With Excision of Deep Fascia
37760	Ligation of Perforator Veins, Subfascial, Radical (Linton Type) Including Skin Graft, When Performed, Open, 1 Leg
37761	Ligation of Perforator Vein(S), Subfascial, Open, Including Ultrasound Guidance, When Performed, 1 Leg
37765	Stab Phlebectomy Of Varicose Veins, 1 Extremity; 10-20 Stab Incisions
37766	More Than 20 Incisions
37780	Ligation and Division of Short Saphenous Vein at Saphenopopliteal Junction (Separate Procedure)
37785	Ligation, Division, And/or Excision Of Varicose Vein Cluster(S) 1 Leg
38205, 38206	Stem Cell Harvesting
38230	Bone Marrow Harvesting
36511	Therapeutic Apheresis Of WBC ‘s
36512	Therapeutic Apheresis Of RBCs
38204	Unrelated Harvesting Of Cells
38205	Stem Cell Harvesting From Siblings
38207	Stem Cell Storage
41899	Gum Surgery Procedure
43770	Laparoscopy, Surgical, Gastric Restrictive Procedure
43771	Laparoscopy, Surgical, Revision Of Adjust Gastric Band
43772	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43773	Laparoscopy, Surgical, Removal & Placement Of Adj Gastric Band
43774	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43775	Lap Sleeve Gastrectomy
43842	Gastroplasty, Vertical Banded, For Morbid Obesity
43843	Gastroplasty, Other Than Vertical-Banded, For Morbid Obesity
43845	Gastroplasty
43846	Gastric Bypass For Obesity
43847	Gastric Restrictive Procedure With Gastric Bypass

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
43848	Revision Of Gastric Restrictive
43886	Gastric Restrictive Procedure
43887	Gastric Restrictive Procedure, Removal Of Subcutaneous Port Component
43888	Gastric Restrictive Proc, Removal & Replacement Of Subcutaneous Port
43999	Stomach Surgery Procedure
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells transplantation of pancreas or pancreatic islet cells
49999	Abdomen Surgery Procedure
54161	Circumcision –TAR not required if patient < 4 months of age (See policy MCUP3121 Neonatal Circumcision)
54360	Penis Plastic Surgery
54400, 54406 - 54440	Penile Prosthesis / Plastic Procedure For Penis
55175/80	Revision Of Scrotum
55200	Incision Of Sperm Duct
56800	Repair Of Vagina
58150 Thru 58294, 58570	Hysterectomy
58350	Reopen Fallopian Tube
58550 Thru 58554	Laparoscopy, Surgical; With Vaginal Hysterectomy With Or Without Removal of Tube(s), With or Without Removal Of Ovary(ies) (Laparoscopic Assisted Vaginal Hysterectomy)
58578/79	Unlisted Procedure, Uterus
58999	Unlisted procedure, female genital system
61867, 61868, 61880, 61888, 64999	Insertion, Revision Or Removal Of Cranial Neurostimulator
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumber (e.g. manual or automated percutaneous discectomy,
62290, ~~thru~~ 62291	Discography, Lumbar (62290) and Cervical/Thoracic (62291)
63650, 63655, 63662, 63664, 63685~~,~~	Insertion or Revision of Spinal Neurostimulator
66987	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth complex
66988	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth
67900 Thru 67924	Repair Brow, Ptosis, Blepharoptosis, Lid
67950 Thru-66	Revision Of Eyelid
67971-75	Reconstruction Of Eyelid
67999	Unlisted Eyelid Procedure
69300	Revise External Ear
69399	Outer Ear Surgery Procedure
72285	Cervical and Thoracic Discography
72295	Lumbar discography

Pain Management CPTs Requiring TAR	
CPT Code	**Description**
22510, 22511, 22512, 22513, 22514, 22515	Percutaneous vertebroplasty and percutaneous vertebral augmentation
27096	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid
62263	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
~~62287~~	~~Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumber (e.g. manual or automated percutaneous discectomy, percutaneous laser discectomy)~~
62290, 62291	Discography, Lumbar (62290) and Cervical/Thoracic (62291)
62360, 62362	Implantable or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
63650, 63655, ~~63658,~~ ~~63661~~63662, ~~thru~~ 63664, 63685~~,~~ ~~63688~~	Insertion or revision of spinal neurostimulator
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
64480	Cervical or thoracic, each additional level
64483	Lumbar or sacral, single level
64484	Lumbar or sacral, each additional level
64490	Injection(s), diagnostic or therapeutic agent, Paravertebral facet (zygapophyseal) joint with image guidance (fluoroscopy or CT), cervical or thoracic; single level.
64491	Second level (List separately in addition to code for primary procedure)
64492	Third level (List separately in addition to code for primary procedure
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT, lumbar or sacral; single level)
64494	Second level (List separately in addition to code for primary procedure)
64495	Third level (List separately in addition to code for primary procedure)

64633	Destruction by neurolytic agent, paravertebral facet joint nerve. cervical or thoracic, single level
64634	Cervical or thoracic, each additional level
64635	Destruction by neurolytic agent, paravertebral facet joint nerve. single level lumbar or sacral
64636	Lumbar or sacral, each additional level
72285	Cervical and Thoracic Discography
72295	Lumbar discography

PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

A. **Acupuncture** *(see policy MCUG3002 Acupuncture Service Guidelines)*
A RAF is required for the first visit, and then members are limited to 2 visits per month. A TAR is required if services exceed two visits per month.

B. **Allergy Injections** – A TAR is required when services exceed Medi-Cal frequency limit of eight (8) allergy injections in any 120-day period for code 95115 or four (4) allergy injections in any 120-day period for code 95117. (For codes 95115 and/or 95117 in any combination, a maximum of eight (8) allergy injections in any 120-day period is reimbursable to any provider for the same recipient without authorization.)

C. **Cardiac Rehabilitation** – Phase II and pediatric *(see policy MCUP3128 Cardiac Rehabilitation)*

D. **Chiropractic Services** *(see policy MCUG3010 Chiropractic Services)*
A RAF is required for the first visit, and then members are limited to 2 visits per month. A TAR is required if services exceed two visits per month.

E. **Community Health Worker (CHW) Services** *(see policy MCCP2033 Community Health Worker (CHW) Services Benefit)* Partnership does not require prior authorization for CHW services as preventive care for the first 12 units. A TAR is required for Members who need multiple CHW services or continued CHW services in excess of 12 units.

F. **Community Supports** A TAR is required for all members receiving a Community Supports service. *[see policies MCUP3142 CalAIM Community Supports (CS) and MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)]*

G. **Dental Anesthesia** *(see policy MPUP3048 Dental Services (including Dental Anesthesia)*

H. **Diagnostic Studies**
1. CT Scans: TARs are required for all CT scans for Members under age 21 years. For adults age 21 years and older, TARs are required for CT scans of the chest, abdomen, and/or pelvis. *No TARs are required for other CT scans of the extremities, head, neck, or spine, for CT angiograms, or for screening CT colonograms - effective 7/1/2024*
2. MRI: TARs are required for all MRIs for Members under age 21 years. For adults age 21 years and older, TARs are required for MRIs of the chest (including Cardiac MRI 05561), abdomen, and/or pelvis. *No TARs are required for other MRI scans of the extremities, head, neck, or spine, for MR elastography, or for breast MRIs - effective 7/1/2024*
3. MRA (MR Angiogram)
4. MSI
5. MEG
6. PET scan *[see policy MPUP3116 Positron Emission Tomography Scans (PET Scans)]*
7. Transcranial Doppler
8. Sleep Studies / Polysomnography: Facility based sleep studies/polysomnography always require a TAR. Home based studies/polysomnography require a TAR when more than 1 per year is requested. *(see policy MCUG3110 Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal)*
9. Non-specific radiology codes for X-rays and ultrasound including 76497, 76380, 76506

I. **Doula Services** *(see policy MCNP9006 Doula Services Benefit*) While most doula services are provided with no TAR requirement, please refer to the policy for details on when a TAR may be required for additional visits (beyond eight) during the postpartum period.

J. **Durable Medical Equipment (DME) Supplies** – *(see policy MCUP3013 DME Authorization*)
1. Orthotics – Cumulative costs for repair/maintenance or purchase exceeds $250 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines*)

2. Prosthetics – Cumulative costs for repair / maintenance or purchase exceeds $500 / item (*see policy MCUG3032 Orthotic and Prosthetic Appliances Guidelines).* ***Also any unlisted / miscellaneous code and any custom made item that does not have a Medi-Cal rate (by-report or by-invoice)***
3. Hearing Aids and Cochlear Implant Replacement Supplies – (*see policy MCUG3019 Hearing Aid Guidelines*)
4. Repairs or maintenance over $250.00 / item - (Out of guarantee repairs are to be guaranteed for at LEAST three (3) months from the date of repair. Reimbursement will NOT be allowed for parts or labor during a guarantee period if due to a defect in material or workmanship)
5. Oxygen and related supplies
6. Positive Airway Pressure (PAP) devices - No TAR is required for PAP supplies for a PAP machine owned by the member (as per Medi-Cal guidelines for ordering/quantity limits).
7. Purchase items when the cumulative cost of items within a group exceeds $100.00 within the calendar month. Providers may refer to the *Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates* section in the Medi-Cal manual to determine if items are related within a group. Items grouped together under specific headings, such as "Hospital Beds" or "Bathroom Equipment," are considered within the same group. (Vendor to guarantee for a MINIMUM of six (6) months from the date of purchase)
8. Rental items when the cumulative cost of rental for items within the group exceeds $50.00 within a 15-month period. This includes any daily amount that an individual item, or a combination of a similar group of DME items, exceeds the $50 threshold. The 15-month period begins on the date the first item is rented. (Rental rate includes equipment related supplies.)
9. Purchase of any wheelchairs for Medi-Medi members
10. Purchase of knee scooters with appropriate criteria met, Invoice is required and maximum payable benefit amount is $200. *(see policy MCUP3013 DME Authorization*)
9. Incontinence Supplies *(see policy MCUG3022 Incontinence Guidelines*)
    a. Note that codes A4335 for skin wash and A4665 for skin cream for members with incontinence do not require a TAR unless claim quantity exceeds normal frequency limits. However, providers are encouraged to include these items on the incontinence supply TAR as the authorization will be good for one year and the provider will be able to submit claims electronically without attaching the prescription each month. If these items are not included on the incontinence supply TAR, then the provider must submit a paper claim and attach a prescription form with each submission.

K. **Enhanced Care Management (ECM)** A TAR is required for all members receiving the ECM Benefit. *[see policies MCCP2032 CalAIM Enhanced Care Management (ECM) and MCUP3143 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)]*

L. **EPSDT** (Early and Periodic Screening, Diagnosis and Treatment) Supplemental Services (*see policy MCCP2022 Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services)*

M. **Fecal Microbiota Transplant (FMT)** A TAR is required for all procedures related to fecal microbiota transplant. *(see policy MCUP3136 Fecal Microbiota Transplant)*

N. **Gender Dysphoria** – A TAR is required for all procedures related to gender dysphoria. *(see policy MCUP3125 Gender Dysphoria/ Surgical Treatment)*

O. **Genetic Testing and Screening** – A TAR is required for certain genetic testing and screening as outlined in Attachment A of policy *MCUP3131 Genetic Screening and Diagnostics*

P. **Home Health Care** *(see policy MCUG3011 Criteria for Home Health Services)*

Q. **Home Infusion Therapy**

R. **Hysterectomy**

S. **Hospice Care (Inpatient Only)** *(see policy MCUP3020 Hospice Service Guidelines*)

T. **Hospitalization**
1. The hospital must notify Partnership of any admission within 24 hours of the admission.
2. Authorization for elective admission must be requested by the admitting physician prior to the admission.

U. **Hyperbaric Oxygen Pressurization**

V. **Long Term Care**
The LTC facilities must notify Partnership of any admissions, transfer, bed hold/ leave of absence, or change in payor status within one working day. (Examples include Medicare non-coverage or exhaustion of benefits/ hospice election.) *See policy MCUG3038 Review Guidelines for Member Placement in Long Term Care (LTC) Facilities.*

W. **Medical Supplies***
1. Nebulizers – When the billed price including tax is $200 or more *(see policy MPUG3031 Nebulizer Guidelines*)
2. Ostomy Supplies+ (Note: NU modifier may not be used for "disposable" ostomy supplies)
3. Urological Supplies+ (Note: NU modifier may not be used for "disposable" urological supplies)
4. Tracheostomy Supplies+
5. Wound Care Supplies+ TAR requirements may vary.
6. Negative Pressure Wound Therapy Devices [*see policy MPUP3059 Negative Pressure Wound Therapy (NPWT) Device/Pump]*
7. Nutritional Supplements - *(see policy MCUP3052 Medical Nutrition Services*) Physician administered nutritional supplements require a TAR to be submitted to Partnership when the item is billed to Partnership's medical benefit and is not included in Partnership's Medical Drug List (MDL) Navigator, or when the Partnership MDL indicates a prior authorization is required. Nutritional supplements provided by a Pharmacy must be submitted through Medi-Cal Rx TAR processes* when not on the Medi-Cal Rx Contract Drugs List (CDL). Enteral formulas require a Medi-Cal Rx TAR when provided by a pharmacy.

***Note:** *Effective January 1, 2022, with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 Revised. TARs will be operationally denied if submitted to Partnership for supplies which are carved out from managed care reimbursement and are only provided through Medi-Cal Rx as Pharmacy claims. See Medi-Cal Rx Provider Manual for covered medical supplies and limits. Supplies that can only be billed to Medi-Cal Rx include Insulin Syringes, Pen needles, Lancets, Diabetic Test Strips, Peak Flow Meters, and Inhaler Assistive Devices.*
+ **Note**: *For detailed information regarding Medi-Cal frequency limits and TAR requirements for ostomy, urological, tracheostomy and wound care supplies, please reference Medi-Cal Provider Manual/ Guidelines section Medical Supplies Billing Codes, Units and Quantity Limits*

X. **Medications Provided by a Pharmacy:** Effective January 1, 2022 with the implementation of Medi-Cal Rx, the pharmacy benefit is carved-out to Medi-Cal Fee-For-Service as described in APL 22-012 *Revised* and all medications (Rx and OTC) which are provided by a pharmacy must be billed to State Medi-Cal/DHCS contracted pharmacy administrator instead of Partnership.

Y. **Medications Administered in a Medical Setting, and Billed as a Medical Claim [Physician Administered Drugs (PADs) given in an outpatient clinic, office, dialysis center, hospital]:**

Partnership requires a TAR for certain prescription drugs, over-the-counter drugs and injectable drugs (including drugs compounded for IV infusion therapy) as outlined in policy *MCRP4068 Medical Benefit Medication TAR Policy*.

Z. **Non-Emergency Medical Transportation:** [*see policy MCCP2016 Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)*]

AA. **Occupational Therapy** *(see policy MCUP3114 Physical, Occupational and Speech Therapies)*
- Partnership Members under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
  Note: *No TAR is required for Members age 21 and over up to 12 visits (limit one visit per day) for OT services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
- A TAR is required for all OT services provided as Home Health or by Non-contracted Providers

BB. **Outpatient Hemo / Peritoneal Dialysis** Initial authorization will be limited to 90 days and a lifetime authorization may be granted with annual certification, only after submission of Medicare determination.)

CC. **Outpatient Surgical Procedures** – see **CPTs Requiring TAR** list (page 5)

DD. **Pain Management** – see **Pain Management CPTs Requiring TAR** list (page 8) and policy *MCUP3049 Pain Management Specialty Services*

EE. **Phototherapy** for dermatological condition

FF. **Physical Therapy** *(see policy MCUP3114 Physical, Occupational and Speech Therapies)*
- Partnership Members under age 21 can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
  Note: *No TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) for PT services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
- A TAR is required for all PT services provided as Home Health or by Non-contracted Providers

GG. **Pulmonary Rehabilitation** *(see policy MCUP3111 Pulmonary Rehabilitation)*

HH. **Speech Therapy** *(see policy MCUP3114 Physical, Occupational and Speech Therapies)*
- Partnership members age 21 and over can be referred by a licensed clinician for one consultation visit through a physician order. Partnership's referral authorization system need not be used. Following the initial evaluation, the service provider must submit a TAR for the requested services.
  Note: *No TAR is required for Members age 21 and over for up to 12 visits (limit one visit per day) for ST services in a rolling 12-month period. (A TAR will be required for services in excess of 12 visits.)*
- A TAR is required for all ST services provided as Home Health or by Non-contracted Providers

II. **Transplants** (*see policy MCUP3104 Transplant Authorization Process)*

JJ. **ANY UNLISTED OR MISCELLANEOUS CODE**

HCPCS Codes	Description
P9020	Platelet rich plasma unit

HCPCS Codes	Description
V2531	Contact Lens, Scleral, Gas Permeable, Per Lens
C9757	Spine/Lumbar Surgery

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
10040	Acne Surgery
15769	Graft of Autologous Soft Tissue, Other, Direct Excision
15771	Graft of Autologous Fat Harvested by Liposuction; 50cc or less injectate
15772	Graft of Autologous Fat Harvested by Liposuction; each additional 50cc
15773	Graft of Autologous Fat Harvested by Liposuction; 25cc or less injectate
15774	Graft of Autologous Fat Harvested by Liposuction; each additional 25cc
15788 Thru 15793	Chemical Peel, Facial Et Al
15820 Thru 15823	Revision Of Lower Or Upper Eyelid
15845	Skin And Muscle Repair, Face
17360	Skin Peel Therapy
17999	Skin Tissue Procedure
19300	Mastectomy For Gynecomastia
19316	Mastopexy
19318	Reduction Mammoplasty
19324/25	Breast Augment; W/O Prosthetic Implant
19499	Correction Of Inverted Nipples
19380	Revise Breast Reconstruction
19396	Design Custom Breast Implant
19499	Unlisted Procedure, Breast
20999	Musculoskeletal Surgery
21208	Augmentation Of Facial Bones
22899	Spine Surgery Procedure
22999	Abdomen Surgery Procedure
28292, 28296, 28297, 28298, 28299, 28899	Correction Of Bunion
28289	Repair Hallux Rigidus
28300 Thru 28345	Osteotomy / Repair / Reconstruction
30400, 30410, 30420, 30430, 30435, 30450, 30460, 30465, 30468, 30520	Reconstruct Of Nose
30520	Repair Nasal Septum
32999	Chest Surgery Procedure
36299	Vessel Injection Procedure
36522	Photopheresis, extracorporeal

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
37700	Ligation And Division of Long Saphenous Vein at Saphenofemoral Junction, Or Distal Interruptions
37718	Ligation, Division, And Stripping, Short Saphenous Vein
37722	Ligation, Division, And Stripping, Long (Greater) Saphenous Veins from Saphenofemoral Junction to Knee or Below
37735	Ligation And Division And Complete Stripping of Long or Short Saphenous Veins With Radical Excision of Ulcer And Skin Graft And/or Interruption of Communicating Veins Of Lower Leg, With Excision of Deep Fascia
37760	Ligation of Perforator Veins, Subfascial, Radical (Linton Type) Including Skin Graft, When Performed, Open, 1 Leg
37761	Ligation of Perforator Vein(S), Subfascial, Open, Including Ultrasound Guidance, When Performed, 1 Leg
37765	Stab Phlebectomy Of Varicose Veins, 1 Extremity; 10-20 Stab Incisions
37766	More Than 20 Incisions
37780	Ligation and Division of Short Saphenous Vein at Saphenopopliteal Junction (Separate Procedure)
37785	Ligation, Division, And/or Excision Of Varicose Vein Cluster(S) 1 Leg
38205, 38206	Stem Cell Harvesting
38230	Bone Marrow Harvesting
36511	Therapeutic Apheresis Of WBC ‘s
36512	Therapeutic Apheresis Of RBCs
38204	Unrelated Harvesting Of Cells
38205	Stem Cell Harvesting From Siblings
38207	Stem Cell Storage
41899	Gum Surgery Procedure
43770	Laparoscopy, Surgical, Gastric Restrictive Procedure
43771	Laparoscopy, Surgical, Revision Of Adjust Gastric Band
43772	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43773	Laparoscopy, Surgical, Removal & Placement Of Adj Gastric Band
43774	Laparoscopy, Surgical, Removal Of Adjustable Gastric Band
43775	Lap Sleeve Gastrectomy
43842	Gastroplasty, Vertical Banded, For Morbid Obesity
43843	Gastroplasty, Other Than Vertical-Banded, For Morbid Obesity
43845	Gastroplasty
43846	Gastric Bypass For Obesity
43847	Gastric Restrictive Procedure With Gastric Bypass
43848	Revision Of Gastric Restrictive
43886	Gastric Restrictive Procedure
43887	Gastric Restrictive Procedure, Removal Of Subcutaneous Port Component
43888	Gastric Restrictive Proc, Removal & Replacement Of Subcutaneous Port

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	**Description**
43999	Stomach Surgery Procedure
48160	Pancreatectomy, total or subtotal, with autologous transplantation of pancreas or pancreatic islet cells transplantation of pancreas or pancreatic islet cells
49999	Abdomen Surgery Procedure
54161	Circumcision –TAR not required if patient < 4 months of age (See policy MCUP3121 Neonatal Circumcision)
54360	Penis Plastic Surgery
54400, 54406 - 54440	Penile Prosthesis / Plastic Procedure For Penis
55175/80	Revision Of Scrotum
55200	Incision Of Sperm Duct
56800	Repair Of Vagina
58150 Thru 58294, 58570	Hysterectomy
58350	Reopen Fallopian Tube
58550 Thru 58554	Laparoscopy, Surgical; With Vaginal Hysterectomy With Or Without Removal of Tube(s), With or Without Removal Of Ovary(ies) (Laparoscopic Assisted Vaginal Hysterectomy)
58578/79	Unlisted Procedure, Uterus
58999	Unlisted procedure, female genital system
61867, 61868, 61880, 61888, 64999	Insertion, Revision Or Removal Of Cranial Neurostimulator
62287	Aspiration or decompression procedure, percutaneous, of nucleus pulposus of intervertebral disk, any method, single or multiple levels, lumber (e.g. manual or automated percutaneous discectomy,
62290, 62291	Discography, Lumbar (62290) and Cervical/Thoracic (62291)
63650, 63655, 63662, 63664, 63685	Insertion or Revision of Spinal Neurostimulator
66987	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth complex
66988	Extracapsular Cataract Removal W/ Insertion Of Intraocular Lens Prosth
67900 Thru 67924	Repair Brow, Ptosis, Blepharoptosis, Lid
67950 Thru-66	Revision Of Eyelid
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67999	Unlisted Eyelid Procedure
69300	Revise External Ear
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72285	Cervical and Thoracic Discography
72295	Lumbar discography

Pain Management CPTs Requiring TAR

CPT Code	Description
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27096	Injection procedure for sacroiliac joint, arthrography and/or anesthetic/steroid
62263	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 2 or more days
62264	Percutaneous lysis of epidural adhesions using solution injection (e.g., hypertonic saline, enzyme) or mechanical means (e.g., catheter) including radiological localization (includes contrast when administered), multiple adhesiolysis sessions; 1 day
62290, 62291	Discography, Lumbar (62290) and Cervical/Thoracic (62291)
62360, 62362	Implantable or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
63650, 63655, 63662, 63664, 63685	Insertion or revision of spinal neurostimulator
64479	Injection(s), anesthetic agent and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT); cervical or thoracic, single level
64480	Cervical or thoracic, each additional level
64483	Lumbar or sacral, single level
64484	Lumbar or sacral, each additional level
64490	Injection(s), diagnostic or therapeutic agent, Paravertebral facet (zygapophyseal) joint with image guidance (fluoroscopy or CT), cervical or thoracic; single level.
64491	Second level (List separately in addition to code for primary procedure)
64492	Third level (List separately in addition to code for primary procedure
64493	Injection(s), diagnostic or therapeutic agent, paravertebral facet (zygapophyseal) joint (or nerves innervating that joint) with image guidance (fluoroscopy or CT, lumbar or sacral; single level)
64494	Second level (List separately in addition to code for primary procedure)
64495	Third level (List separately in addition to code for primary procedure)
64633	Destruction by neurolytic agent, paravertebral facet joint nerve. cervical or thoracic, single level
64634	Cervical or thoracic, each additional level
64635	Destruction by neurolytic agent, paravertebral facet joint nerve. single level lumbar or sacral
64636	Lumbar or sacral, each additional level
72285	Cervical and Thoracic Discography
72295	Lumbar discography

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Medical Necessity Criteria for Pain Management Procedures

22510, 22511, 22512, 22513, 22514, ~~–~~ 22515 Percutaneous vertebroplasty and percutaneous vertebral augmentation	**InterQual® criteria followed.** **Subset:** *Vertebroplasty or Kyphoplasty* **Exception(s) to InterQual criteria:** None Well-controlled study shows no benefit over placebo for longstanding vertebral fractures/pain. (Reference: Treatment of Symptomatic Osteoporotic Spinal Compression Fractures, *Journal of the American Academy of Orthopedic Surgeons*, March 2011; Spine J. 2012 Nov; 12(11): 998-1005)
27096 SI joint injection	**InterQual® criteria followed.** **Subset:** *Sacroiliac (SI) Joint Injection* **Exception(s) to InterQual criteria:** • Imaging to confirm sacroiliac joint disease is not required
62263, 62264 Percutaneous lysis of epidural adhesions	**Requests are reviewed on a case-by-case basis** upon review of clinical information provided.
62290, ~~to~~ 62291 Discography, Lumbar and Cervical	**InterQual® criteria followed.** **Subset:** *Discography, Spine, Lumbar* InterQual criteria shows limited evidence to support this procedure.
62360, ~~to~~ 62362 Implantable or replacement device for intrathecal or epidural drug infusion; subcutaneous reservoir	**InterQual® criteria followed.** **Subset:** *Epidural or Intrathecal Catheter Placement* **Exception(s) to InterQual criteria:** • Physician review required
63650, 63655, ~~63661~~ 63662, ~~-~~63664, 63685 **~~, 63688~~** Insertion, revision, or removal of spinal neurostimulator	**InterQual® criteria followed.** **Subset:** *Spinal Cord Stimulator (SCS) Insertion* **Exception(s) to InterQual criteria:** None **Note:** Revisions/Replacements may be considered when the Elective Replacement Indicator (ERI) reflects that replacement is required in ≤ 6 months.

64479, 64480, 64483, 64484 Transforaminal epidural injection	**InterQual® criteria followed.** **Subset:** *Epidural Steroid Injection* **Exception(s) to InterQual criteria:** 1. A minimum of 30 days conservative treatment is required before eligible for epidural steroid injection. 2. TFESI may be considered for cervical radicular pain with nerve root impingement confirmed by imaging or testing. 3. Repeat injections require a minimum of 50% improvement in pain symptoms lasting a minimum of 8 weeks from previous injection. 4. The interval between injections per site must be no more frequent than every 3 months, and the maximum number of injections per site is 3 per year.
64490, 64491, 64492, 64493, 64494, ~~to~~ 64495 Paravertebral facet injections and medial branch blocks	**InterQual® criteria followed.** **Subset:** *Facet Joint Injection* **Exception(s) to InterQual criteria:** 1. The progress note should document a physical examination of the back, including pain elicited with movement. 2. Trial of physical therapy & NSAIDS/ acetaminophen is not required. 3. Imaging required only to rule out nerve root impingement for any radicular complaints. 4. No more than 3 levels will be approved, either 3 levels unilaterally or 3 levels bilaterally.
64633, 64634, 64635, ~~to~~ 64636 Destruction by neurolytic agent, paravertebral facet joint	**InterQual® criteria followed.** **Subset:** *Neuroablation, Percutaneous* **Exception(s) to InterQual criteria:** None
72285, 72295 Cervical, Thoracic, Lumbar discography	*Same as 62290 and 62291 above.* **InterQual® criteria followed.** **Subset:** *Discography, Spine, Lumbar* InterQual criteria shows limited evidence to support this procedure.

Health Equity Health Grand Analysis

Mohamed Jalloh, PharmD

Dorian Roberts

October 2024

About Us

Mission:

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

Vision:

To be the most highly regarded managed care plan in California.

Region and Other Definitions

Measurement Year: 2023

Number of Counties: 14

NW = Del Norte & Humboldt

NE = Modoc, Lassen, Siskiyou, Shasta & Trinity Counties

SW = Lake, Marin, Mendocino & Sonoma

SE = Solano, Napa, Yolo

 Statistically Performed Worse

 Statistically Performed Better

Methodology

Received HEDIS Measure Data

Submission to Health Analytics Team

Evaluation by HEO/QI Team

Evaluation Methodology for HEDIS Data

Statistical Difference to Comparator

Regions below MPL (50th Percentile)

Regions below 25th percentile

Reviewed HEA Quality Measures vs Full MCAS Spectrum

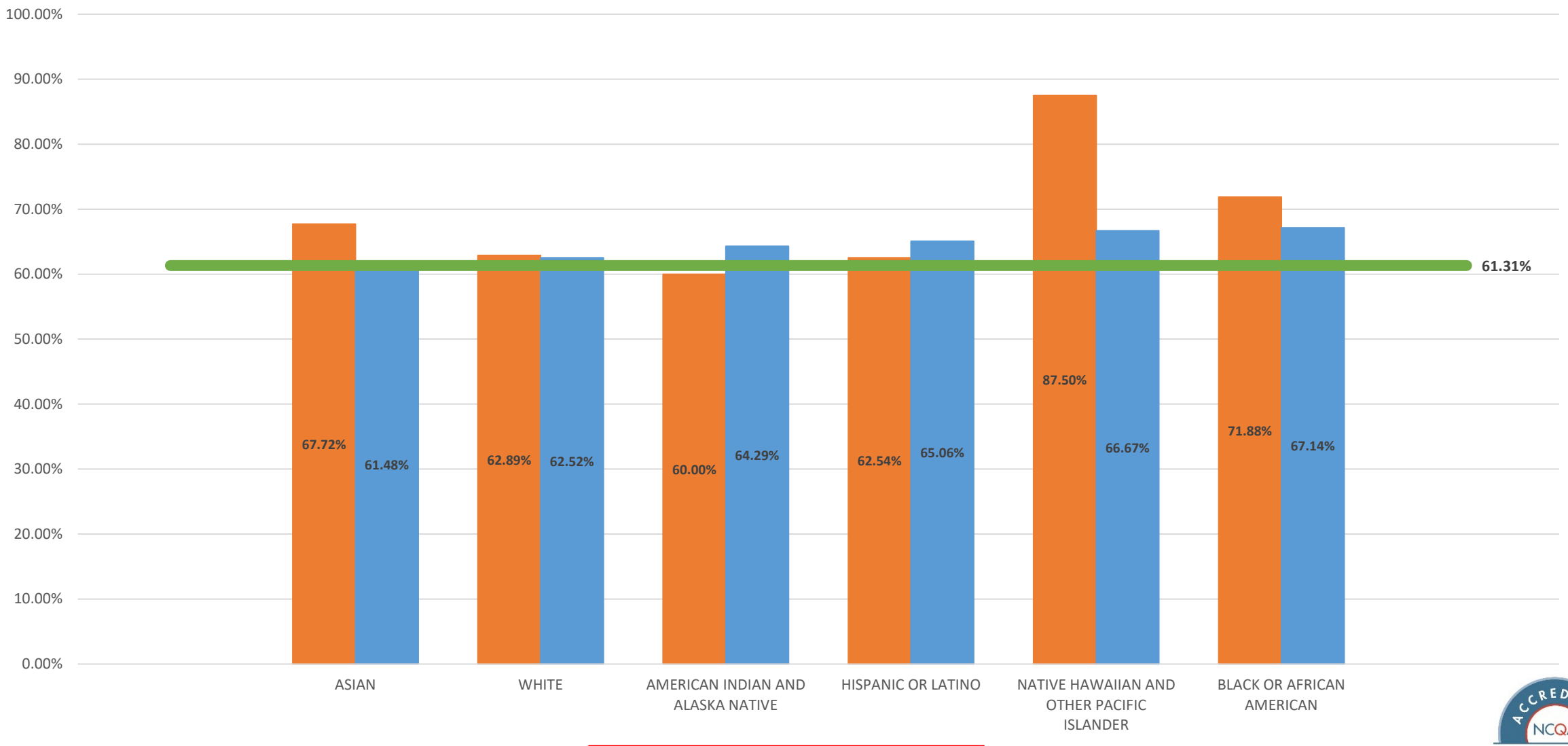
Evaluation with Race/Ethnicity***

Group Specific Inequity Definition (Strong Disparity)

(A) Meets at least three of following factors:

- ❑ Group is performing statistically worse in at least one region when compared to the comparator group
- ❑ Absolute Average Percentage deficit between group and minimum percentile level is at least 15% (multiple regions) or 20% in single region
- ❑ Multiple regions (≥2) where specific group falls below 25th percentile per MCAS measure

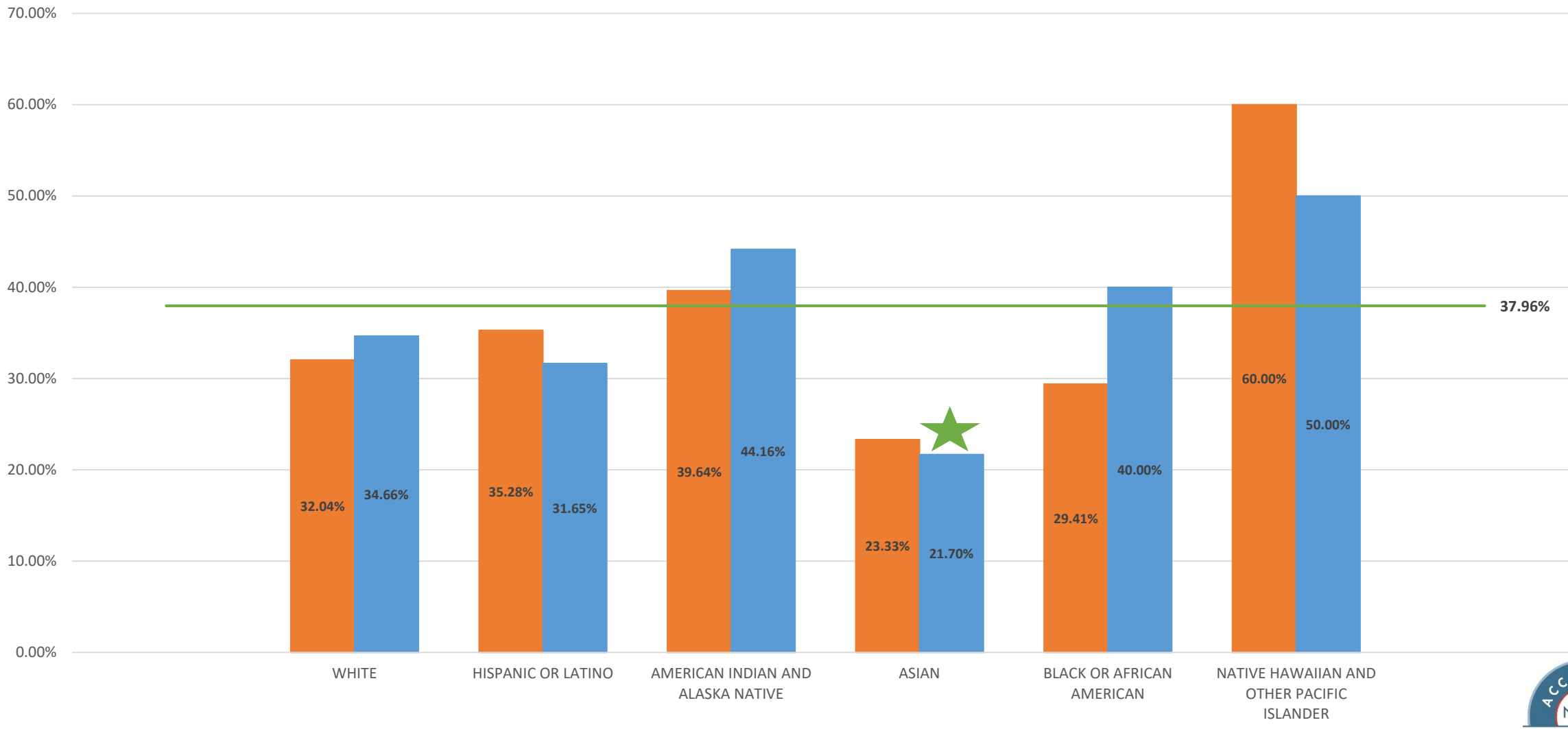
Controlling High Blood Pressure



Controlling Blood Pressure

- All Race/Ethnicity groups met **MPL threshold** of at least 61% control
- **Hispanic/Latino** and **American Indian/Alaska** Native community had marginal (<5%) increase in blood pressure control
  - AI/AN above threshold in both NE/NW regions
- **Asian, Black, and Native Hawaiian/Pacific Islander** communities trending downward

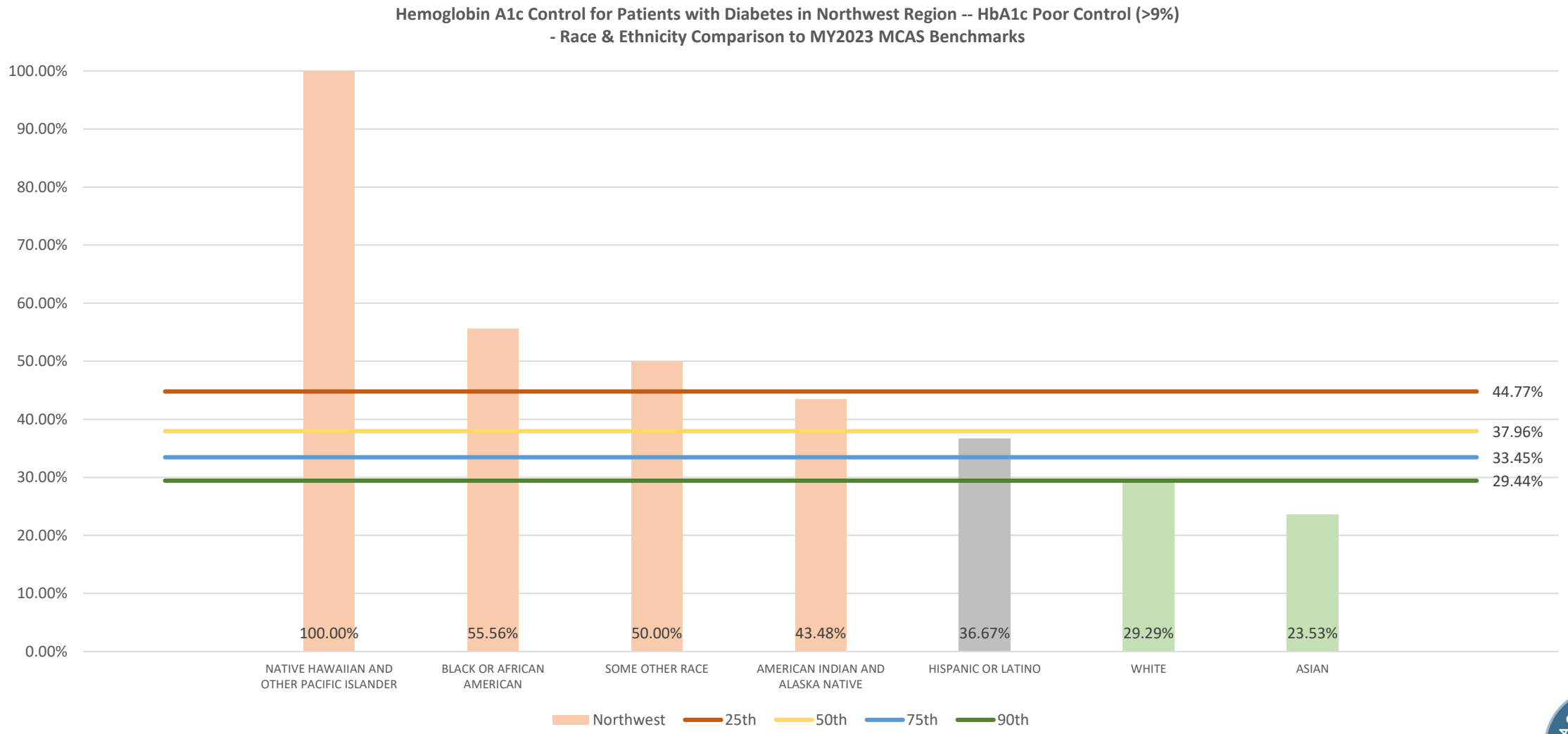
Poor Hemoglobin Control (>9%)



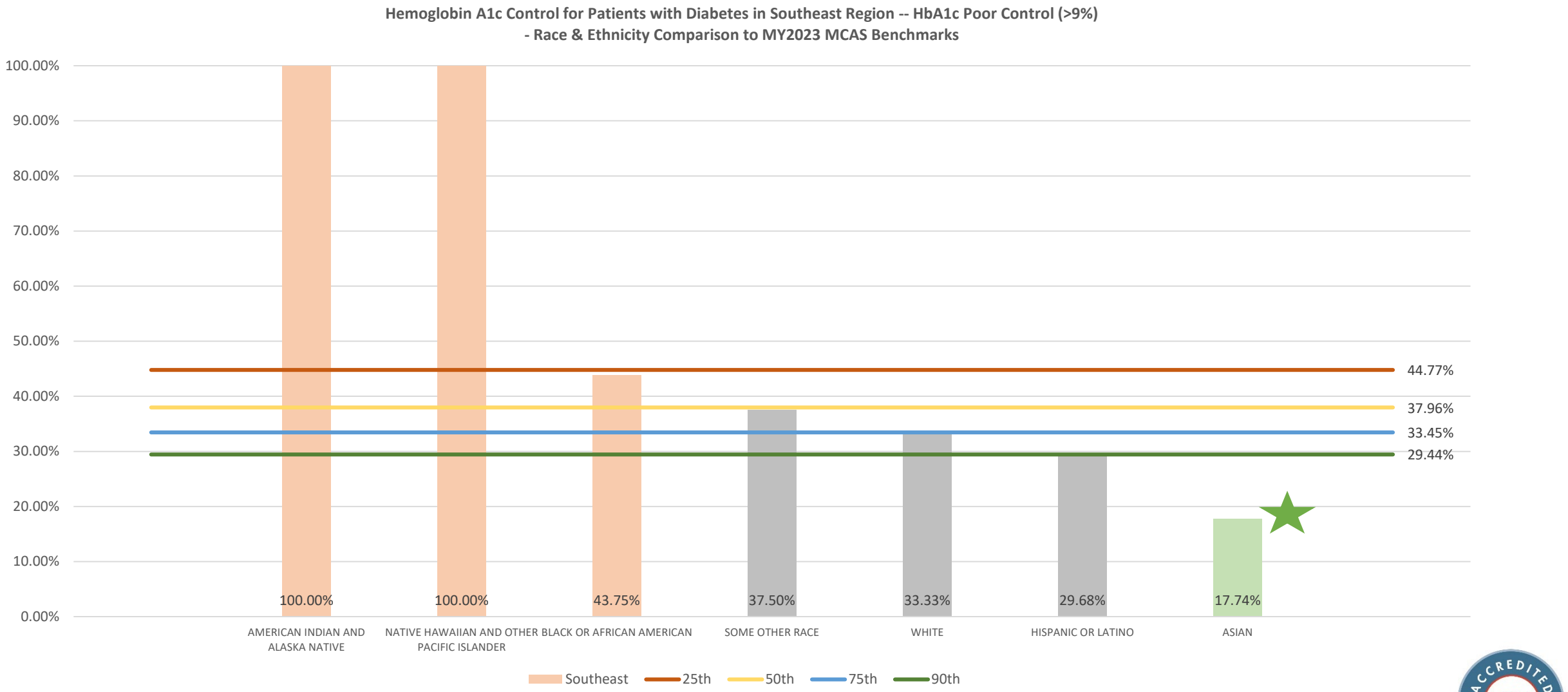
Poor Hemoglobin Control (>9%)

- **Asian Community** lowest and had slight improvement. Followed by Hispanic/Latino and White communities
- **American Indian/Alaska Native and Black** communities trending toward poorer control
- **Native Hawaiian** and other **Pacific islander** communities trending toward improved control

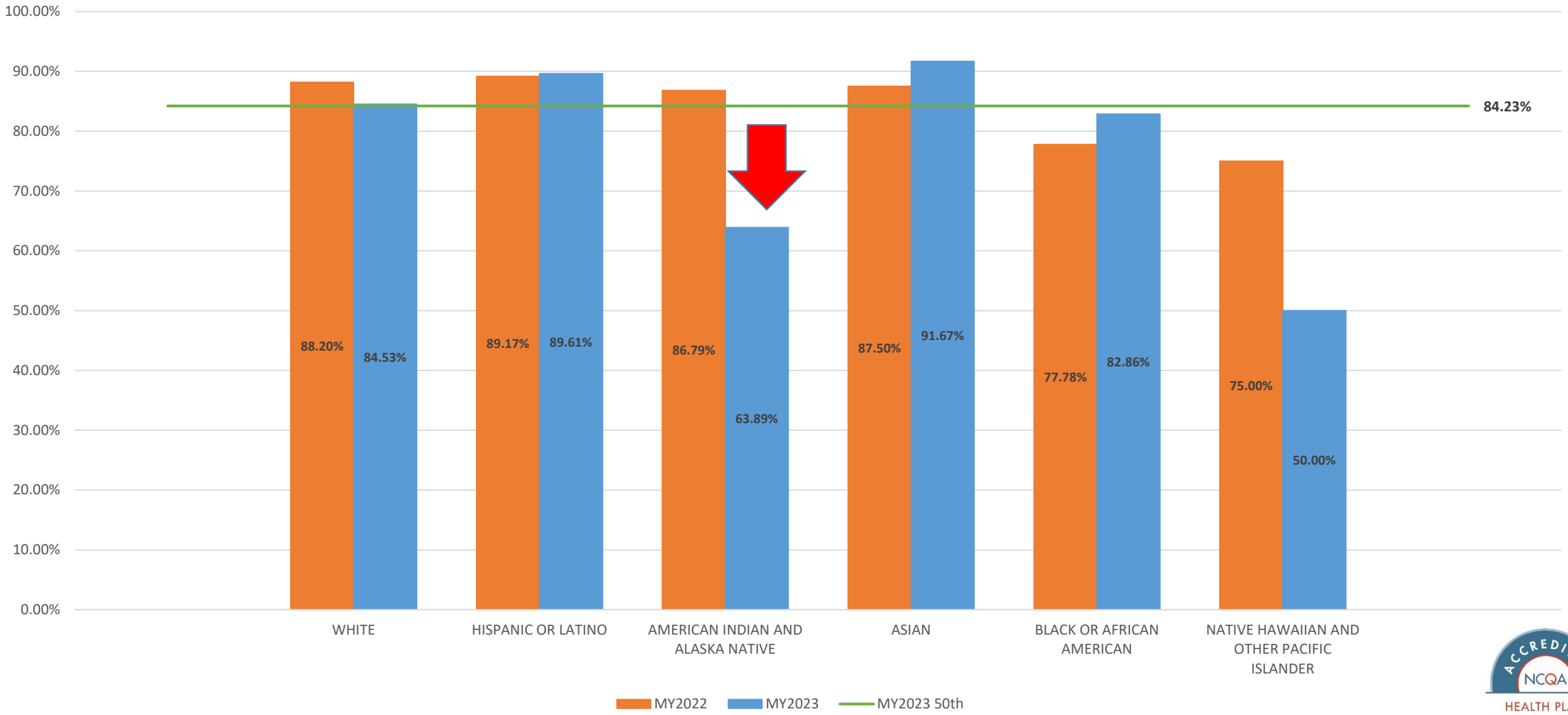
Northwest Region Findings



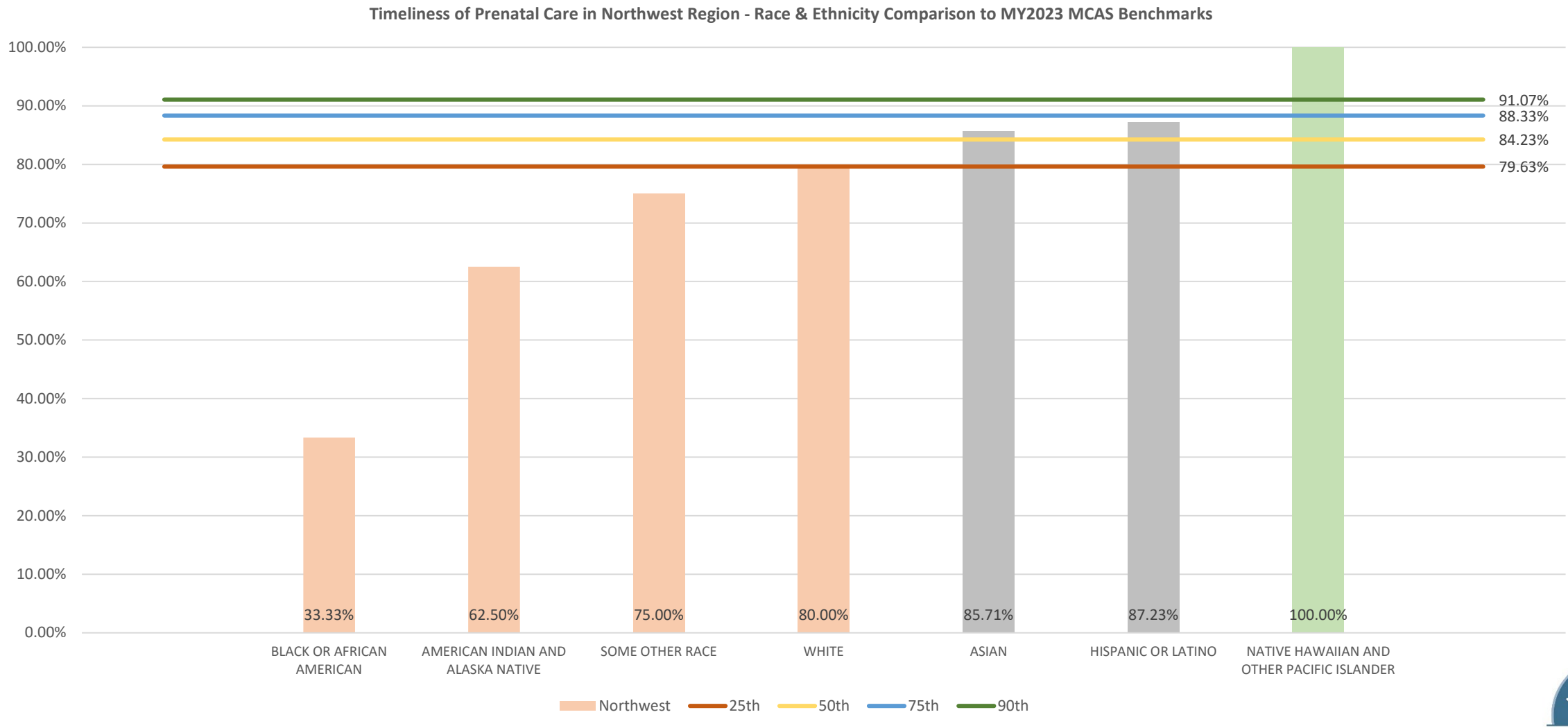
Southeast Region Findings



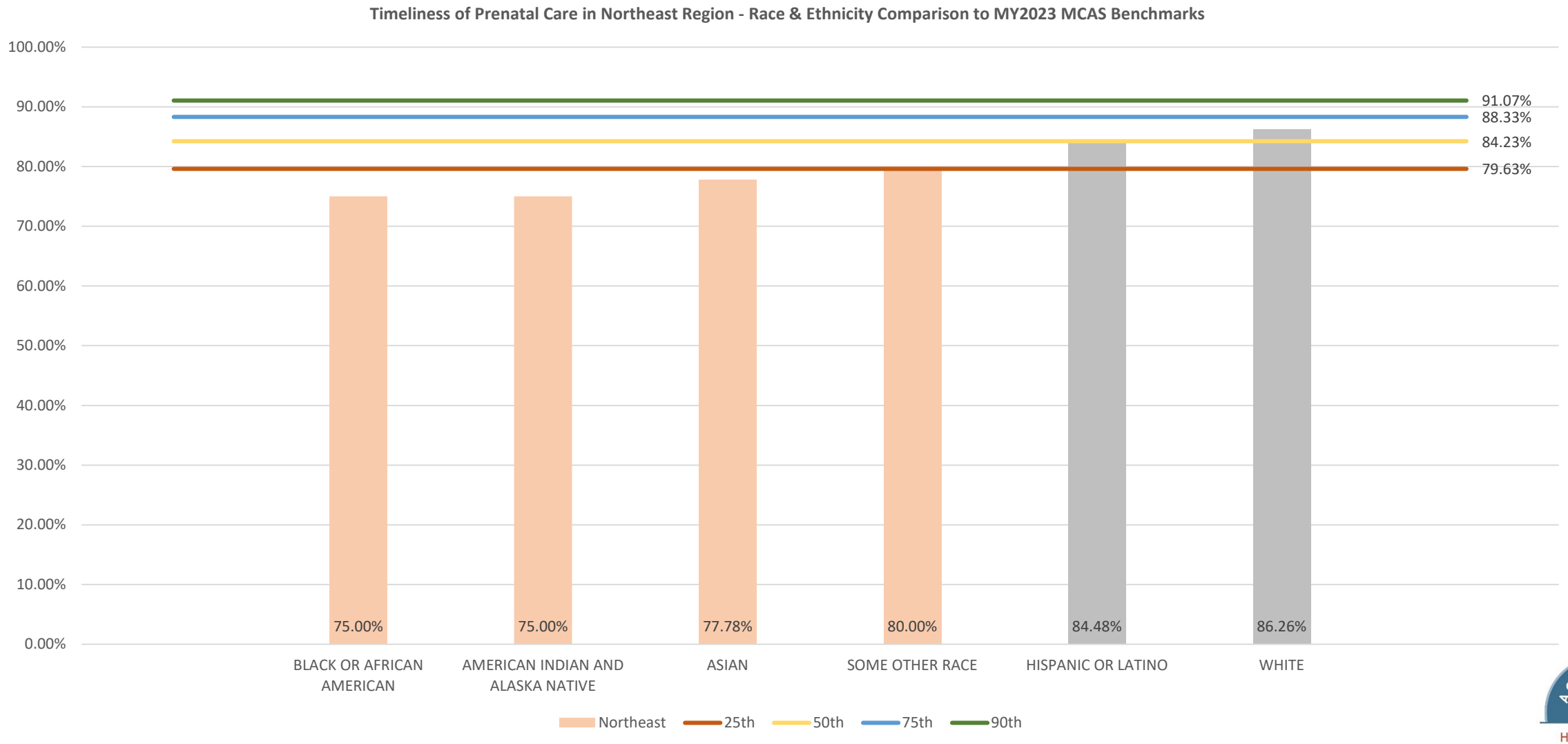
Timeliness of Prenatal Care



Northwest Region Findings



Northeast Region Findings



American Indian/Alaska Native Prenatal Care

Strong Disparity

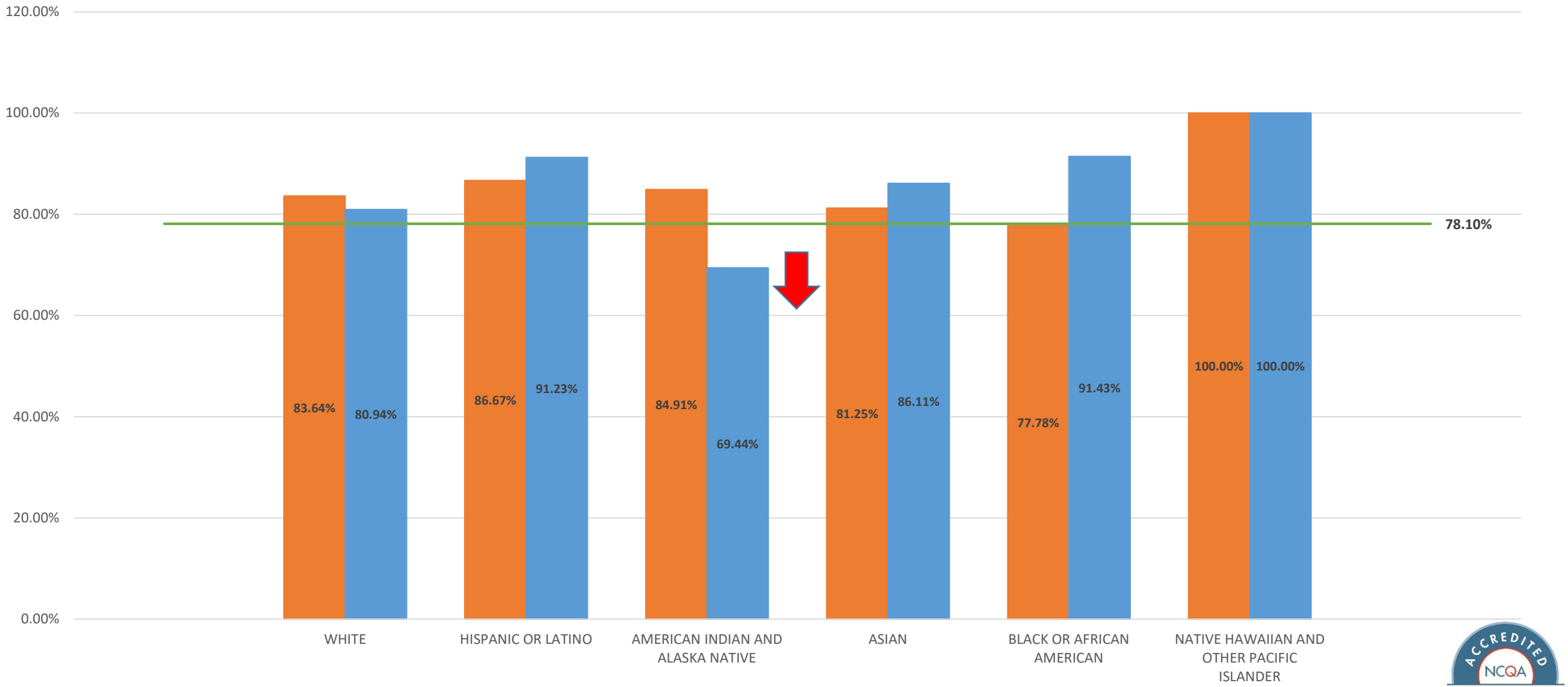
- **DHCS Bold Goal:** Yes
- **MCAS Eligible Sanction:** Yes
- **HEA Measure:** Yes
- **Statistical Significance :** Statistical Difference in SW Region
- **Clinical Significance:** Yes
  - 3 Regions below 25th Percentile (NE, NW, SW)
  - Average % Below MPL : 21.78%
- **Potential Goal: Increase Prenatal Care Visit by 9% in NE region, 21% in NW region, and 34% SW region to have all regions achieve 50th percentile in 12 to 24 months**

Black Prenatal Care

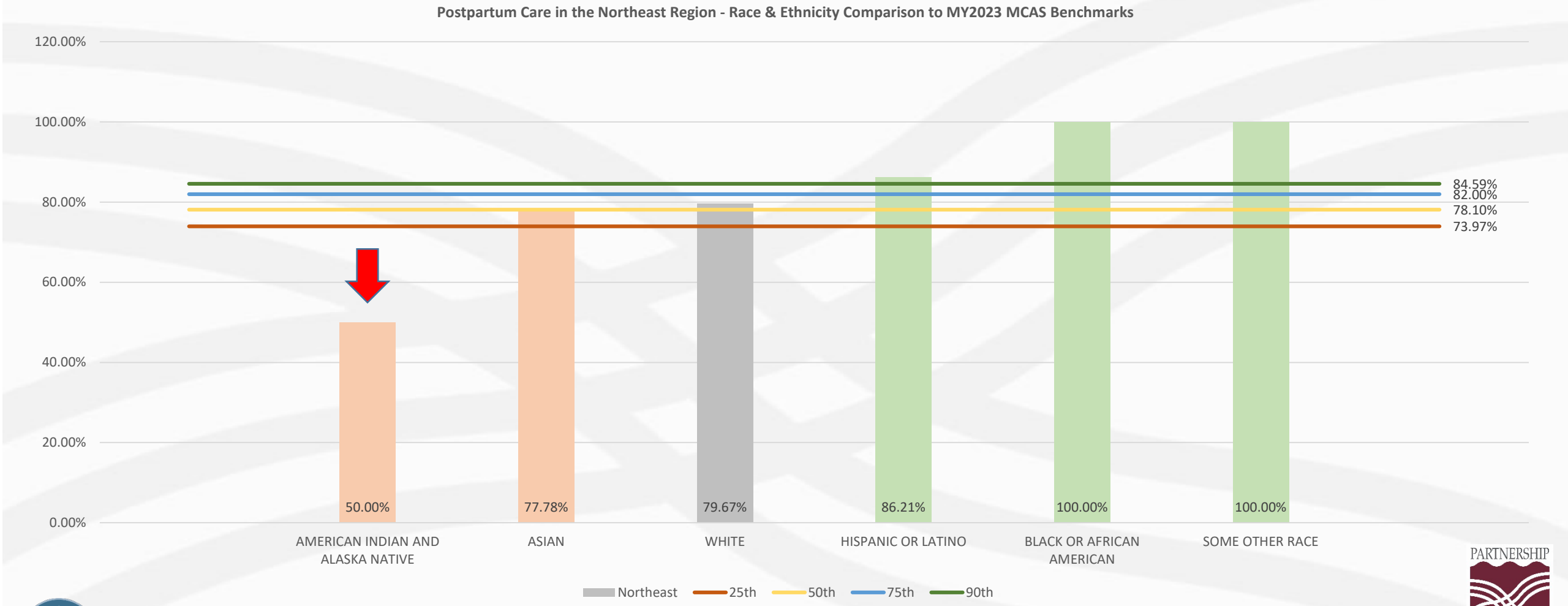
Strong Disparity

- **DHCS Bold Goal:** Yes
- **MCAS Eligible Sanction:** Yes
- **HEA Measure:** Yes
- **Statistical Significance :** None
- **Clinical Significance:** No
  - 2 regions below 25th Percentile (NE, NW) → Low Sample
  - Average % Below MPL = 30.1%
- **Potential Goal: Increase Prenatal Care Visit by 5% in NE region and 37% in NW region to have all regions achieve 50th percentile in 12 to 24 months**

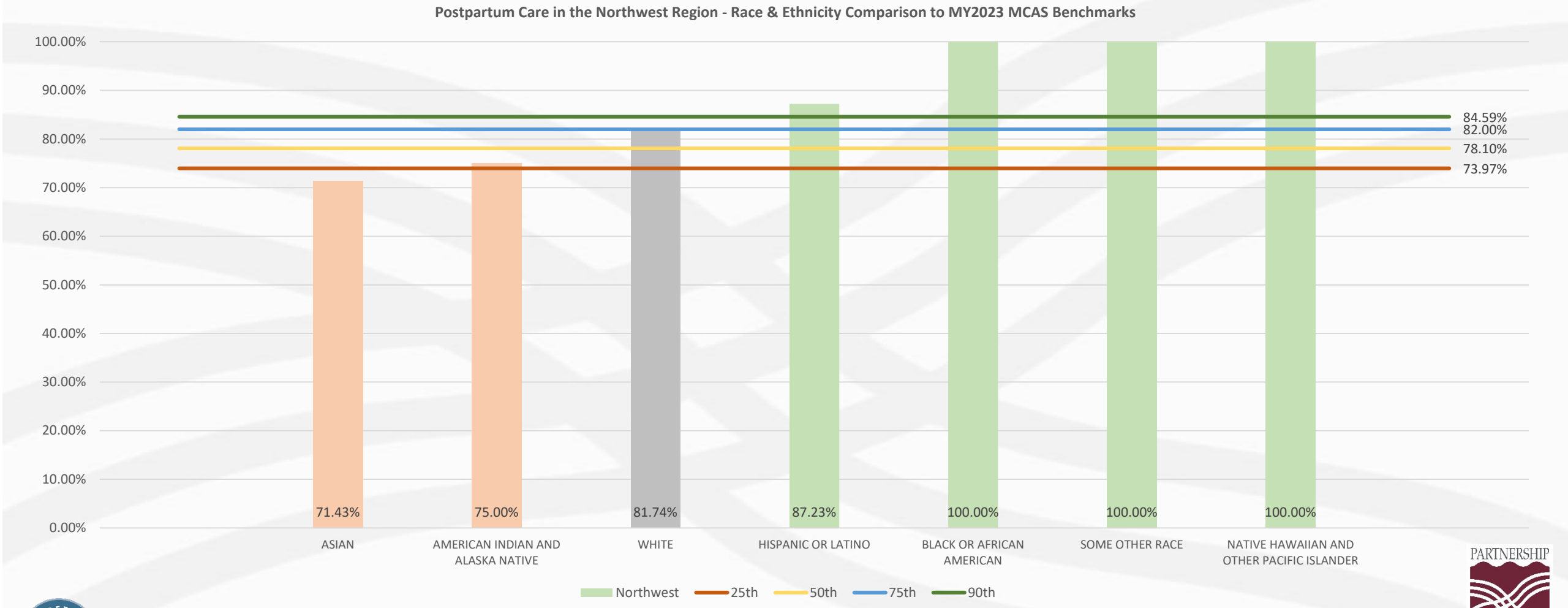
Postpartum Care



Northeast Region Findings



Northwest Region Findings

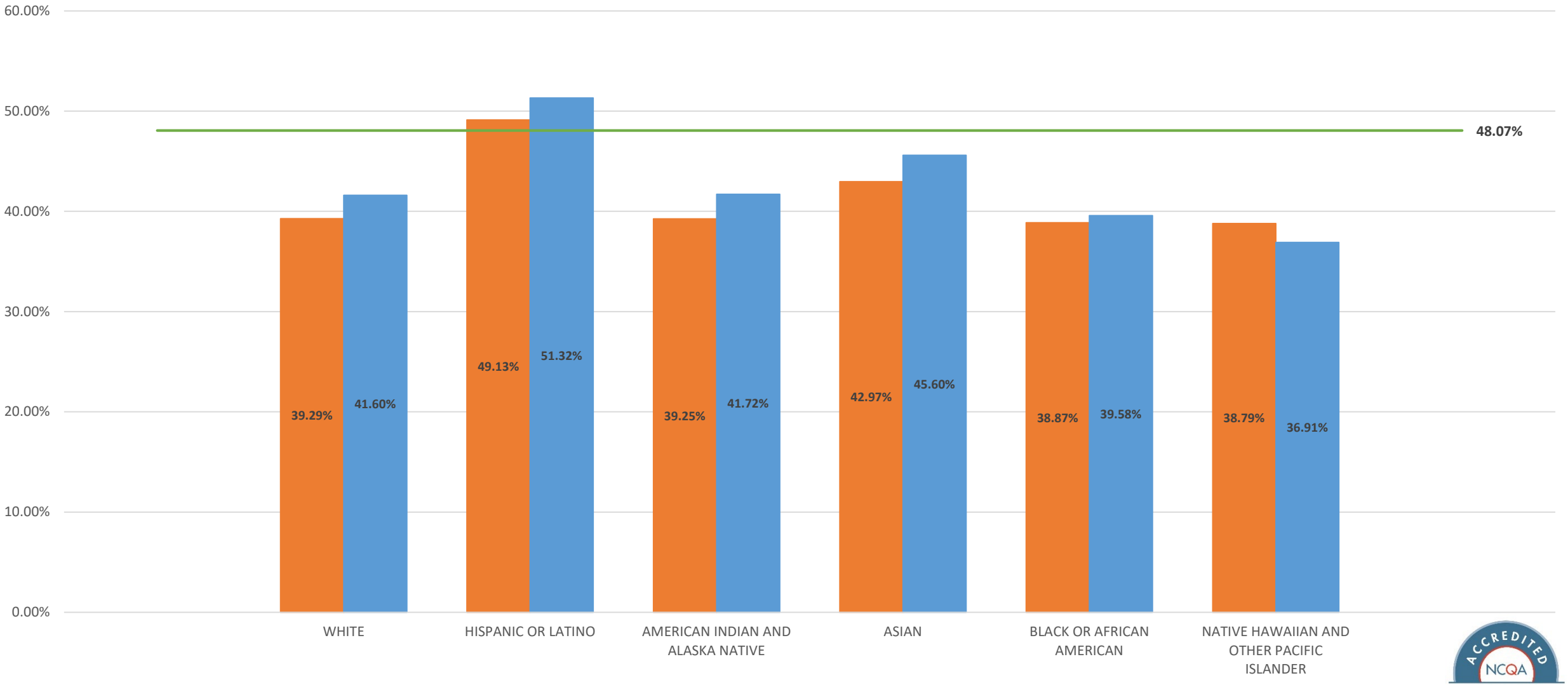


Postpartum Care

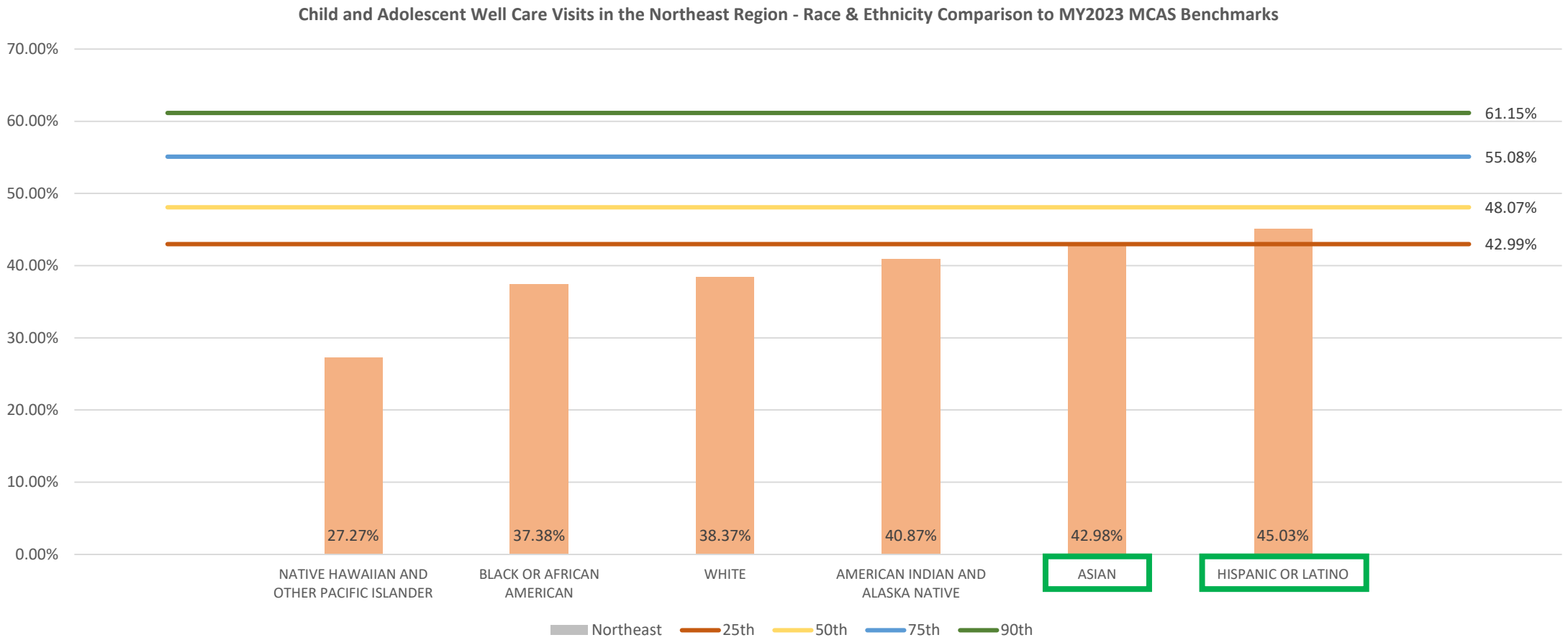
American Indian/Alaska Native Community

- **DHCS Bold Goal:** Yes
- **MCAS Eligible Sanction:** Yes
- **HEA Measure:** Yes
- **Statistical Significance:** Statistical difference in NW Region
- **Clinical Significance:** Yes
  - 1 regions below 25th Percentile (NE)
  - 2 Regions below 50th Percentile (NW, SE)
- **Potential Goal: Increase Prenatal Care Visit by 25% in NE region and 5% in NW and SE region in 24 months to have all regions achieve 50th percentile**

Well Child Visits (WCV) – Total**



Well Child Visits (WCV) - Northeast

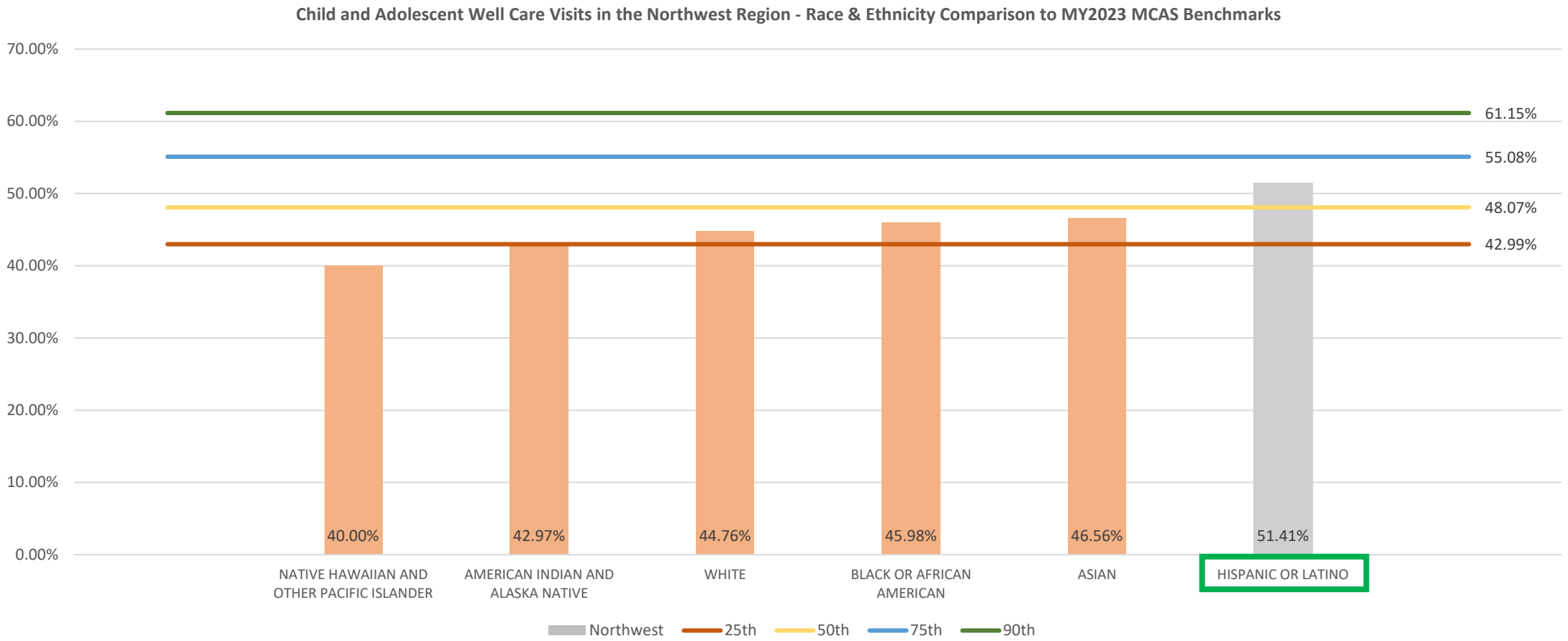


Performed statistically significantly **better** than the comparator group

Performed statistically significantly **worse** than the comparator group

Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

Well Child Visits (WCV) - Northwest

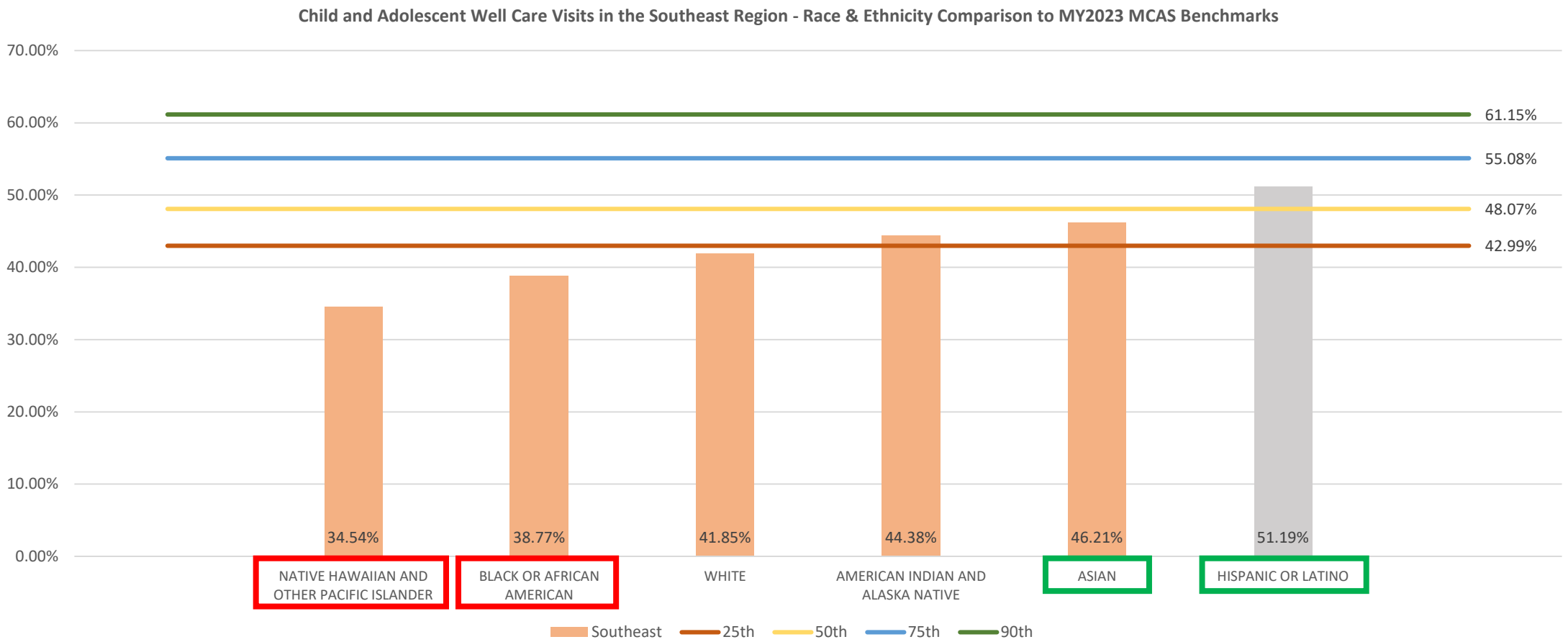


Performed statistically significantly **better** than the comparator group

Performed statistically significantly **worse** than the comparator group

Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

Well Child Visits (WCV) - Southeast

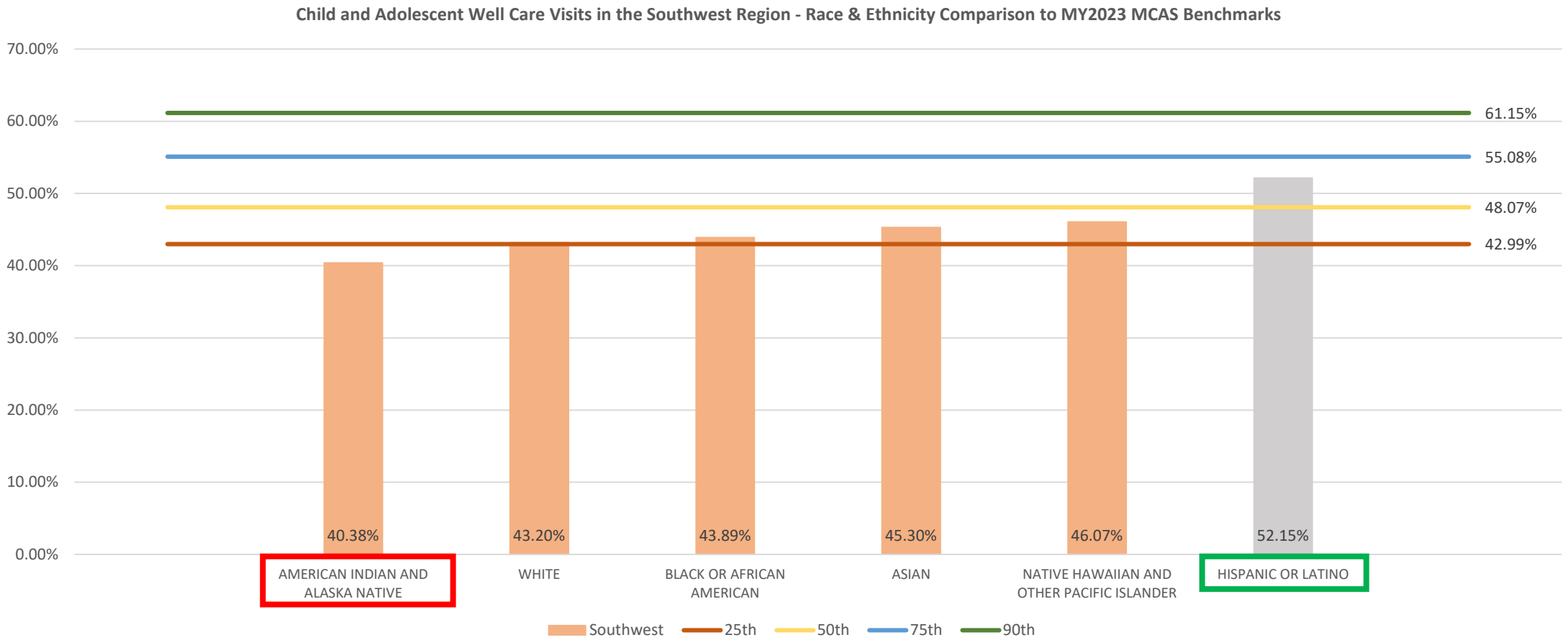


Performed statistically significantly **better** than the comparator group

Performed statistically significantly **worse** than the comparator group

Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

Well Child Visits (WCV) - Southwest



Performed statistically significantly **better** than the comparator group

Performed statistically significantly **worse** than the comparator group

Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

Well Care Visits

- **Hispanic/Latino** performed significantly better than the **white** community in all regions
- **AI/AN** performed significantly worse in SW region
- **Black** and **Native Hawaiian/Pacific Islander** performed significantly worse in SE region
- All others performed significantly or numerically better than **white** community

Health Inequity Prioritization

Preliminary Priorities

All Groups

- Low in WCV across majority of race groups

American Indian/Alaska Native

- Had 3 additional strong disparities in prenatal, postpartum, and poor hemoglobin control

Black/African American

- Had additional strong disparities in prenatal care and WCV in SE region

White and Rural Community

- Strong disparity in WCV measure

NCQA Work Plan

Health Equity Strategic Plan

- Health Equity Disparity Analysis
- Hiring bilingual employees
- Submit DEI Training

CLAS

- Providing timely translation materials to members

Measures

- Prenatal Care
- Well Care Visits

Health Equity Standards –
HE 6: Reducing Healthcare Disparities

October 2024

Table of Contents

Introduction

The HE 6 report summarizes the work of Partnership HealthPlan of California (Partnership) to analyze potential disparities within the member population through an analysis of race and ethnicity, language, and gender data, as well as Partnership's effort to implement impactful interventions to reduce inequities and improve any culturally and linguistically appropriate services (CLAS) identified through the analysis.

For the purposes of this grand analysis, health inequities are significant differences in health between racial or ethnic groups, gender groups, sexual orientation, age, disability status, socioeconomic status, geographic location, etc. For most groups, health disparities result in significantly higher rates of chronic disease and/or premature death when compared to a historically dominant group, which is why positively impacting these inequities is important (National Academies Press, 2017). The current demographics of Partnership members are listed below:

Table I: Partnership Demographic Information per Race (as of August 2024)

Race/Ethnicity	Membership (n, %)
African American/Black	31,327 (3.50%)
American Indian/Alaska Native	15,947 (1.78%)
Asian Indian	14,072 (1.57%)
Asian or Pacific Islander	12,419 (1.39%)
Filipino	9,961 (1.11%)
Hispanic/Latino	300,739 (33.57%)
Other	36,713 (4.10%)
Unknown	122,361 (13.66%)
Vietnamese	3,707 (.41%)
White	348,514 (38.91%)

Objective

In 2024, Partnership convened a multidisciplinary team to collect and review the data, prioritize the findings, recommend interventions, and prioritize opportunities for improvement in specific groups.

The primary HE 6 team members include:

1. Robert Moore, MD MPH MBA, Chief Medical Officer
2. Mohamed Jalloh, Pharm.D. BCPS, Health Equity Officer
3. Nancy Steffen, Senior Director of Quality and Performance Improvement
4. Dorian Roberts, Senior Project Manager, Performance Improvement
5. Anthony Sackett, Program Manager II, Performance Improvement
6. Cyress Mendiola, Senior Manager of Member Services
7. Latrice Innes, Manager of Grievance and Appeals
8. Sue Quichocho, Manager of Quality Measurement
9. Margarita Garcia-Hernandez, Director of Health Analytics
10. Shivani Sivasankar Ph.D., M.S, Senior Health Data Analyst II

The measures of focus for this report are:

1. Controlling High Blood Pressure (CBP).
2. Hemoglobin A1c Control for Patients with Diabetes (HBD).
3. Prenatal and Postpartum Care (PPC).
4. Child and Adolescent Well Care Visits (WCV).

The stratifications of the quality measures include:

1. Race/Ethnicity
2. Language
3. Gender Identity

Methodology

Step 1: Sample Selection to Evaluate Disparities

Partnership initially utilized Measurement Year 2023 (MY 2023) Health Plan Accreditation final measure samples (n=186 to 167,450 members) to evaluate each of the clinical measures of focus. The rates for each measure are comprised of the members included in each measure's audit for Partnership's Health Plan Accreditation Plan-wide summary of performance report. The random member sample that was generated for each hybrid measure and full member denominator along with member race/ethnicity demographic information, was provided by Partnership's HEDIS vendor, Inovalon. Inovalon has been classified is a direct data source.

Through the initial analysis of MY 2023 Health Plan Accreditation sample, Partnership identified no statistically significant lower rates of performance for many of the race-stratified measures highlighted in Element A that aligned with our internal quality improvement data and state health managed care accountability final rate samples. These consistent insignificant findings were likely secondary due to the small sample sizes included in each hybrid measure sample when trying to evaluate and compare groups to the White, English-speaking, and Male populations, respectively.

As a result of the limited findings from the analysis of the NCQA Final rates and the limitations of the NCQA Final data, and to truly identify and evaluate other inequities, Partnership chose to evaluate the MY 2023 Managed Care Accountability Set (MCAS) final rate samples (n=812 to 167,450 members) for the measures included in the Grand Analysis report to provide a more meaningful analysis for the measures of focus for this report. The MCAS samples may be theoretically more consistent with current Partnership member demographics due to their included region stratifications. However, this is relative to the comparison to the Health Plan Accreditation sample. Finally, the MCAS rates have a greater denominator in the hybrid measure samples for the represented race and ethnicity groups and Partnership is able to evaluate rates per region—which provides a more comprehensive and tailored approach to prioritizing disparities.

Step 2: Statistical Analysis to Identify Key Disparities

After receiving the data from Inovalon, members from Partnership's Health Analytics team conducted various statistical analyses. The Chi-Square and Fisher's Exact statistical tests were utilized, based upon sample size, to determine if there were significant differences for the various categorical measure outcomes.

When analyzing disparities based upon race/ethnicity, Partnership conducted various statistical analyses using the White group as the key comparator group. When analyzing disparities based upon language, Partnership conducted various statistical analyses using the English language group as the key comparator group. Finally, when analyzing disparities based upon gender, Partnership conducted various statistical analyses using the Male gender identity group as the key comparator group. A statistically significant difference was classified as a p value less than 0.05 when comparing the categorical outcomes of one group versus the key comparator group, respectively (i.e. White, English-speaking, Male).

These comparators were identified based upon various literature suggesting that such groups, respectively, have had significantly more political, economic, and/or social advantages within the United States (Malat et al., 2018). Data, that were excluded from the evaluation, were findings from patients who reported "Unknown" in race, language, and gender identity.

Step 3: Analysis of Measures

Due to the low sample sizes for the hybrid measures included in the Health Plan Accreditation data (n=186 to 368), a lack of statistically significant inequities identified for all measures, and low number of disparities found through this analysis, Partnership again chose to also evaluate the MCAS final sample measures (at sub region level) to assess, identify, and prioritize any disparities identified through this additional analysis.

Partnership also reviewed the performance of each race/gender identity/linguistic group in comparison to the MCAS benchmarks to asses not only how each group performed statistically in comparison to the White/Male/English speaking group, but in comparison to the national Medicaid benchmarks. In MY 2023, DHCS is holding managed care plans (MCPs) accountable and imposing sanctions on selected Hybrid and Administrative measures performing below the minimum performance level (MPL) (50th national Medicaid percentile) by reporting region, and as a result, Partnership thought it valuable to assess how each group is performing in comparison to that benchmark to assess whether group performance could also have an impact on accountable measures.

As a result, Element A and the prioritization of activities to address and reduce disparities is based on the MCAS samples for the measures of focus. The HPA final rate stratifications can be found in the Appendix of the report, however it is not included in the classification table or the prioritization of activities to address and reduce disparities for the limitations mentioned above.

Step 4: Presentation of Data

After the first data analysis was completed, members of the primary HE 6 team placed the data points in graphs and included various percentile targets per various National benchmarks. To aid in the evaluation of outcomes, Partnership color coded the bar graphs with the color orange indicate a group percentile performance below the MPL; bars highlighted in green indicated groups performed above the 90th percentile.

Finally, Partnership created a table (Table XXXI) to classify and provide guidance to help prioritize inequities identified through this analysis. While these classifications are referenced in the measure descriptions below, this table can be found in Element D, Factors 1 & 3.

Element A: Reporting Stratified Measures

Element Summary: Partnership found statistically significant lower rates when comparing each race/ethnicity group to the white group while using the NCQA Health Plan Accreditation generated sample for WCV, CBP, and PPC - Prenatal, and HBD – Poor Control per the analysis that was produced on July 24th, 2024. PPC – Postpartum included statistically significant higher rates for the Hispanic or Latino group. When comparing each group to the Health Plan Accreditation National Medicaid Benchmarks, The Asian group had the lowest performance and was the only group below the 33.33rd percentile for CBP. Interestingly, the American Indian and

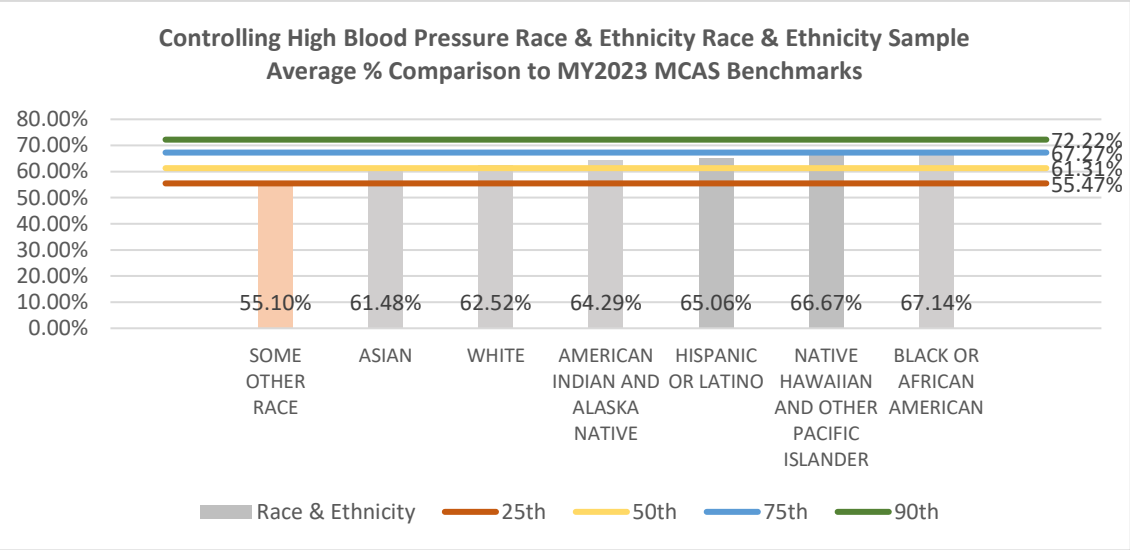
Alaska Native group had the lowest performance and was the only group below the 10th percentile for PPC – Prenatal, PPC Postpartum, and HBD – Poor Control. The Native Hawaiian and Pacific Islander group was the lowest performing and only group below the 10th percentile for WCV.

*Due to the low sample sizes for the hybrid measures included in the Health Plan Accreditation data (*n=186 to 368*), a lack of statistically significant inequities identified for all measures, and low number of disparities found through this analysis, Partnership chose to also evaluate the MCAS final sample measures (at sub region level) to assess, identify, and prioritize any disparities identified through this additional analysis.*

Element Key Methodology: The sections below highlight the results of the statistical significance testing done for each measure by race for the MCAS samples. "Unknown" and "some other race group" data were excluded from the evaluation. Additional analysis of the HPA samples can be found in the Appendix.

Controlling High Blood Pressure (CBP):

Partnership found that no group had a statistically significantly lower rate of CBP when compared to the White group while using the MCAS generated hybrid sample in all four reporting regions (n=1,395) (Table III). Overall, groups performed at average across respective regions, or above the Minimum Performance Level (MPL – 50th). However, when comparing each group's performance in comparison to the National Medicaid benchmarks in each of Partnership's regions (Graphs II – V), the American Indian/Alaska Native population had rates below the 25th percentile in 2 of 4 regions (Southeast and Southwest). The Asian group performed below the Minimum Performance Level (MPL – 50th) in 2 regions (Northeast and Southeast), and the 'Some Other Race' Group in 3 (Northeast, Northwest, and Southwest). The Native Hawaiian and Other Pacific Islander, Hispanic or Latino, and White groups only performed below the MPL in 1 region respectively (Northeast for Hispanic or Latino and Native Hawaiian and Other Pacific Islander, Northwest for White group). Interestingly, the Black/African American group performed better than the White group in 3 of the 4 regions (Northeast, Northwest, and Southeast).

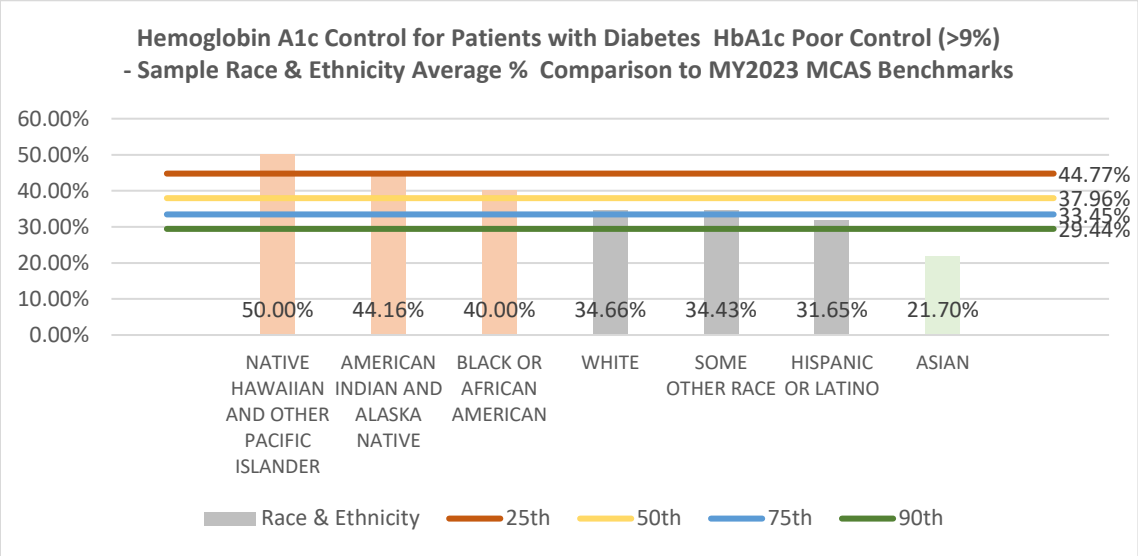


Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When taking the average rate for each race/ethnicity group in comparison to the MCAS benchmarks, Partnership found that the 'Some Other Race' group was the only group that performed below the MPL – 50th, and no group performed above the 90th percentile.

Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%):

Partnership found that the American Indian and Alaska Native group in the Southwest region performed significantly worse than the White population and the Asian population performed significantly better in the Southeastern region (Table V) when reviewing the MCAS data. It was identified that although there was a small sample of Native Hawaiian and Other Pacific Islander members included in the sample, this group did not meet the MPL percentile in 2 regions (Northwest, Southeast) in which they were included. Also, the American Indian/Alaska Native did not meet the MPL in 3 regions (Northwest, Southeast, Southwest). The Black/African American population also did not meet the MPL in 2 regions (Northwest and Southeast). Finally, the White population in the Northeast region was the lowest performing group, and did not meet the MPL (1.54% away from MPL) in comparison to the benchmarks, with the Hispanic or Latino group performing only marginally better in the region (.22% away from MPL), the only region in which they did not meet the MPL for the measure (Graphs VII – X).

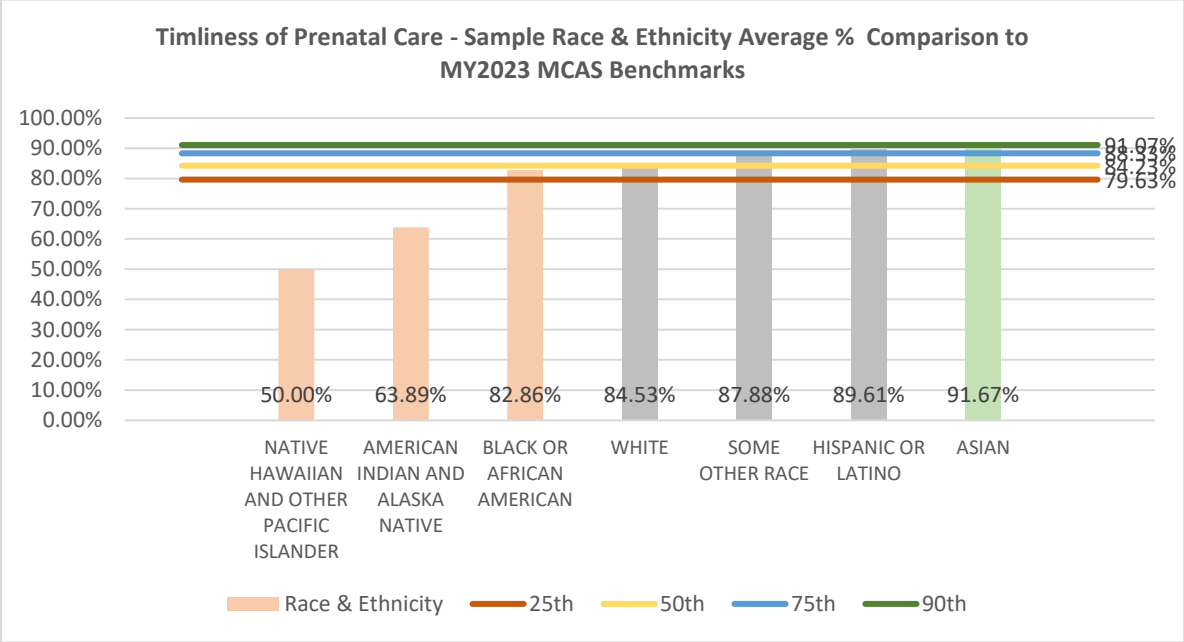


Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, Partnership found that the Native Hawaiian and Other Pacific Islander, American Indian and Alaska Native, and Black or African American groups all performed below the MPL – 50th, and only the Asian group performed above the 90th percentile.

Timeliness of Prenatal Care (PPC – Pre):

Partnership found that only the American Indian and Alaska Native group in the Southwest region performed significantly worse than the White population (Table VII) per the MCAS sample. However, the Black/African American group was well below the 25th performing percentile in 2 of 4 regions (Northeast, Northwest). This is likely due to the very small sample size of Black/African American group members within these regions (n=7). In the Northeast region, 4 groups performed below the MPL (Black or African American, American Indian and Alaska Native, Asian, and 'Some Other Race'), and in the Northwest, 4 different groups performed below the MPL (Black or African American, American Indian and Alaska Native, 'Some Other Race', and White). Also, the American Indian and Alaska Native group performed numerically worse than the White population, and was below the MPL in 3 regions (Northeast, Northwest, Southwest). In the Southeast region, only the Native Hawaiian and Other Pacific Islander group performed below the 25th (n=1) (Graphs XII – XV).



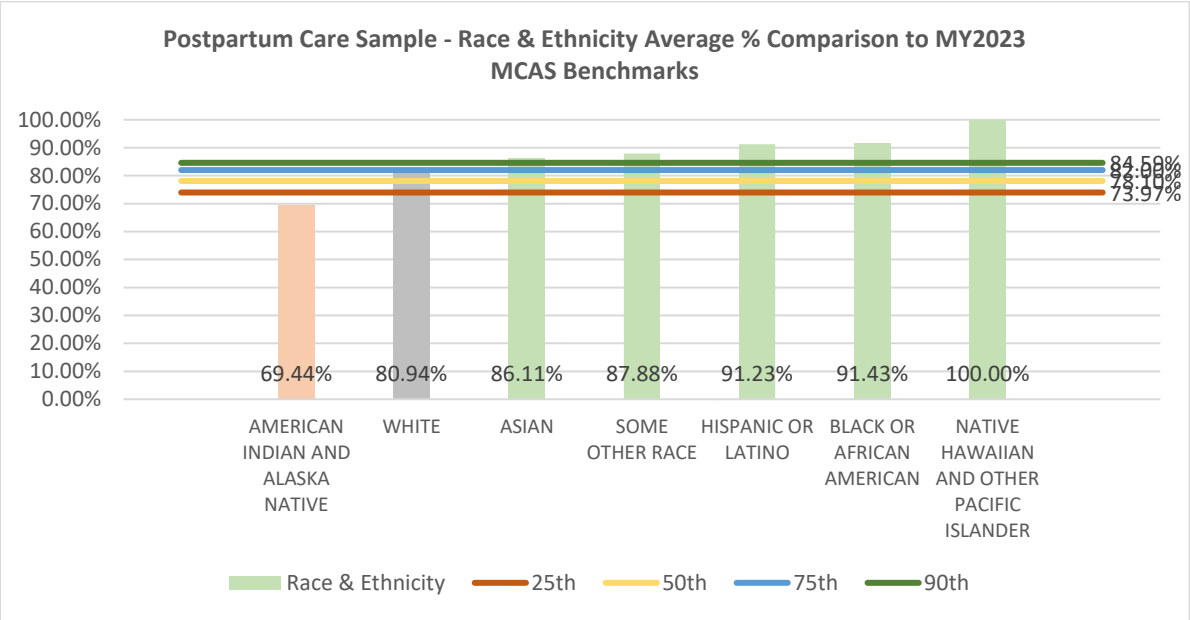
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, Partnership found that the Native Hawaiian and Other Pacific Islander, American Indian and Alaska Native, and Black or African American groups all performed below the MPL – 50th, and only the Asian group performed above the 90th percentile.

Postpartum Care (PPC – Post):

Partnership found that only the American Indian and Alaska Native group in the Northeast region performed significantly worse than the White population (Table IX) per the MCAS sample. However, when comparing each group to the MCAS benchmarks, the American Indian and Alaska Native population performed below the MPL in 3 out of 4 regions (Northeast,

Northwest, Southwest). The Asian population also performed below the MPL in 2 regions (Northeast and Northwest), and the 'Some Other Race' group performed below the MPL in 1 region (Southeast). It is also worth noting that the Black or African American and Hispanic or Latino groups were the only groups to perform above the 90th percentile in all regions (Graphs XVII – XX).

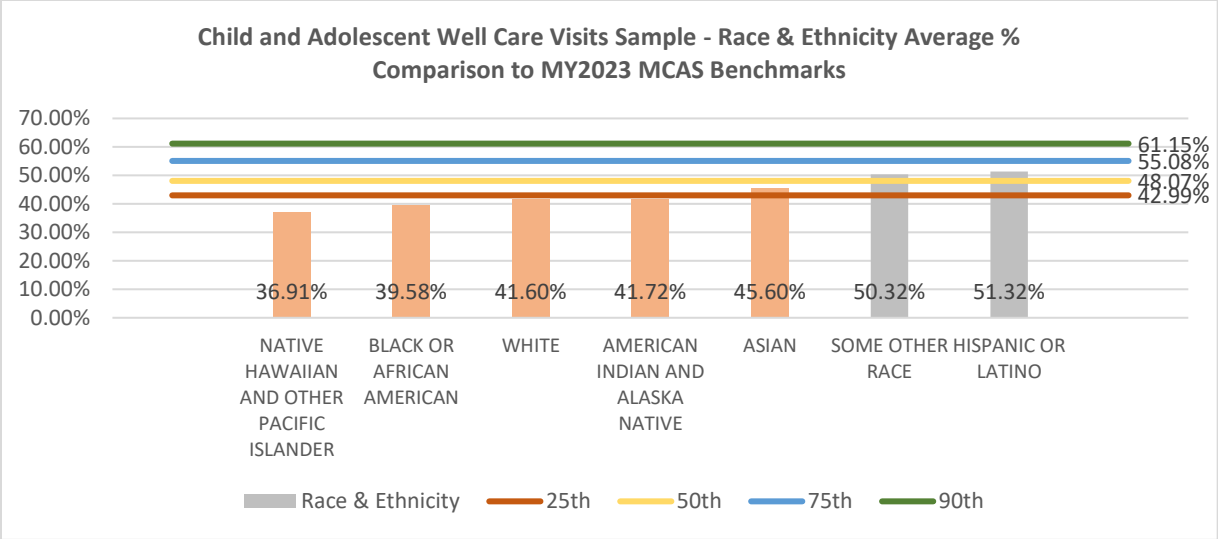


Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, Partnership found that the American Indian and Alaska Native groups was the only group that performed below the MPL – 50th, and the Asian , 'Some Other Race', Hispanic or Latino, Black or African American, and Native Hawaiian and Other Pacific Islander groups all performed above the 90th percentile.

Child and Adolescent Well Care Visits (WCV):

When reviewing the MCAS sample for the measure, Partnership found that the majority of groups did not perform to the Minimum Performance Level (MPL – 50th) for WCVs throughout all 4 regions suggesting a greater concern in the infrastructure for attending WCVs. Interestingly, various groups performed statistically significantly better than the White group in the MCAS sample in all four reporting regions (n=167,450) despite still performing below the MPL. The American Indian and Alaska Native population had a significantly lower rate in the Southwest, and were even below the 25th percentile in 2 of 4 regions (Southeast and Southwest. The Black/African American and Native Hawaiian and Other Pacific Islander group had a significantly lower rate in comparison to the White group in the Southeast region, and both were also below the 25th percentile in the region. (Graphs XXII – XXV).



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

When comparing the sample's average rate for each race/ethnicity group to the MCAS benchmarks, Partnership found that the Native Hawaiian and Other Pacific Islander, Black or African American, White, American Indian and Alaska Native, and Asian groups all performed below the MPL – 50th, and no group performed above the 90th percentile.

Appendix 1: Table II: Controlling High Blood Pressure (CBP) HPA Statistical Significance Results

Appendix 2: Graph I: Controlling High Blood Pressure - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

Appendix 3: Table III: Controlling High Blood Pressure (CBP) MCAS Statistical Significance Results

Appendix 4: Graph II: Controlling High Blood Pressure in Northeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 5: Graph III: Controlling High Blood Pressure in Northwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 6: Graph IV: Controlling High Blood Pressure in Southeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 7: Graph V: Controlling High Blood Pressure in Southwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 8: Table IV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) HPA Statistical Significance Results

Appendix 9: Graph XI: Hemoglobin A1c Control for Patients with Diabetes -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

Appendix 10: Table IV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) MCAS Statistical Significance Results

Appendix 11: Graph VII: Hemoglobin A1c Control for Patients with Diabetes in Northeast Region -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 12: Graph VIII: Hemoglobin A1c Control for Patients with Diabetes in Northwest Region -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 13: Graph IX: Hemoglobin A1c Control for Patients with Diabetes in Southeast Region -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 14: Graph X: Hemoglobin A1c Control for Patients with Diabetes in Southwest Region -- HbA1c Poor Control (>9%) - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 15: Table VI: Timeliness of Prenatal Care (PPC-Pre) HPA Statistical Significance Results

Appendix 16: Graph XI: Timeliness of Prenatal Care - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

Appendix 17: Table VII: Timeliness of Prenatal Care (PPC – Pre) MCAS Statistical Significance Results

Appendix 18: Graph XII: Timeliness of Prenatal Care in Northeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 19: Graph XIII: Timeliness of Prenatal Care in Northwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 20: Graph XIV: Timeliness of Prenatal Care in Southeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 21: Graph XV: Timeliness of Prenatal Care in Southwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 22: Table VIII: Postpartum Care (PPC – Post) HPA Statistical Significance Results

Appendix 23: Graph XVI: Postpartum Care in Northeast Region - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

Appendix 24: Table IX: Postpartum Care (PPC – Post) MCAS Statistical Significance Results

Appendix 25: Graph XVII: Postpartum Care in Northeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 26: Graph XVIII: Postpartum Care in Northwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 27: Graph XIX: Postpartum Care in Southeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 28: Graph XX: Postpartum Care in Southwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 29: Table X: Child and Adolescent Well Care Visits (WCV) HPA Statistical Significance Results

Appendix 30: Graph XXI: Child and Adolescent Well Care Visits in Northeast Region - Race & Ethnicity Comparison to MY2023 NCQA Benchmarks

Appendix 31: Table XI: Child and Adolescent Well Care Visits (WCV) MCAS Statistical Significance Results

Appendix 32: Graph XXII: Child and Adolescent Well Care Visits in Northeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Appendix 33: Graph XXIII: Child and Adolescent Well Care Visits in Northwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 34: Graph XXIV: Child and Adolescent Well Care Visits in Southeast Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks
Appendix 35: Graph XXV: Child and Adolescent Well Care Visits in Southwest Region - Race & Ethnicity Comparison to MY2023 MCAS Benchmarks

Element B: Use of Data to Assess Disparities

Element Methodology: Partnership conducted the same steps highlighted in the Methodology section, however, stratifying based on preferred language and gender identity versus race/ethnicity. The sections below highlight the results of the statistical significance testing done for each measure stratified by language and gender identity. Each language was statistically compared to English. In addition, each language group was compared with the Minimum Performance Level (MPL – 50th). "Other" language data were excluded from the evaluation. For gender identity, Partnership is only able to assess comparisons between the Male and Female gender identities due to only being able to receive such information from the state member files. The Male group was designated as the dominant group, and both the Male and Female groups were compared with the Minimum Performance Level (MPL – 50th).

Element Summary: Partnership only found a statistically significant lower rate when comparing the Hmong language group to the English group while using the NCQA Health Plan Accreditation generated sample for WCV, per the analysis that was produced on July 24th, 2024. The Spanish and Farsi groups had significantly higher rates for this measure. The were no additional statistically significant differences for any additional groups in comparison to the English group for all other measures.

Partnership also found no statistically significant differences between the Female and Male gender identities for all measures.

Due to the low sample sizes for the hybrid measures included in the Health Plan Accreditation data (n=205 to 394 for language, n=205 to 405 for gender identity), a lack of statistically significant inequities identified for measures, and low number of disparities found through this analysis, Partnership chose to also evaluate the MCAS final sample measures (at sub region level) to assess, identify, and prioritize any disparities identified through this additional analysis for both language and gender identity.

Factor 1: Analyzing clinical performance measures by race/ethnicity

NA. Included in Element A.

Factor 2: Analyzing clinical performance measures by preferred language

Factor Summary: Overall, Partnership found that no linguistic group had a statistically significantly worse rate of CBP, PPC – Pre, PPC – Post when compared to the English-speaking group while using the MCAS generated hybrid sample in all four reporting regions

(n=885 to 1,489). The English-speaking group had worse HBD in at least 2 regions, when compared to the Spanish speaking population. Also, the English-speaking group had worse WCVs when compared to the Spanish speaking population in all 4 regions. The Vietnamese population had a significantly worse WCV in the SE region, however majority of the linguistic groups (except the Spanish population) were below the Minimum Performance Level (MPL – 50th).

Factor Methodology: The sections below highlight the results of the statistical significance testing done for each measure stratified by language. Each language was statistically compared to English. In addition, each language group was compared with the Minimum Performance Level (MPL – 50th). "Other" language data were excluded from the evaluation.

Controlling High Blood Pressure (CBP):

Partnership found that no linguistic group had a statistically significantly lower rate of CBP when compared to the English-speaking group while using the MCAS generated hybrid sample in all four reporting regions (Table XXIII). When comparing each group's performance in comparison to the National Medicaid benchmarks in each of Partnership's regions, the Spanish-speaking group had rates below the MPL – 50th in 2 regions (5.75% below in Northeast, 11.31% below in Northwest). The Tagalog speaking population also performed below the MPL – 50th in 2 regions (6.76% below in Southeast, 11.31% below in Southwest).

Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%):

Partnership found that the Spanish group performed significantly better than the English speaking group in the Northeast and Southwest regions respectively using the MCAS generated hybrid sample in all four reporting regions (Table XXV). Specifically, the Spanish-speaking group performed 14.40% above the MPL – 50th in the Northeast and 7.55% above the MPL – 50th in the Southwest.

Timeliness of Prenatal Care (PPC – Pre):

Partnership found that no linguistic group had a statistically significantly lower rate for PPC – Prenatal when compared to the English-speaking group while using the MCAS generated hybrid sample in all four reporting regions (Table XXVII). All regions had at least 1 linguistic group who had achieved 100% of timeliness in the prenatal care. The Spanish speaking group had the highest performance while the Southeast and Southwest regions had the highest number of linguistic groups who achieved the 100% of timeliness in the prenatal care.

Postpartum Care (PPC – Post):

Partnership found that no linguistic group had a statistically significantly lower rate of PPC – Postpartum when compared to the English-speaking group while using the MCAS generated hybrid sample in all four reporting regions (Table XXIX). The Spanish speaking group had a significantly higher performance postpartum care in the SW region and had the highest number of regions that achieved 100% of postpartum care.

Child and Adolescent Well Care Visits (WCV):

Partnership found that the Spanish speaking community performed significantly better in WCV in all four regions when compared to the English-speaking community with an average rate of 53.40% versus 44.98% in the English-speaking community. The English speaking community was below the MPL – 50th in all four regions with an average absolute percentage below of 3.09%. The Farsi speaking community also had a significantly higher rate of completion of WCVs in the SE region in comparison to the English community. Specifically, the Russian community (n=372) had a 25.41% higher rate when compared to the English-speaking community. Finally, the Vietnamese-speaking community had a significantly lower rate of WCV in the SE region. The Vietnamese-speaking community had a 9.35% lower rate when compared to the English community and was 12.21% below the MPL.

Appendix 36: Table XII: Controlling High Blood Pressure (CBP) Language HPA Statistical Significance Testing
Appendix 37: Table XIII: Controlling High Blood Pressure (CBP) Language MCAS Statistical Significance Testing
Appendix 38: Table XIV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Language HPA Statistical Significance Testing
Appendix 39: Table XV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Language MCAS Statistical Significance Testing
Appendix 40: Table XVI: Timeliness of Prenatal Care (PPC-Pre) Language HPA Statistical Significance Testing
Appendix 41: Table XVII: Timeliness of Prenatal Care (PPC-Pre) Language MCAS Statistical Significance Testing
Appendix 42: Table XVIII: Postpartum Care (PPC – Post) Language HPA Statistical Significance Testing
Appendix 43: Table XIX: Postpartum Care (PPC – Post) Language MCAS Statistical Significance Testing
Appendix 44: Table XX: Child and Adolescent Well Care Visits (WCV) Language HPA Statistical Significance Testing
Appendix 45: Table XXI: Child and Adolescent Well Care Visits (WCV) Language MCAS Statistical Significance Testing

Factor 3: Analyzing clinical performance measures by gender identity and/or sexual orientation

Factor Summary: In analyzing each measure based on gender identity and comparing each gender identity to the Male group, Partnership found that no significant difference between the two genders for CBP. Partnership did identify a significant difference between the Male and Female group for HBD and WCS with the Female group performing significantly better than Male group in the Southeast for HBD, and the Female group performing significantly better than the Male group in the Southwest for WCV.

Table XVII: Partnership Demographic Information per Gender Identity and/or Sexual Orientation

Estimated Total Population: 895,760 (As of August 2024)

Gender Identity	Membership (n, %)
Female	466,464 (55.1%)
Male	429,136 (47.9%)

Factor Methodology: Partnership stratified the clinical measures included in this report by using individual-level data to identify the members captured in the measures numerators and denominators, and stratified by individual's self-identified gender and/or sexual orientation. Partnership collects gender identity utilizing the two gender options of Male and Female. Therefore, analysis was conducted utilizing those two gender options with the Male population listed as the dominant group. Currently, Partnership does not directly collect sexual orientation data directly from members, as of 2024. As a result, Partnership only had Female members in the Timeliness of Prenatal Care and Postpartum Care measures, and therefore did not include the statistical significance testing outlined for the measure. The information below highlights the results of the statistical significance testing done for each measure by the two gender identities.

Controlling High Blood Pressure (CBP):

Partnership found no statistically significant difference when comparing each gender identity group to the Male gender identity group while using the MCAS generated sample (drawn from the eligible population) for Controlling High Blood Pressure (n=1,534) (Table XXIII).

Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%):

Partnership found no statistically significant difference when comparing each gender identity group to the Male gender identity group while using the MCAS generated sample (drawn from the eligible population) for HbA1c Poor Control in the Northeast, Northwest, and Southwest. Partnership found the Female group performed significantly better than Male group, with a rate 13% better than the Male group and 12.55% above the MPL – 50th, while the Male group performed below the MPL – 50th in the region (Table XXV).

Child and Adolescent Well Care Visits (WCV):

Partnership found that the Female group performed significantly better than the Male group in the Southwest region while using the MCAS generated sample (drawn from the eligible population) for Child and Adolescent Well Care Visits. Specifically, the Female population had a .77% higher rate of Child and Adolescent Well Care when compared to the Male population in the region. However, Partnership found no statistically significant difference between the Male and Female group for Child and Adolescent Well Care Visits in the remaining 3 regions. (Table XXVII).

Appendix 46: Table XXII: Controlling High Blood Pressure (CBP) Gender Identity HPA Statistical Significance Testing

Appendix 47: Table XXIII: Controlling High Blood Pressure (CBP) Gender Identity MCAS Statistical Significance Results

Appendix 48: Table XXIV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Gender Identity HPA Statistical Significance Testing

Appendix 49: Table XXV: A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Gender Identity MCAS Statistical Significance Results

Appendix 50: Table XXVI: Child and Adolescent Well Care Visits (WCV) Gender Identity HPA Statistical Significance Testing

Appendix 51: Table XXVII: Child and Adolescent Well Care Visits (WCV) Gender Identity MCAS Statistical Significance Results

Factor 4: Analyzing individual experience measures by race/ethnicity or preferred language

Factor Summary Findings: At the conclusion of the 2022 CAHPS® survey period, Partnership received 372 completed adult surveys, representative of a 14% survey completion rate for Partnership's adult member population. White adult members (n=246) reported lowest score in care coordination; African American/Black members reported the lowest score in customer service; Asian members reported the lowest score in getting needed care; Native Hawaiian members reported the lowest score in rating of health care, American Indian/Alaska Native reported the lowest score in rating of personal doctor and health plan; and Hispanic/Latino reported the lowest score in rating of customer service.

Factor Methodology: Partnership measured members' experience through monitoring of annual regulated and non-regulated surveys, and grievance and appeals reporting. The member experience and respective quality outcomes are driven and measured by interdepartmental health plan coordinated efforts that support operational and strategic member and provider-focused activities. For the analysis of individual experience by race and ethnicity, Partnership utilized MY 2022 annual CAHPS® survey for both adults and children to analyze individual experience measures for Partnership members by race and ethnicity.

Partnership contracts with an NCQA-certified vendor, PressGaney to administer the annual regulated survey and provide results of CAHPS® survey on a yearly basis, which are the data points used throughout this evaluation. Partnership reports on the eight CAHPS® composites categories, including Rating of Health Plan, Rating of Health Care, Rating of Personal Doctor, Rating of Specialist, Getting Needed Care, Getting Care Quickly, Care Coordination, and Customer Service. PressGaney provided category responses stratified by race and ethnicity in comparison to the overall health plan score (percentage in grey at top of table). The brighter red shading (highlighted in key below) indicates a larger disparity.

The Adult survey had the most completed surveys from the White population, with 246 member responses. All other groups had less than 100 responses respectively (Black/African American: 26, Asian: 34, Native Hawaiian and Other Pacific Islander: 8, American Indian/Alaska Native: 27, Other: 58, Hispanic/Latino: 90), which limits the applicability of the data.

In addition, the following limitations exists.

The CAHPS® regulated and non-regulated surveys provided insight, albeit some of the response data was limited. This fiscal year we created the foundation to continue to monitor member

satisfaction within the Health Equity framework. The established performance threshold is a starting point to observe year-over-year progress.

Important to note, the regulated and drill-down surveys are only offered in English and Spanish language formats, which limits Partnership's ability to proactively solicit members for all threshold languages. Partnership is actively exploring the option for adult population only that will include adding Chinese (Mandarin and Cantonese) as another threshold language to regulated and non-regulated surveys. Presently, Partnership's DHCS assigned Chinese population relative to all threshold languages is low. The 2021 DHCS Threshold and Concentration Languages report demonstrates lower Chinese population within Partnership's 24 county service area. The return on investment to include Chinese language format for CAHPS® surveys may be cost-prohibitive relative to the insight low response may offer. The CAHPS® program team will continue to evaluate and explore alternative options to measure member satisfaction for all threshold languages.

Since the survey response rate for [1]CAHPS® Non-Regulated Survey is low, and linked to 28 fewer survey field days, Partnership surmised the low performance gap to be an outlier and therefore we excluded this data set while focusing on improvement activity discussions. The performance for CAHPS® regulated survey noted, the plan service delivery for adult population is marginally below the 70th percentile threshold. Comparing both populations, the team concludes that members in general are satisfied with Partnership's service delivery. Moving forward, the internal team will continue to refine and facilitate transparent and consistent benefit coverage communication and training with Partnership's contracted providers.

The Quality Improvement (QI) CAHPS® program team in collaboration with key stakeholders are leading a process improvement that carried forward from prior fiscal year to this fiscal year 2023-2024. The premise is to use real-time operational data sources to proactive identify member abrasion, through theme related categories that link to provider network or health plan delivery barriers.

Table XXVII: Adult CAHPS® Survey Findings

		Rating of Health Plan	Rating of Health Care	Getting Needed Care	Getting Care Quickly	Coordination of Care
Demographic	**Total**	**54.5%**	**51.5%**	**76.0%**	**72.9%**	**81.3%**
White	*n =246*	-1%	-1%	1%	5%	-7%
Black / African American	*n =26*	-1%	7%	4%	-6%	19%
Asian	*n =34*	8%	6%	-18%	-15%	8%
Native Hawaiian/Pacific Islander	*n =8*	3%	-52%	24%	-6%	19%
American Indian/Alaska Native	*n =27*	-27%	-22%	-2%	-4%	19%

Other	*n =58*	13%	11%	10%	8%	19%
Hispanic/Latino	*n =90*	7%	13%	0%	3%	2%

		Rating of Personal Doctor	Rating of Specialist	Customer Service	How Well Doctors Communicate	Ease of Filling Out Forms
Demographic	**Total**	**61.8%**	**66.7%**	**87.2%**	**88.5%**	**91.8%**
White	*n =246*	-7%	-3%	1%	-3%	0%
Black / African American	*n =26*	16%	17%	-9%	3%	4%
Asian	*n =34*	21%	-3%	0%	4%	-1%
Native Hawaiian/Pacific Islander	*n =8*	-29%	-17%	NA	12%	8%
American Indian/Alaska Native	*n =27*	-29%	-22%	0%	-2%	-1%
Other	*n =58*	12%	22%	5%	12%	5%
Hispanic/Latino	*n =90*	9%	-4%	-3%	6%	0%

Group is performing…

- **Above the plan score by 5 or more points**
- **Above the plan score**
- **Below the plan score**
- **Below the plan score by 5 or more points**
- **Above/below plan score but has low base (<30)**

Factor Summary Findings: At the conclusion of the CAHPS® survey period, Partnership received 587 completed child surveys, representative of a 14.5% survey completion rate for Partnership's pediatric member population. The Hispanic/Latino group had the largest amount of survey completions (n=323) and did not have any low scores. The White group, had lowest scores in coordination of care—comparable to adult group; the Black/African American group and reported lowest scores in 'rating of health plan'; the Asian and American Indian/Alaska Native groups had lowest scores in rating of personal doctor; Native Hawaiian members reported the lowest score in rating of health plan.

Table XXVIII: Child CAHPS® Survey Findings

		Rating of Health Plan	Rating of Health Care	Getting Needed Care	Getting Care Quickly	Coordination of Care
Demographic	**Total**	**66.9%**	**65.6%**	**79.6%**	**84.1%**	**85.3%**
White	*n =312*	-3%	-4%	-1%	1%	-5%
Black / African American	*n =46*	-20%	-10%	9%	6%	4%
Asian	*n =57*	10%	14%	-7%	-9%	8%
Native Hawaiian/Pacific Islander	*n =16*	-11%	-2%	10%	7%	15%

American Indian/Alaska Native	*n =37*	-2%	-3%	-5%	9%	-4%
Other	*n =145*	5%	5%	8%	-3%	7%
Hispanic/Latino	*n =323*	7%	7%	4%	0%	6%

		Rating of Personal Doctor	Rating of Specialist	Customer Service	How Well Doctors Communicate	Ease of Filling Out Forms
Demographic	**Total**	**74.6%**	**70.4%**	**89.4%**	**94.7%**	**95.4%**
White	*n =312*	-3%	-6%	1%	1%	-1%
Black / African American	*n =46*	-2%	5%	-1%	-1%	2%
Asian	*n =57*	-5%	17%	-4%	-4%	3%
Native Hawaiian/Pacific Islander	*n =16*	10%	-10%	11%	2%	5%
American Indian/Alaska Native	*n =37*	-11%	-25%	-8%	-2%	2%
Other	*n =145*	4%	12%	-1%	1%	3%
Hispanic/Latino	*n =323*	6%	11%	3%	1%	0%

Element C: Use of Data to Monitor and Assess Services

Partnership conducts an annual Utilization and Experience review to identify potential areas of opportunity at the organizational level. At a health plan level, the annual member experience is monitored through various data sources. These data sources include Language Service Utilization Reports, Internal Satisfaction Survey, Member Satisfaction, Grievance and Appeals data, CAHPS® regulated and non-regulated[1] survey ratings for health plan and personal doctor encounters.

Factors 1 & 3: Utilization of language services for organization functions and staff experience with language services for organization functions

<u>Factors 1 & 3 Summary Findings:</u> Interpreting sessions increased by 10,372 sessions or a +13% growth, period over period. Spanish was the top requested language and accounted for 79.9% of total interpreting sessions reported within the current period. Vietnamese, Russian, Dari, and Punjabi rounded out the top 5 requested languages for interpreting. One thing to note is that one of Partnership's threshold language, Tagalog was not represented within the top 5 most requested languages. In regards to translations, Partnership experienced -19% or 80 less translation requests period over period. Similar to our interpreting results, Spanish as a whole (Latin America + Mexico) was the most requested language, contributing to 48% of total translation requests. Russian, Tagalog, Hmong made up the remaining top 5 languages requested for the current period. This slightly differs from the previous period in which Lao was represented in the top 5.

Overall, internal employee surveys suggested that Member Services (48%), Transportation (17%), and Care Coordination (13%) employees were the heaviest utilizers of translation / interpreter services within the organization. Of the 5 reporting categories, Partnership exceeded our internal threshold for the "An interpreter(s) was available at the time of request" and the

"Overall, the interpreter(s) met the interpreting needs of the member" categories. Partnership experienced either a positive trend or flat to last year for 2 of the categories that did not meet the established threshold. Additionally, the number of respondents increased by 69%.

Methodology: Language Services utilization reports are extracted through Partnership's vendor(s) reporting portal on a quarterly basis. In addition, Partnership administers an annual internal satisfaction survey to all member-facing positions. The objective of this survey is to assess staff experience with obtaining Language Services through Partnership's contracted providers. For transparency, all member-facing positions flow into the following departments:

- Member Services
- Population Health
- Care Coordination
- Utilization Management
- Grievance & Appeals
- Transportation

To track and trend Partnership's Language Service utilization, the team established a ratio of the number of translations and interpreting sessions per 1,000 members. The numerator will be the total amount of interpreting sessions or translations requests for the reporting period, and the denominator will be the average membership base of each reporting period. Note that Kaiser Members were excluded from this reporting as Kaiser was a delegated entity within our lookback period and Language Services fall under the scope of services that Kaiser provides. Additionally, the membership base is representative of members that have indicated a primary language other than English.

In regards to the reporting period, Partnership referenced reporting data from January 2023 through December 2023. The reporting data is divided into two periods. The "Previous Period" will include data from Quarter 1 and 2 (January – June) whereas the "Current Period" will include data from Quarter 3 and 4 (July – December). Note that for the purpose of this report, we observed the traditional calendar year, not fiscal.

To establish a threshold, Partnership determined that the interpreting and translation ratio would increase/decrease proportionally with any shift in the quarterly average member base of members who have indicated a primary language other than English. To meet the intent of this deliverable, Partnership identified the percentage shift in membership between the Previous and Current Period and compared that against the percentage shift in Language Services utilization. Moving forward, Partnership will implement a yearly look back period where the previous year ratio will be compared to the current year ratio. Partnership may re-evaluate utilization on a yearly basis and adopt a new threshold for the purpose of this deliverable. Table XXIX lists the membership base whereas Table XXX illustrates the established Current Period threshold for this initiative:

Table XXIX: Membership Base

*Membership Base		
Previous Period	**Current Period**	**% Difference**
130,905	132,345	+ 1.1%

** Representative of members that have indicated a primary language other than English*

Table XXX: Language Service Type

Language Service Type	Current Period Threshold
Interpreting	≥ 618.21
Translation	≥ 3.19

In addition, Partnership administers an internal satisfaction survey to gauge staff experience with language service providers. This internal survey contains five experience/service based questions with a five-point rating scale ("Strongly Disagree", "Disagree", "Neutral", "Agree", and "Strongly Agree"). To assess staff experience with the services received, Partnership established an internal threshold in which 80% of Partnership staff provide a favorable response for each of the experience/service based questions. Note that a favorable response is defined as a response that is either "Agree" or "Strongly Agree".

To assess the utilization of language services and staff experience, select staff conducted analysis work groups. Through these work groups, contributors reviewed the aforementioned data sources to understand the current state of Partnership's Language Service utilization and staff experience levels. The Member Services team compared the utilization data of the Current Period against the Previous Period and monitored any shifts in the utilization. As evidenced in Table XXIX, Partnership experienced a 1.1% increase in the analysis membership figures between periods. When looking at the results, Partnership exceeded the threshold established for the interpreting category only. When comparing the utilization ratio between periods, interpreting saw a 13% increase, whereas as translation requests experienced a 19% decrease in utilization (Table XXXI).

Table XXXI: Language Service Utilization Data

Category	# of Sessions / Requests - Per 1,000 Members		Threshold	Partnership ≥ Threshold
	Previous Period	Current Period		
Interpreting	611.48	683.20	≥ 618.21	**YES**
Translation	3.15	2.52	≥ 3.19	**NO**

Category	Total # of Sessions / Requests		
	Previous Period	Current Period	% Diff
Interpreting	80,046	90,418	**+13%**
Translation	413	333	**-19%**

Notable Findings – Utilization / Staff Experience

To better understand the utilization data, the team took a closer look at each Language Service category (Table XXXII) in an effort to understand the composition of the utilization data. While the demand for interpreting continues to grow, we noticed a significant percentage shift in the amount of translation requests. We attributed this decrease to timing of events in which Partnership provides translations. It's worth noting that Q1 typically sees an increase in translation requests as new member material may be distributed more frequently during the start of the year. This is evidenced through the data captured as Q1 2023 contributed 31% to the total number of translations in 2023 and 56% of translations for the reporting period. In addition, we saw an uptick in both interpreting and translation requests during Q4. This was primarily driven by the increase in call volume into our Call Center (+15%, Q4 2024 vs. Q4 2022) and a result of Partnership's expansion into 10 additional counties.

Table XXXII: Utilization Demographics

Interpreting - Previous Period			
	Language	# of Trans.	% to Total
1.	Spanish	63,852	79.8%
2.	Russian	2,524	3.2%
3.	Vietnamese	2,392	3.0%
4.	Punjabi	1,252	1.6%
5.	Dari	1,242	1.6%

Interpreting - Current Period			
	Language	# of Trans.	% to Total
1.	Spanish-Lat.Am	72,165	79.9%
2.	Spanish-Mexico	2,644	2.9%
3.	Russian	2,460	2.7%
4.	Tagalog	1,398	1.5%
5.	Hmong	1,346	1.5%

Translation - Previous Period			
	Language	# of Trans.	% to Total
1.	Spanish-Lat.Am	95	23.0%
2.	Spanish-Mexico	81	19.6%
3.	Tagalog	50	12.1%
4.	Russian	47	11.4%
5.	Lao	14	3.4%

Translation - Current Period			
	Language	# of Trans.	% to Total
1.	Spanish-Lat.Am	93	27.9%
2.	Spanish-Mexico	67	20.1%
3.	Russian	52	15.6%
4.	Tagalog	50	15.0%
5.	Hmong	8	2.4%

When reviewing the results of the internal survey, Partnership exceeded the internal threshold for two out of the five survey questions (Table XXXIV). While the "Overall, the interpreter(s) was professional, respectful, and polite" category did not meet our internal threshold, we saw a positive increase of 2% over last year's result. The most glaring opportunity was seen in the "The turnaround time in obtaining interpreting services was acceptable" category in which 12 additional respondent provided a neutral response over last year. The increase in neutral respondents led to the overall decrease in performance for the category. In an effort to mitigate further timeliness issues, Partnership will incorporate additional collaborative sessions

throughout the year with our contracted vendor. These collaborative sessions with have an emphasized focus on workforce planning as well as identifying potential process improvement efforts around our intake process.

Table XXXIV: Internal Survey Results

Internal Survey Question	Favorable Rating % to Total	Threshold Met?
An interpreter(s) was available at the time of request.	85%	YES
The turnaround time in obtaining interpreting services was acceptable.	77%	NO
Overall, the interpreter(s) was professional, respectful, and polite.	76%	NO
Overall, the interpreter(s) met the interpreting needs of the member.	84%	YES
Overall, I was satisfied with the level of services that the interpreter(s) provided.	79%	NO

Factors 2 & 4: Individual experience with language services for organization functions and during health care encounters

Factors 2 & 4 Summary Findings: In comparing Grievance & Appeals (G&A) 2023 to 2022 cases, Language Assistance Services decreased by 22 cases in 2023 compared 2022. Language Barrier / Limited English Proficiency case filings increase by five (5) cases. Non-Threshold Language case type consisted of an increase of one (1) new case for 2023 compared to zero (0) in 2022. Auxiliary Aids and Services had eight (8) cases in 2023, four (4), from prior year. CAHPS® Regulated Survey for Measure Year 2022 sample frame consisted of 2,700 Adults, and 4,125 Child, achieving are response rate of 14.3% (380) Adult, and 14.9% Child (611).

In comparing survey performance by health plan target at or above 70th percentile threshold, Adult satisfaction was -2.3% below target and Child performed slightly above the target at 0.7%. Comparing survey performance by provider at or above 70th percentile threshold, Adult satisfaction was 1% above the target and 4.8% for Child satisfaction.

Methodology: In addition to the quantitative analysis above, we evaluated utilization data and results of the internal satisfaction survey and CAHPS® regulated and non-regulated[1] member experience survey questions specific to interpreting and translation language services. Qualitative findings and observations are detailed within this section. Grievance and Appeals (G&A) data is another source the analysis workgroup uses to evaluate real time member abrasion or dissatisfaction. Custom G&A reports provide case filings by type, category, status, outcome and whether grievances involve the health plan or provider network. The following category types and definitions support the intent to reduce healthcare disparities.

Category Type	Definition
Language Assistance Services	Case involves interpretation services that help people with a Limited English Proficiency communicate in English.
Language Barrier / Limited English Proficiency	Case involves a person whose first language is not English and has trouble reading, writing, speaking, or understanding English.
Non-threshold Language	Case involves a non-threshold spoken language. Threshold languages are; English, Armenian, Cambodian, Chinese, Farsi, Korean, Tagalog, Russian, Spanish and Vietnamese.
Auxiliary Aids and Services	Case involving services used by a member who is deaf, blind, hard of hearing or seeing to help them communicate. These services include sign language, text telephones, or other such devices to get information. This also includes any effective method to improve reading such as large print.

Notable Findings - Grievance & Appeals (G&A)

The analysis workgroup observed two notable findings while comparing year-over-year covered member benefit and G&A case filings: One) an increase in 2023 member utilization of interpreter or language services (UILS), and 2) a decrease in Culturally and Linguistically Appropriate Services (CLAS) member filed G&A cases compared to 2022. The overall assessment is the member UILS rate relative to the G&A CLAS case filings are low.

Referenced below is a year-over-year case comparison by category type.

Language Assistance Services

- 2023 - 2 Cases
- 2022 - 24 Cases
- - 22 Cases
- Noted improvement

Non-threshold Language

- 2023 - 1 Case
- 2022 - 0 Cases
- + 1 Case
- Noted increase

Language Barrier / Limited English Proficiency

- 2023 - 15 Cases
- 2022 - 10 Cases
- + 5 Cases
- Noted increase

Auxiliary Aids and Services

- 2023 - 8 Cases
- 2022 - 4 Cases
- + 4 Cases
- Noted increase

The 2023 case filings yielded a score of 0.03% relative to language service utilization and was below the threshold target of (1/10th of one percent) 0.10%. Although the goal was met the analysis workgroup established a priority ranking based the on number of case filings by category (Table XXXV).

Table XXXV

2023 Annual Grievance & Appeals Priority By Category Type	
Language Barrier / Limited English Proficiency	15
Auxiliary Aids and Services	8
Language Assistance Services	2

The workgroup focused on the top three case category types to identify service abrasion/dissatisfaction themes. Partnership further compiled case filings by service delivery and identified correlating themes (italicized) for Health Plan and Provider/Network (Table XXXVI) and NCQA Health Equity (HE) 6 Case Analyses (Table XXXVII).

Table XXXVI: Member Dissatisfaction Theme

Service Delivery	Member Dissatisfaction Theme
Partnership	• Service provider - technical/connectivity issues • *Service provider - dialect/translation issues* • *Covered member - translation and interpreter benefit literacy*
Provider/Network	• Customer service/cultural sensitivity training • *Covered benefit awareness and training* • *Service provider - dialect/translation issues*

Table XXXVII: NCQA Health Equity (HE) 6 Case Analyses

Case Category Type	2023 Grievance & Appeals Case Totals	NCQA Health Equity (HE) 6 Case Analyses
Language Assistance Services	2	Case filings offer different perspectives specific to Language Assistance Services. Theme: Familiarity of benefit literacy and breakdown in communication.
Language Barrier / Limited English Proficiency	15	Case filings offer a combination of unconfirmed and confirmed perceptions of discrimination associated with language barriers. Case filing themes: benefit literacy, scheduling, and communication breakdown. Per the Partnership Member Hand-book, members are encouraged to schedule interpreter services when confirming a medical appointment. In some instances, provider sensitivity training, and reminders of CLAS-covered benefits are warranted.

Non-threshold Language	1	Partnership Member Services (MS) employee created an unintended abrasion/experience while following procedure to authenticate plan covered member over the phone. The language barrier occurred between member ad hoc interpreter (family member) and MS employee. Assessment: Although plan MS employee adhered to procedure, there is an employee lesson learned/training opportunity. Learn to take verbal/conversation ques to know when to transfer to a bilingual MS employee or qualified interpreter services (AMN) delegated vendor.
Auxiliary Aids and Services	8	Case filings offer different perspectives specific to Auxiliary Aids and Services. Theme: Familiarity with covered benefits (varied clinical settings) literacy and breakdown in communication.

CAHPS® Survey Data

The CAHPS® program added NCQA approved supplemental questions specific to interpreting and translation language services for adult and child 2022 Measure Year (MY) CAHPS® regulated survey. Important to note, the survey is only available in two language formats, English and Spanish. A targeted focus to improve child survey scores, and to address regulated survey limitations, we included additional questions in English and Spanish in the child non-regulated[1] CAHPS® drill-down survey. Partnership has implemented this strategic step to align with NCQA standards and NCQA Health Equity Accreditation requirements. The survey oversample frame for the CAHPS® regulated consisted of; Adult 2,700, and Child 4,125, members survey and for the CAHPS® non-regulated[1] survey, Child 2,000. The following regulated supplemental questions were assessed:

Adult Experience with Language Services

Question
Q42. In the last 6 months, if you utilized an interpreter or language services to help speak with your Health Plan, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?
Q43. In the last 6 months, if you utilized an interpreter or language services to help speak with your doctors or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?

Medicaid Adult Regulated Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 99)	Q42. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 244		67.7%	25.3%	7.1%	
Valid Responses (n= 100)	Q43. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 240		71.0%	21.0%	8.0%	

Child Experience with Language Services

Question
Q43. In the last 6 months, if you utilized an interpreter or language services to help speak with your Health Plan, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?
Q44. In the last 6 months, if you utilized an interpreter or language services to help speak with your child's doctors or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?

Medicaid Child Regulated Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 239)	Q43. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 308		70.7%	17.6%	11.7%	
Valid Responses (n= 238)	Q44. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 304		74.8%	16.8%	8.4%	

Survey Section: Your Child's Personal Doctor

Question
Q13. In the last 6 months, have you ever had a hard time speaking with or understanding your child's doctor or other health care provider because you spoke different languages?
Q14. In the last 6 months, if you used an interpreter or language services to help speak with your child's doctors or other healthcare providers, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?
14a. Please share more about your rating.

Survey Section: Your Child's Health Plan

Question
21. In the last 6 months, if you used an interpreter or language services to help speak with your child's Health Plan, how would you rate your experience (with 0 being the worst possible experience, and 10 being the best possible experience)?
21a. Please share more about your rating.

Performance Summary by Survey and Service Delivery

The analyst workgroup evaluated the CAHPS® Regulated and [1]CAHPS® Non-Regulated Drill-Down Surveys (Section II) results against the Plan 70th percentile performance threshold (Section III) to determine if we met or exceeded the performance target (Table XXXVIII).

Located below is a summary of the survey findings:

Table XXXVIII

Population	Survey Type	Plan Satisfaction Rating Score (% 9 or 10)	Performance Target Met?	Provider Satisfaction Rating Score (% 9 or 10)	Performance Target Met?
Adult	Regulated	67.7%	NO	71.0%	YES
Child		70.7%	YES	74.8%	YES
Child	Non-Regulated	62.5%	NO	57.1%	NO

- Adult Population:
  - Plan Satisfaction: Performance -2.3% below threshold target
  - Provider Satisfaction: Performance 1% above threshold target
- Child Population
  - Plan Satisfaction: Performance 0.7% above threshold target
  - Provider Satisfaction: Performance 4.8% above threshold target

[1]CAHPS® Non-Regulated Survey

- Child Population
  - Plan Satisfaction: Performance -8.5% below threshold target
  - Provider Satisfaction: Performance -12.9% below threshold target

CAHPS® Regulated Survey

Survey scores for adult and child questions (Table XXXIX) and (Table XL).

- **Adult CAHPS® Regulated Survey (Table XXXIX)**
  - **Q42** (utilization with plan) 244 chose "not applicable"
  - Valid response (n = 99)
  - Experience rating scale 0 - 10 (0=worst 10=best)

        - 9 or 10 (67.7%), 7-8 (25.3%), 0-6 (7.1%)
        - Target Met: **No**
    - **Q43** (utilization with provider) 240 chose “not applicable”
    - Valid response (n=100)
    - Experience rating scale 0 - 10 (0=worst 10=best)
        - 9 or 10 (71.0%), 7-8 (21.0%), 0-6 (8.0%)
        - Target Met: **Yes**

Table XXXIX

Medicaid Adult Regulated Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 99)	Q42. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 244		67.7%	25.3%	7.1%	
Valid Responses (n= 100)	Q43. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 240		71.0%	21.0%	8.0%	

- **Child CAHPS® Regulated Survey (Table XL)**
    - **Q43** (utilization with plan) 308 chose “not applicable”
    - Valid response (n = 239)
    - Experience rating scale 0 - 10 (0=worst 10=best)
        - 9 or 10 (70.7%), 7-8 (17.6%), 0-6 (11.7%)
        - Target Met: **Yes**
    - **Q44** (utilization with provider) 240 chose “not applicable”
    - Valid response (n=304)
    - Experience rating scale 0 - 10 (0=worst 10=best)
        - 9 or 10 (74.8%), 7-8 (16.8%), 0-6 (8.4%)
        - Target Met: **Yes**

Table XL

Medicaid Child Regulated Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 239)	Q43. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 308		70.7%	17.6%	11.7%	
Valid Responses (n= 238)	Q44. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 304		74.8%	16.8%	8.4%	

The child MY 2022 [1]CAHPS® non-regulated drill-down survey (Section III) sample frame of 2,000 members, of the surveyed we had a respondent rate of 9.5% and/or 189 completed surveys.

[1]CAHPS® Non-Regulated Survey
Survey scores by child questions only (Table XL).

- **Child [1]CAHPS® Non-Regulated Drill-Down Survey**
  - **Q14** (utilization with provider)
  - Valid response (n=8)
  - Experience rating scale 0 - 10 (0=worst 10=best)
    - 9 or 10 (62.5%), 7-8 (0%), 0-6 (37.5%)
    - Target Met: **No**
  - **Q21** (utilization with plan)
  - Valid response (n=14)
  - Experience rating scale 0 - 10 (0=worst 10=best)
    - 9 or 10 (57.1%), 7-8 (29%), 0-6 (13.9%)
    - Target Met: **No**

Table XL

Medicaid Child Non-regulated Drill Down Survey		Category Responses Based on Valid Responses Per Question			MY 2022 Performance Target
Valid Responses (n= 8)	Q14. Overall experience with interpreter/language services utilized with Dr. (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	70th Percentile
Not Applicable 181		62.5%	--	37.5%	
Valid Responses (n = 14)	Q21. Overall experience with interpreter/language services utilized with plan (% 9 or 10 - Best possible experience)	9 or 10 - Best possible experience	7-8	0-6	
Not Applicable 175		57.1%	29%	13.9%	

Grievance & Appeals
The workgroup priority to evaluate Language Assistance Services case filings started with causal factor analysis. Through the discovery process, we identified linked dissatisfaction themes between the Health Plan and Provider/Network service delivery. Additionally, Partnership's analysis includes specific examples of service abrasion (Table XLI).

Table XLI

Service Delivery	Member Dissatisfaction Theme	Examples
Partnership	• Service provider - dialect/interpreter issues • Covered member - translation and interpreter benefit literacy	• Interpreter is not adequately communicating because of dialect grammar, word usage/ variations.

Provider/Network	• Covered benefit awareness and training • Service provider - dialect/interpreter issues	• Provider education. Not aware of covered benefit. Members misinformed or general communication barriers.

The concept of inverse logic was used while evaluating G&A case filings as a method to measure member satisfaction for all language thresholds. The logical premise is low G&A-CLAS case filings relative to the utilization of interpreter and translation services demonstrates satisfaction (26/85,605[+]).

[+]*Language Service Utilization includes services for Language or Interpreter. Threshold (Combined Category Total / Annual Utilization Average)*

Element D: Use of Data to Measure CLAS and Inequities

Factor 1: Identifies and prioritizes opportunities to reduce health care inequities

Factor Summary:

Overall, researchers found that Well Care Visits (WCV) was the clinical measure with a majority of race/ethnic groups not meeting the minimum performance threshold in all of Partnership's regions. The American Indian/Alaska Native, African American/Black, and White groups had a Strong Disparity for this measure. The Black/African American group, the additional disparity of focus is Timeliness of Prenatal Care due to some findings that were statistically significant and having an average percentage below the MPL across various regions. The American Indian/Alaska Native group, had a Strong Disparity in prenatal care, postpartum care due to having an average rate of performance 13% below the MPL across 3 regions.

Methodology:

Partnership's original goal in defining and prioritizing disparities to reduce health care disparities was to utilize statistical significance to identify measures with an opportunity for improvement. Currently, there are no gold standards for evaluating disparities, therefore Partnership developed the following disparity classification system to aid in prioritizing disparities based upon measure findings. This is based upon the Strength of recommendation taxonomy used in various clinical guidelines to stratify recommendations. Partnership identified opportunities to reduce health care inequities after evaluating both Health Plan Accreditation and MCAS final rates for the measures of focus for the Grand Analysis Report. Identified opportunities to reduce inequities were then prioritized using the strong/moderate/weak disparity classification system referenced in Table XLII, with Partnership ultimately prioritizing opportunities classified as a Strong Disparity.

Table XLII: Strength of Disparity Classification

Disparity Classification

Strong Disparity (Disparity is clearly present when compared to comparator group or goal)
• Meets at least three of any of following factors below
  ○ MCAS Sample Measure
  ▪ Group is performing statistically worse in at least one region when compared to the comparator group
  ▪ Absolute Average Percentage Difference between specific group and minimum performance level is at least 10% (multiple regions) or 15% in single region in MCAS/HEA measure
  ▪ Multiple regions (≥2) where specific group falls below 25th percentile per MCAS measure

Moderate Disparity (Disparity is moderately present when compared to comparator group or goal)
• Meets at least three of any of the following factors
  ○ MCAS Sample Measure
  ▪ Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 10% (multiple regions) or 15% in single region
  ▪ No group is performing significantly better than comparator group yet at least one group is performing significantly worse per MCAS measure
  ▪ Multiple regions (≥2) where group falls below 50th percentile
  ▪ At least 1 region where group falls below 25th percentile

Weak Disparity (Disparity is uncertain when compared to comparator group or goal)
• Meets at least two of any of the following factors:
  ○ MCAS Sample Measure
  ▪ No statistical difference between groups in a region
  ▪ Absolute Average Percentage deficit between group and comparator (minimum performance level) is at least 5% (multiple regions) or 7% in single region
  ▪ Only 1 region where group falls below 50th percentile and no region fall below 25th percentile

Partnership created the table below (Table XLII) to not only highlight the disparities identified from all analyses, but to classify the level of priority for each identified disparity based on the utilization of the Strength of Disparity Classification table (Table XLIII). The table below lists the overall disparity findings with prioritization for each race/ethnicity group included in this Grand Analysis.

Table XLIII: Health Inequities Areas of Focus

Group	Key HEA Measure	MCAS Number of Regions with Statistically Worse Disparity	MCAS Number of Regions with disparity (below 25th)	MCAS Number of additional Regions with disparity (below MPL – 50th)	Absolute % Average BELOW MPL across regions below 50th Percentile	Category of Disparity (S/M/W)	Number of Years with Same Disparity from 2024
White	Controlling High Blood Pressure (CBP)	-	1	0	-1.21%	WEAK	N/A
	Poor HbA1c Control (>9%)	-	0	1	-5.54%	WEAK	N/A
	Postpartum Care	-	0	0	-----	N/A	N/A
	Timeliness of Prenatal Care	-	0	1	-4.33%	WEAK	N/A
	Well Child Visits (WCV)	-	1	3	-6.02%	MODERATE	N/A
Native Hawaiian and Other Pacific Islander	Controlling High Blood Pressure (CBP)	0	1	0	-61%	MODERATE	N/A
	Poor HbA1c Control (>9%)	0	2	0	-12.04%	STRONG	N/A
	Postpartum Care**	0	-	-	---	N/A	N/A
	Timeliness of Prenatal Care**	0	-	-	---	N/A	N/A
	Well Child Visits (WCV)	1	3	1	-11.16%	STRONG	N/A
Hispanic or Latino	Controlling High Blood Pressure (CBP)	0	0	1	4.22%	WEAK	N/A
	Poor HbA1c Control (>9%)	0	0	1	-1%	WEAK	N/A
	Postpartum Care	0	0	0	N/A	NONE	N/A
	Timeliness of Prenatal Care	0	0	0	N/A	NONE	N/A
	Well Child Visits (WCV)	0	0	1	-3.08%	WEAK	N/A
Black or African American	Controlling High Blood Pressure (CBP)	0	0	0	N/A	NONE	N/A
	Poor HbA1c Control (>9%)	0	1	1	12%	STRONG	N/A
	Postpartum Care	0	0	0	N/A	NONE	N/A
	Timeliness of Prenatal Care	0	2	0	-30.12%	STRONG	N/A
	Well Child Visits (WCV)	1	2	2	-6.57%	STRONG	N/A
Asian	Controlling High Blood Pressure (CBP)	0	0	2	-0.17%	WEAK	N/A
	Poor HbA1c Control (>9%)	0	0	0	N/A	NONE	N/A
	Postpartum Care	0	0	1	-6.71%	WEAK	N/A

	Timeliness of Prenatal Care	0	1	0	-6.53%	WEAK	N/A
	Well Child Visits (WCV)	0	0	4	-2.81%	WEAK	N/A
American Indian and Alaska Native	Controlling High Blood Pressure (CBP)	0	2	0	-11.26%	MODERATE	N/A
	Poor HbA1c Control (>9%)	1	1	2	-33%	STRONG	N/A
	Postpartum Care	1	0	2	-15.57%	STRONG	N/A
	Timeliness of Prenatal Care	1	3	0	-21.78%	STRONG	N/A
	Well Child Visits (WCV)	1	1	3	-5.91%	MODERATE	N/A

Native Hawaiian and other pacific islander measures not evaluated due to lack of sample size in each region to be sufficient

From the table above, Partnership prioritized the following identified health inequities (highlighted in orange) based on their inclusion in the "strong" disparity category:

1. Timeliness of Prenatal Care (PPC – Pre): Black/African American Members
2. Timeliness of Prenatal Care (PPC – Pre): American Indian/Alaska Natives
3. Timeliness of Postpartum Care (PPC – Post): American Indian/Alaska Natives
4. Well Care Visits (WCV): All Pediatric Members

However, there are some significant limitations to note in Partnership's analysis. The major limitation is the lack of a gold standard to evaluate and quantify disparities between various groups. Experts have debated and have not developed a consensus on how to effectively measure disparities between groups. While team members reviewed this information, we developed modifications of such systems of evaluating the disparities, which may produce bias. Also, the system and metrics previously used have not been tested to validate their accuracy. For example, in utilizing the scoring model and analyzing findings, Partnership prioritized Controlling High Blood Pressure, Hemoglobin A1c Control, and Prenatal and Postpartum Care for Black members. While a disparity was identified for the Black/African American population for CBP, only 20 members identified as Black/African American were included in the MCAS hybrid sample, and of those 20, only 8 (40%) were noncompliant in the measure over all four regions. The small denominator for this group made the Black population a larger priority in addressing inequities identified for this measure.

Additionally, Partnership's utilization of state data for the race and ethnicity information included in this analysis was done to provide the most up to date member demographic information for members included in each measure sample. However, members where race or ethnicity were unknown fell into the "Unknown" category, and as such, these members were not included in the final analysis. As shown in Element A, 59,918 (8.9%) of Partnership members have "Unknown" listed for their race and ethnicity demographic information. Partnership is exploring ways to strengthen race and ethnicity demographic information for members in this category, to more appropriately impact them in future analysis and create more tailored interventions.

Another major limitation was evaluating and integrating CAHPS® responses. In addition to the prioritized opportunities listed above, Partnership also identified a need to explore potential

solutions to impact CAHPS® responses. Partnership recognizes that the CAHPS® response rate from members is low, and is exploring options to increase survey access, and acknowledge the diverse language demographics of Partnership members. As such, Partnership is also exploring how to ensure the survey is available in additional languages to Spanish and English to encourage responses are being received from a diverse population of eligible survey recipients, findings are more representative of the communities served, and can be acted upon.

Finally, as highlighted previously, a major limitation of all of these findings is that the sample sizes were significantly smaller, therefore significantly lowering the likelihood of finding significant differences. NCQA team auditors may want to suggest threshold demographic sample sizes for each measure to improve likelihood of validity when comparing stratified languages while working with plans that utilize the MCAS measures.

Factor 2: Identifies and prioritizes opportunities to improve CLAS

When reviewing the utilization data, Spanish was the most requested language for both interpreting sessions and translation requests. To continue to support the demand for Spanish Language Services, Partnership's Member Services Call Center strives to ensure Member Service Representatives (MSR) are bilingual. At the department level, there is an internal goal to maintain ¾ or 75% of Partnership's MSR's are bilingual. To be considered a "bilingual" employee, applicable staff must pass a Partnership administered language competency exam. Upon completion, bilingual staff are able to provide customer support in the language in which they exemplified competency. With that said, the Department is currently at 70% and will continue to work towards achieving and sustaining this internal goal.

In regard to Partnership's threshold languages, we noticed that Tagalog was not within the top seven requested languages for interpreting. Although the volume was small, Tagalog accounted for 12.9% of the translation requests in the Current Period. Another language that is gaining adoption is Vietnamese. Vietnamese was the second most requested language for interpreting. In terms of translation requests. Knowing that Vietnamese is not a threshold language, there may be future opportunities for Partnership to further understand the demand for this language through the continued analysis of utilization data.

When looking at the results of the Internal Satisfaction Survey, Partnership provided staff with the opportunity to provide candid feedback through an open-ended/optional question. Through this question, we were able to understand some of the challenges that Partnership staff experienced. One of the leading causes of staff dissatisfaction was that interpreters disconnected from the session prematurely. To address this opportunity, Partnership will collaborate with contracted vendors to reiterate expectations and ensure that the interpreters are adequately trained on closing each interpreting session. Another common concern was that select languages had a longer hold time than usual. This typically happens with languages of lesser diffusion, such as Samoan and Mixteco. This concern has been thoroughly discussed with Partnership's provider base. Contracted providers will continue to make a good-faith effort to ensure that their internal workforce-planning department is aware of these deficits. Another solution is that Partnership has the ability to pre-schedule interpreting sessions for the

languages of lesser diffusion. Partnership will continue to assess staff experience and work with contracted providers on areas of opportunities in an effort to improve staff experience with the interpreting services received.

In identifying opportunities to improve CLAS, Partnership utilized measure performance stratified by language and sexual orientation, CAHPS® and Grievance and Appeals data. Partnership's original goal when assessing opportunities to improve CLAS was defined as:

Goal: There will be no statistically significant lower performance for each measure included in this report for each language group in comparison to the English group.

Status: Goal Met.

Goal: There will be no statistically significant lower performance for each measure included in this report for the Female group in comparison to the Male group.

Status: Goal Met.

As each of these goals was met, Partnership reviewed the CAHPS® data findings. Although the CAHPS® survey yields insight into the interpreting and translation language services, respondent samples specific to each supplemental question in the CAHPS® regulated and non-regulated survey are statistically insignificant relative to the non-English speaking surveyed member population. Important to note, the regulated and drill-down surveys are only offered in English and Spanish language formats, which limits Partnership's ability to proactively solicit members for all threshold languages. As a result of the barriers identified, Partnership did not identify any opportunities based on responses to CAHPS® questions.

Partnership also created a goal to evaluate member satisfaction relative to language service utilization. This goal was defined as:

Goal: Maintain member abrasion or dissatisfaction below 1/10th of one percent (0.10%).

Status: Goal Met.

As outlined in Element C, Partnership met or performed better than the member satisfaction target. The 2023 case filings yielded a score of 0.03% relative to language service utilization and was slightly above the threshold target of (1/10th of one percent) 0.10%. The analysis workgroup established a priority ranking based the on number of case filings by category (Table XLIV). As illustrated in Table XLIV, the Language Barrier/Limited English Proficiency category type resulted in roughly 60% of the total grievances within the 2023 Annual Grievance & Appeals Priority by Category Type, which highlights an opportunity for improvement.

Table XLIV

2023 Annual Grievance & Appeals Priority By Category Type	
Language Barrier / Limited English Proficiency	15
Auxiliary Aids and Services	8

Language Assistance Services	2

Based on the priority, the workgroup approached each Language Assistance Service case (TTL: 26) with the purpose to identify service abrasion/dissatisfaction themes. Partnership further compiled case filings by service delivery and identified correlating themes (italicized) for Health Plan and Provider/Network (Table XLV) and NCQA Health Equity (HE) 6 Case Analyses (Table XLVI).

Table XLV

Service Delivery	Member Dissatisfaction Theme
Partnership	• Service provider - technical/connectivity issues • *Service provider - dialect/translation issues* • *Covered member - translation and interpreter benefit literacy*
Provider/Network	• Customer service/cultural sensitivity training • *Covered benefit awareness and training* • *Service provider - dialect/translation issues*

Table XLVI: NCQA Health Equity (HE) 6 Case Analyses

Case Category Type	2023 Grievance & Appeals Case Totals	NCQA Health Equity (HE) 6 Case Analyses
Language Assistance Services	2	Case filings offer different perspectives specific to Language Assistance Services. Theme: Familiarity of benefit literacy and breakdown in communication.
Language Barrier / Limited English Proficiency	15	Case filings offer a combination of unconfirmed and confirmed perceptions of discrimination associated with language barriers. Case filing themes: benefit literacy, scheduling, and communication breakdown. Per the Partnership Member Handbook, members are encouraged to schedule interpreter services when confirming a medical appointment. In some instances, provider sensitivity training, and reminders of CLAS-covered benefits are warranted.
Non-threshold Language	1	Partnership Member Services (MS) employee created an unintended abrasion/experience while following procedure to authenticate plan covered member over the phone. The language barrier occurred between member ad hoc interpreter (family member) and MS employee. Assessment: Although plan MS employee adhered to procedure, there is an employee lesson learned/training opportunity. Learn

		to take verbal/conversation ques to know when to transfer to a bilingual MS employee or qualified interpreter services (AMN) delegated vendor.
Auxiliary Aids and Services	8	Case filings offer different perspectives specific to Auxiliary Aids and Services. Theme: Familiarity with covered benefits (varied clinical settings) literacy and breakdown in communication.

Factor 3: Implements at least one intervention to address an inequity

In addressing disparities and impacting health equity at a global scale, Partnership has worked to improve tools used both internally and externally to ensure they address disparities at the plan-wide level. Race and ethnicity data has been added to external tools to allow network practitioners to facilitate targeted outreach, and understand demographic information for members seen at their clinics. Demographic information has been added to Partnership's eReports (an online system built by Partnership's Web team for the PCP QIP Clinical measures; it is the mechanism by which providers can monitor their performance and submit supplemental medical record data to Partnership to enhance their performance), and member lists available to providers like Partnership's Preventive Care dashboard.

Furthermore, Partnership is adding race and ethnicity data to internal tools like the Maternity Services dashboard to bring more visibility to this data, and facilitate targeted outreach when tools are utilized. Health equity has also been added to the *Improving Measure Outcomes* webinar series Partnership hosts to QI teams within the network to ensure teams understand measure specifications and performance, and best practices for each of the measures included. The addition of health equity focus and member demographic information to these externally facing webinars was done to help QI teams within Partnership's network develop strategies for measure improvement with this information in mind. This has been added to webinars that address all measures of focus included in this report.

Lastly, Partnership identified a number of opportunities to improve health and CLAS inequities based on the analysis included in Factor 1 (Table XLIII). Opportunities to address inequities have been highlighted below by measure category.

Timeliness of Prenatal Care (PPC – Pre)	
Group(s) of Focus	Black/African American Members
Percentage Below Minimum Performance Level (MPL)	*NE Region: 9.28% below* *NW Region:50.97* % below Non-Weighted Average: 30.12%
Goal for Specific Group	Improve prenatal visits by at least 5% in the NE or NW region in the Black/African American Member Population within 12 months with the global goal of improvement by 30% in the next 5 years.
Root Cause Analysis	Timely prenatal care is recommended to promote healthy pregnancies via screening and preventative management of a woman's risk factors. Unfortunately, various studies have suggested that fewer timely prenatal visits are associated with poorer pregnancy outcomes such as severe maternal morbidity, maternal death, and infant mortality (Howell, 2018). Research has suggested that insurance availability, transportation, and access to specific providers are key driving factors for receiving timely prenatal care. Partnership identified inequities for Black/African American members in the Northeast and Northwest regions for Timeliness of Prenatal Care.
Barrier Analysis	For prenatal care, researchers found that policy changes that improved eligibility for individuals, made insurance coverage more comprehensive, and improved maternity reimbursement rate was associated with greater attendance in postpartum visits (Saldanha et al., 2023). There has been limited research evaluating prenatal care and postpartum interventions in specific patient groups—namely Black/African American patients. Currently, Black/African American women are at least 3x more likely to experience a pregnancy-related death when compared to White women and have the largest disparity among all the conventional population perinatal health measures (Howell, 2018). However, partnership is currently exploring interventions to positively impact their prenatal and postpartum care. In 2023, the Department of Health Care Services (DHCS) added doula services as a covered benefit. In 2023, Sobczak et al. conducted a literature review of 16 studies (cohort and randomized trials) to evaluate the benefits of utilizing a doula. Their findings suggested that doula support decreased incidence of cesarean or premature labor, low birth weight, and epidural/medical pain management. Finally, Partnership conducted a focus-group-like survey of Black prenatal and postpartum members (n=12) to conduct a survey to better understand if the member attended their appointments, as well as to understand the barriers faced, if any at the Solano County Family Health Services site—which has the largest population of Black/African American members. Overall, the members highlighted that they didn't attend their visits due to one of the following three categories: (1)

	Incorrect Staff Actions, (2) Schedule Unavailability, (3) Lack Of Transportation. This has motivated Partnership to explore utilizing group visits to streamline staff actions, schedule availability, and coordinate transportation. In 2017, Byerley and Hass conducted a systematic review of 38 studies (8 randomized trials, 23 nonrandomized studies, 6 reports of group outcomes without controls) to evaluate group prenatal care in 20,000+ women. Overall, Byerley et al. (2017) found a significant increase in rates of breastfeeding and satisfaction in Black/African American members after implementing group prenatal care interventions. Partnership may explore whether clinical site locations will be interested in conducting a pilot to validate the efficacy of utilizing such group visits with Doulas. Long-term, Partnership will explore utilizing a combination of interventions to likely meet the large threshold of members who are not meeting the goal.
Actions for Direct Clinical/Service Measure Improvement	**Intervention #1: Contracting Doulas in Partnership Network:** Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network, and has at least one doula in each region of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. **Intervention #2: Increase Diversity of OB GYNs:** Partnership is investigating how to improve the diversity among Obstetrics-Gynecology doctors. To this, Partnership is exploring how to do a baseline assessment of the race and ethnicity demographics of OBs within the network to assess. Partnership will then share this information with respective HR departments to provide guidance to the provider recruitment team at Partnership and incentivize increasing diversity hiring throughout the network to reflect the populations served. Partnership has launched a new provider retention initiative. Specifically, partnership will provide $45,000 award to a doctor of medicine/doctor of osteopathic medicine (DO) or $30,000 award to a nurse practitioner/physician assistant for a 3-year commitment. This intervention will be applicable to all clinical sites—especially OB/GYN sites that inhabit locations that serve a large Black/African American population. **Intervention #3: Encourage Clinical Sites to Utilize Dyadic Care Models** Dyadic care models are considered effective for optimizing the care of both the mother and infant. Dyadic care is considered when a provider provides care for a birthing mother and their infant during the same visit. Specifically, the American Academy of Pediatrics recommends prenatal visits to establish pediatric medical homes and postnatal depression screening for the birthing person during pediatric visit (Choy et al. *PLoS One*. 2024 Apr 16;19(4):e0298927). This is based upon the

	postnatal period being seen as a critical time to support and improve health outcomes of birthing people and their infants. Unfortunately, pregnancy-related morbidity and mortality often occurs within the 6-week postpartum period and this has been attributed to difficulty in accessing care. Partnership will continue to advocate for sites to adopt dyadic care models—especially in regions where there are limited OB/GYNs and primary care providers.

Prenatal and Postpartum Care (PPC)	
Group(s) of Focus	American Indian/Alaska Native
Prenatal Percentage Below Minimum Performance Level (MPL)	*NE Region: 9% Below* *NW Region:* 22% below *SW Region:* 34% below *Non-Weighted Average:* 21.78% Below
Goal for Specific Group	Improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement of 22% in the next 5 years.
Postpartum Percentage Below Minimum Performance Level (MPL)	*NE Region: 28% Below* *NW Region:* 3% below *SW Region:* 3% below *Non-Weighted Average:* 11.4% Below
Goal for Specific Group	Improve postpartum visits by at least 5% in the NE region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 12% in the next 5 years.
Root Cause Analysis	Currently, majority of our American Indian/Alaska Native members are located in Humboldt, Mendocino, and Shasta Counties in our NW and NE regions. Tertiary research has suggested that there is a significantly higher rate of maternal morbidity and mortality among this group due to centuries of human rights violations (e.g. massacres, forced relocation, boarding schools) which has translated into generational trauma via epigenetics (Burns et al. *Soc Sci Med*. 2023 Jan;317:115584.). In addition, researchers has identified the following predictors of maternal mortality: older maternal age, pre-existing conditions, prior cesarean section, transportation issues, travel time, administrative burdens which limit Medicaid enrollment and prenatal care update; and various structural racism incidents during healthcare interactions.
Barrier Analysis	Research suggests that there are structural barriers that are exacerbating poor outcomes in our American Indian/Alaska Native community. For example, there are purported to be transportation infrastructure, family welfare system, poor prenatal care infrastructure, and blatant racism that are the key upstream factors that are acting as barriers for improving disparities.

	Within Partnership's service landscape, the region that is experiencing the greatest disparity for this measure is the NW rural region. Currently, many of Partnership's AI/AN members inhabit this area and likely are experiencing lack of clinic access for all providers. Also, various tribal centers utilize various are held financially accountable to government performance and results act (GPRA) versus HEDIS measures—which are considered less stringent. Therefore, various tribal centers do not have the financial incentive to be intensive with hypertension treatments versus non-tribal health centers. To improve relations, Manage Care Organizations (MCOs) and Partnership specifically, has explored hiring tribal health center liaisons to improve the collaboration between MCOs and tribal centers.
Actions for Direct Clinical/Service Measure Improvement	**<u>Intervention #1: Tribal Health Liaison Hiring and Hosting Tribal Center Event</u>** Partnership has hired a full-time Tribal health liaison to positively impact relationships with tribal health centers, tribal health community members, and provide guidance to help support Tribal member needs. Partnership has recognized partnering with the Tribal community as an organizational initiative, and is working to positively impact all care received by Tribal members through this partnership and communication with Tribal Health Centers within the network at this time. This work has the potential to improve the member experience of American Indian/Alaska Native members, ensure they are receiving culturally appropriate care, and positively impacting the care received by members who identify with this group. Also, the tribal health liaison will be able to conduct various focal group interviews and possibly identify community based organizations to able to provide tele-nutrition counseling sessions, funds for delivery of DASH-diet aligned foods. **<u>Intervention #2: Contracting Doulas in Partnership Network:</u>** Partnership is also investigating what education doulas share with utilizing members, to ensure members are receiving appropriate information on the importance of early access to prenatal care as well as postpartum care. Partnership has worked to add doulas to the network, and has at least one doula in each region of the network. The health equity officer and other staff have ventured into various community events to help with recruiting various Doulas. In addition, Partnership is trying to contract with doula's in the NE/NW regions to ensure that we are able to outreach to our Tribal community members. **<u>Intervention #3: Advertisements of Transportation Benefit with Translation into Tribal Languages:</u>** Partnership is also investigating what education we can share with utilizing members, to ensure members are receiving appropriate information on the importance of

	early access to prenatal care as well as postpartum care. For example, partnership has recognized that many members are unaware of the transportation benefit afforded to them. Therefore, they may be unaware that Partnership is able to pay for the lodging fees and transportation for a tribal member anywhere they would like to go if they are seeking prenatal/postpartum care in a separate county. Finally, partnership will like to engage with and survey members to assess whether they should advertise certain education materials into different languages to ensure they are receptive to our various tribal communities.

Well Care Visits (WCV)	
Group(s) of Focus	American Indian/Alaska Native Black/African American White
Goal for Specific Group	Improve Well Care Visit attendance by at least 2.5% across multiple regions or at least 5% in 1 single region in any group (e.g.) Black/African American, American Indian/Alaska Native, White within 12 months with global goal of improvement by 5% in the next 5 years.
Root Cause Analysis	Per the DHCS Bold goals, the state is looking to close all racial/ethnic disparities in WCVs by 50% by 2025. Currently, WCVs are low for all populations. A proposed hypothesis of the root cause is that there is a significant shortage of pediatrician providers—who are able to conduct the WCVs. Therefore, there is a limitation of conducting the absolute number of visits for all pediatric members—regardless of race/ethnicity/gender identity. Also, by having certain members miss at least 1 visit, this will likely cause a shift to make it impossible to attain the key number of visits by a certain age. Currently, the American Academy of Pediatrics recommends at least 13 well-child visits between birth and 6 years of life.
Barrier Analysis	Overall, researchers found that Well Care Visits (WCV) was the clinical measure that majority of race/ethnic groups have a disparity of not meeting the minimum performance threshold throughout the regions. This suggests that the low WCV rate is more of a quality concern versus a demographic specific concern. Within the American Indian/Alaska Native community, there is a community concern of children being reported for child protective services referrals. Historically, AI/AN children were consistently removed from their homes to adopt western cultures. This has resulted in various family members being concerned with exposing their child to unfamiliar members of the community. Also, Partnership tribal health centers have a challenge with engaging with members due to the ongoing difficulties with recruitment and consistent retention of health

	workers and leadership. This is due to the Indian health serves being consistently underfunded, leading to rationing of needed services and a crumbling infrastructure. Therefore, Partnership may consider helping with provider recruitment and retention since tribal centers are unlikely to financially compete with other centers. Within the Black/African American community, there is an association with low well child visit attendance due to low levels of maternal education, low income, and poor prenatal care (Wolfe et al., 2018). Partnership can explore implementing interventions to improve tailored interventions to improve well-child care in African American/Black groups. For example, in a systematic review of well care visit redesigns researchers highlighted the efficacy of doing group WCVs. (Coker et al., 2013)
Actions for Direct Clinical/Service Measure Improvement	**<u>Intervention #1: Provider Recruitment Program and Provider Retention Initiatives</u>** Partnership has launched a new provider retention initiative. Specifically, partnership will provide $45,000 award to a doctor of medicine/doctor of osteopathic medicine (DO) or $30,000 award to a nurse practitioner/physician assistant for a 3-year commitment. This intervention will be applicable to all of clinical sites—especially Partnership's tribal centers and sites that inhabit locations that serve a large Black/African American population. **<u>Intervention #2: Group Well Child Visits</u>** Partnership is conducting a pilot with a clinical site to start group well child visits in a clinical site in Solano county—which has the greatest diversity among Partnership's 14 counties. Long-term, Partnership can explore utilizing a combination of interventions to likely meet the large threshold of members who are not meeting the goal throughout the network. **<u>Intervention #3: Increase Access to BIPOC-related children's book regarding improving immunizations and attending WCVs</u>** Partnership's HEO previously published a children's book, Andres Armor, which teaches BIPOC children the importance of vaccines using knight and dragon analogies. He is exploring donating copies of the book and videos to clinical sites to hopefully increase the number of children wanting to attend WCVs and watching the free information play during their provider visits.

Factor 4: Implements at least one intervention to improve CLAS

The CLAS team will continue to focus on continued root-cause analyses and improvement activities specific to Grievance & Appeals categories related to language. As illustrated in Table XLIV, the Language Barrier/Limited English Proficiency category type resulted in roughly 60% of the total grievances within the 2023 Annual Grievance & Appeals Priority by Category Type, which highlights an opportunity for improvement.

Table XLIV

2023 Annual Grievance & Appeals Priority by Category Type	
Language Barrier / Limited English Proficiency	15
Auxiliary Aids and Services	8
Language Assistance Services	2

Based on member satisfaction with language related services and the HE 6 Case Analyses (Table XLVI), Member Services and Quality Improvement will implement an intervention in the form of an inter/intradepartmental workgroup. This workgroup will place an emphasized focus on analyzing the leading causes of member dissatisfaction as it relates to CLAS. As a result of the associated grievance volume, the Language Barrier/Limited English Proficiency category type will serve as the basis through which Partnership's intervention workgroup will develop improvement activities.

Table XLVI: NCQA Health Equity (HE) 6 Case Analyses

Case Category Type	2023 Grievance & Appeals Case Totals	NCQA Health Equity (HE) 6 Case Analyses
Language Assistance Services	2	Case filings offer different perspectives specific to Language Assistance Services. Theme: Familiarity of benefit literacy and breakdown in communication.
Language Barrier / Limited English Proficiency	15	Case filings offer a combination of unconfirmed and confirmed perceptions of discrimination associated with language barriers. Case filing themes: benefit literacy, scheduling, and communication breakdown. Per the Partnership Member Hand-book, members are encouraged to schedule interpreter services when confirming a medical appointment. In some instances, provider sensitivity training, and reminders of CLAS-covered benefits are warranted.
Non-threshold Language	1	Partnership Member Services (MS) employee created an unintended abrasion/experience while following procedure to authenticate plan covered member over the phone. The language barrier occurred between member ad hoc interpreter (family member) and MS employee. Assessment: Although plan MS employee adhered to procedure, there is an employee lesson learned/training opportunity. Learn to take verbal/conversation ques to know when to transfer to a bilingual MS employee or qualified interpreter services (AMN) delegated vendor.
Auxiliary Aids and Services	8	Case filings offer different perspectives specific to Auxiliary Aids and Services. Theme: Familiarity with covered benefits (varied clinical settings) literacy and breakdown in communication.

Member Services and Quality Improvement stakeholders will design, assemble, and implement the workgroup that will be comprised of key stakeholders within the organization. The overall deliverable will be focused on addressing and identifying commonalties associated with CLAS member grievances with the intent of reducing the number of member grievances associated with Language Barrier/Limited English Proficiency. This will be accomplished through addressing the Member Dissatisfaction Themes related to translation and interpreter benefit literacy and covered benefit awareness and training, which were both highlighted in the Partnership and Provider/Network service delivery categories in Table XLV.

Through this workgroup, Partnership will engage the impacted stakeholders to understand current state and offering of informative material for both members and providers. This intervention workgroup will also focus on CLAS benefit literacy, educational material, and provider education/communication cadence. Additionally, this workgroup may work with external stakeholders to solicit feedback as we look to refine our communication/education approach while identifying any pertinent causal factors lined to CLAS member dissatisfaction. This intervention also allows internal stakeholders the opportunity to provide direct education and feedback to external stakeholders in an effort to mitigate related grievances in the future.

Measure	Intervention	Goal	Stakeholders
Member Grievances Filed	Internal workgroup to lead intervention efforts centered around CLAS Member Grievances and Provider Education	10% reduction in Member Grievances associated with the *Language Barrier / Limited English Proficiency* filed, using CY2023 Q3/Q4 as the baseline. Results will be assessed no later than July 2025, in which the workgroup will determine the future state of the intervention workgroup and may identify additional areas of opportunity.	Internal: • Member Services • Quality Improvement • Grievance & Appeals • Provider Relations External: • Provider Network • Interpreting Vendor

Partnership will evaluate the effectiveness of the workgroup and its goal of a 10% reduction in Member Grievances associated with the Language Barrier / Limited English Proficiency filed, no later than July 2025. The workgroup will evaluate the effectiveness of the intervention work related to CLAS benefit literacy, educational material, and provider education/communication cadence. This evaluation will determine the future state of the intervention workgroup and may identify additional areas of opportunity.

Furthermore, Partnership's Population Health department will address this goal by addressing the need to provide written materials to members in their choice of format (such as large print, Braille, audio format, or other) to ensure vision-impaired members are able to understand the information Partnership shares. This goal is monitored through the annual C&L Work Plan. This will be done to provide a more proactive approach for language services.

Factor 5: Evaluates the effectiveness of an intervention to reduce an inequity

Partnership has not previously evaluated the effectiveness of an intervention to improve CLAS and reduce inequities in a specific group. Listed below is the plan to evaluate the effectiveness of certain interventions in the future, and these evaluations will be completed by July 2025.

Partnership's Population Health team will evaluate the effectiveness of their hosted events. This will be done through an analysis of the number of members who attended each event, the number of blood pressure cuffs distributed and diabetes checks conducted, the number of members enrolled in Population Health's Healthy Living Tools program, as well as an evaluation of member surveys conducted at these events. Analysis of event impact and member engagement and satisfaction will be used to evaluate if these events should be adapted, spread to additional counties within the network, or abandoned for more impactful events and interactions to address within this population of focus. However, the Population Health team will collaborate with the Health Equity Officer and Quality Improvement Department to identify and implement these activities.

Prenatal and Postpartum Care (PPC):

Partnership will be evaluating the current utilization of the doula benefit, as highlighted in Factor 3. Partnership will also explore additional intervention opportunities to impact the Black population, and will conduct interventions for at least 3 months.

Population	Key Intervention(s)	Effectiveness to Improve Culture and Linguistically Appropriate Services (CLAS)	Effectiveness of Intervention to Reduce Inequities
American Indian/Alaska Native	Tribal Health Liaison Appointment	**Measure (Indirect):** Number of Community Events Attended Number of American Indian/Alaska Native Members Interviewed **Goal:** Engagement with at least 20% of American Indian/Alaska Native attendees **Measure:** Not Collected During Event	**Measure (Direct):** PPC-Pre visit rate in AI/AN community **Preliminary Goal:** 5% Improvement from baseline in 12 months **Global Goal:** Improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 22% in the next 5 years.

Black/African American	Doula Appointments in Regions	**Measure (Indirect):** Number of Events Attended Number of Black/African American Members engaged during Community Screening Event **Goal:** Engagement with at least 20% of Black/African American attendees **Measure:** Not Collected During Event	**Measure (Direct):** Percentage of Black/African American members with adequately controlled BP (<140/90) during measurement year **Goal:** Improve prenatal visits by at least 5% in the NE or NW region in the Black/African American Member Population within 12 months with the global goal of improvement by 30% in the next 5 years. **Measure:** Not Collected During Event

Factor 6: Evaluates the effectiveness of an intervention to improve CLAS

Partnership has not previously evaluated the effectiveness of an intervention to improve CLAS and reduce inequities in a specific group. Listed below is the plan to evaluate the effectiveness of certain interventions in the future.

Partnership will evaluate the effectiveness of the workgroup and its goal of a 10% reduction in Member Grievances associated with the Language Barrier / Limited English Proficiency filed, no later than July 2025. The workgroup will evaluate the effectiveness of the intervention work related to CLAS benefit literacy, educational material, and provider education/communication cadence. This evaluation will determine the future state of the intervention workgroup and may identify additional areas of opportunity.

Partnership's Population Health team will also evaluate member satisfaction with materials received. Grievances can also be evaluated to see if there is a reduction in grievances received related to format.

Measure	Intervention	Effectiveness to Improve Culture and Linguistically Appropriate Services (CLAS)
Member Grievances Filed	Internal workgroup to lead intervention efforts centered around CLAS Member Grievances and Provider Education	**Goal:** 10% reduction in Member Grievances associated with the Language Barrier / Limited English Proficiency filed, using CY2023 Q3/Q4 as the baseline.

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Appendix

1. *Table II: Controlling High Blood Pressure (CBP) HPA Statistical Significance Results*

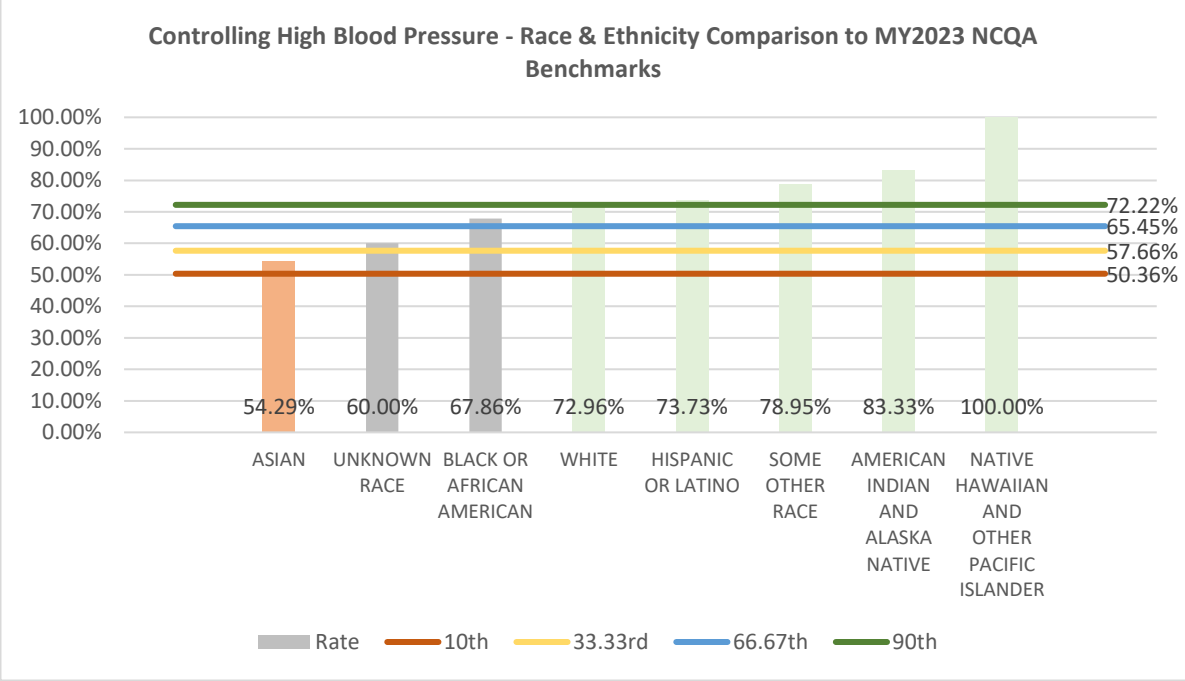
   MY 2023, Run Date: 7/24/2024

   Sample Size: 401

   Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	116	159	73%	Reference
HISPANIC OR LATINO	87	118	74%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `HISPANIC OR LATINO` population, (Rate =73.70%, Chi-Square=0.021, p=.8857)
AMERICAN INDIAN AND ALASKA NATIVE	5	6	83%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =83.38%, Chi-Square=0.342, p=1.000)
ASIAN	19	35	54%	The WHITE population had a statistically significantly higher rate, (72.93%), compared to the `ASIAN` population, (Rate =54.34%, Chi-Square=4.725, p=.0297)
BLACK OR AFRICAN AMERICAN	19	28	68%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =67.87%, Chi-Square=0.308, p=.5787)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.731, p=1.000)
SOME OTHER RACE	15	19	79%	There is no statistically significant difference in rates between the WHITE population, (72.93%), and the `SOME OTHER RACE` population, (Rate =78.98%, Chi-Square=0.314, p=.5755)

2. *Graph I*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

Partnership only found a statistically significant difference in compliance when comparing the Asian group to the White group while using the NCQA Health Plan Accreditation generated sample for Controlling High Blood Pressure (CBP) (n=401) (Table II). Furthermore, after reviewing stratified data in comparison to the National All Lines of Business benchmarks, the Asian population had a numerically lower rate for CBP and was the only racial group that scored below the 33.33rd percentile for the measure. All of the other groups were able to achieve at least the 33.33rd percentile defined by the National Medicaid benchmarks (Graph I).

3. *Table III: Controlling High Blood Pressure (CBP) MCAS Statistical Significance Results*

   MY 2023, Run Date: 7/24/2024

   Sample Size: 1,395

   Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	172	274	63%	
HISPANIC OR LATINO	24	42	57%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `HISPANIC OR LATINO` population, (Rate =57.09%, Chi-Square=0.490, p=.4838)
AMERICAN INDIAN AND ALASKA NATIVE	6	9	67%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =66.66%, Chi-Square=0.057, p=.8120)
ASIAN	9	16	56%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `ASIAN` population, (Rate =56.21%, Chi-Square=0.274, p=.6005)
BLACK OR AFRICAN AMERICAN	7	9	78%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =77.77%, Chi-Square=0.197, p=.4932)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	1	%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.375, p=.3745)
SOME OTHER RACE	1	2	50%	There is no statistically significant difference in rates between the WHITE population, (62.81%), and the `SOME OTHER RACE` population, (Rate =50.05%, Chi-Square=0.470, p=1.000)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	155	261	59%	
HISPANIC OR LATINO	31	45	69%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `HISPANIC OR LATINO` population, (Rate =68.86%, Chi-Square=1.454, p=.2279)
AMERICAN INDIAN AND ALASKA NATIVE	11	16	69%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =68.75%, Chi-Square=0.550, p=.4582)
ASIAN	11	17	65%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `ASIAN` population, (Rate =64.68%, Chi-Square=0.188, p=.6648)

BLACK OR AFRICAN AMERICAN	9	13	69%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =69.19%, Chi-Square=0.499, p=.4798)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.595, p=1.000)
SOME OTHER RACE	2	4	50%	There is no statistically significant difference in rates between the WHITE population, (59.40%), and the `SOME OTHER RACE` population, (Rate =50.05%, Chi-Square=0.352, p=1.000)

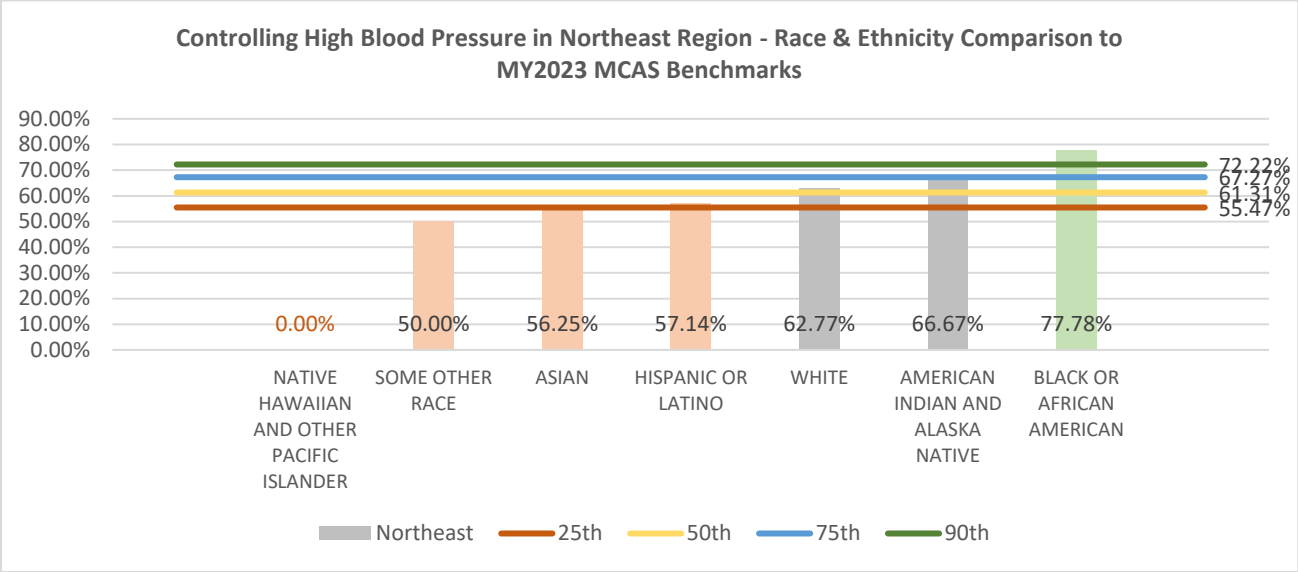
Southeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	57	88	65%	
HISPANIC OR LATINO	84	130	65%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `HISPANIC OR LATINO` population, (Rate =64.57%, Chi-Square=0.001, p=.9810)
AMERICAN INDIAN AND ALASKA NATIVE	0	1	%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =0.000%, Chi-Square=1.801, p=.1795)
ASIAN	45	75	60%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `ASIAN` population, (Rate =59.95%, Chi-Square=0.394, p=.5303)
BLACK OR AFRICAN AMERICAN	26	40	65%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =65.01%, Chi-Square=0.001, p=.9801)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.652, p=1.000)
SOME OTHER RACE	6	9	67%	There is no statistically significant difference in rates between the WHITE population, (64.79%), and the `SOME OTHER RACE` population, (Rate =66.66%, Chi-Square=0.285, p=1.000)

Southwest

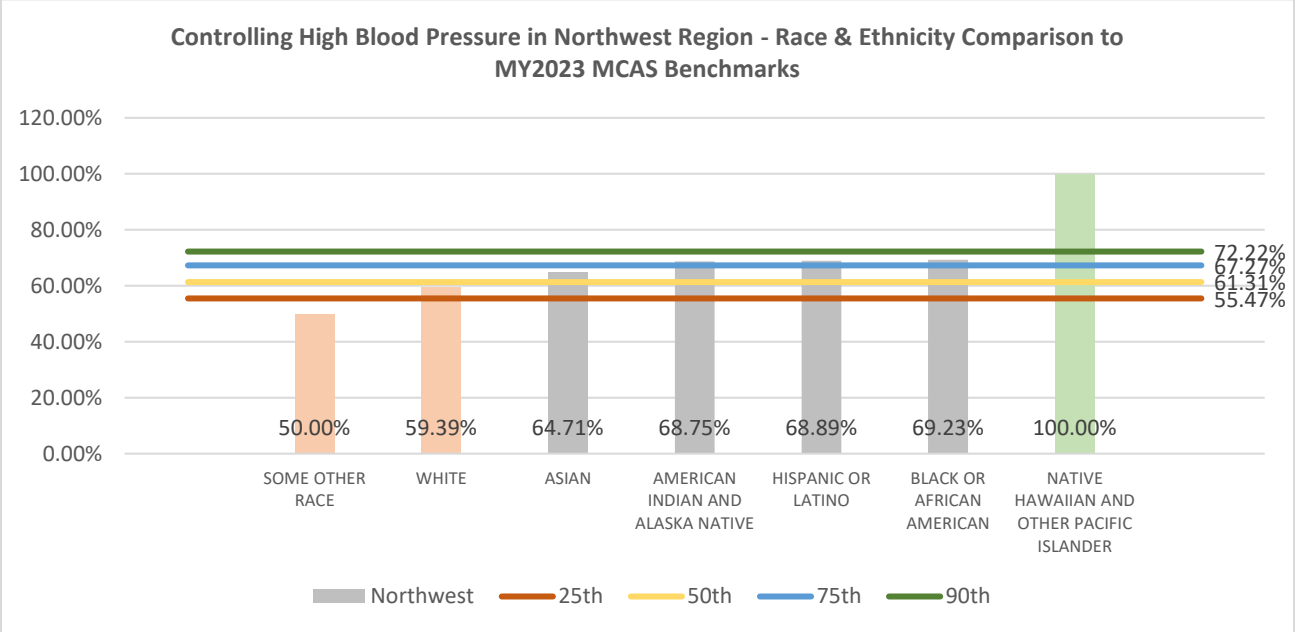
Race	Numerator	Denominator	Rate	Interpretation
WHITE	98	148	66%	
HISPANIC OR LATINO	90	135	67%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `HISPANIC OR LATINO` population, (Rate =66.66%, Chi-Square=0.006, p=.9361)
AMERICAN INDIAN AND ALASKA NATIVE	1	2	50%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =50.05%, Chi-Square=0.231, p=.6306)
ASIAN	10	14	71%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `ASIAN` population, (Rate =71.39%, Chi-Square=0.222, p=.7758)
BLACK OR AFRICAN AMERICAN	5	8	62%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =62.48%, Chi-Square=0.283, p=1.000)
SOME OTHER RACE	18	34	53%	There is no statistically significant difference in rates between the WHITE population, (66.22%), and the `SOME OTHER RACE` population, (Rate =52.91%, Chi-Square=2.108, p=.1465)

4. *Graph II*



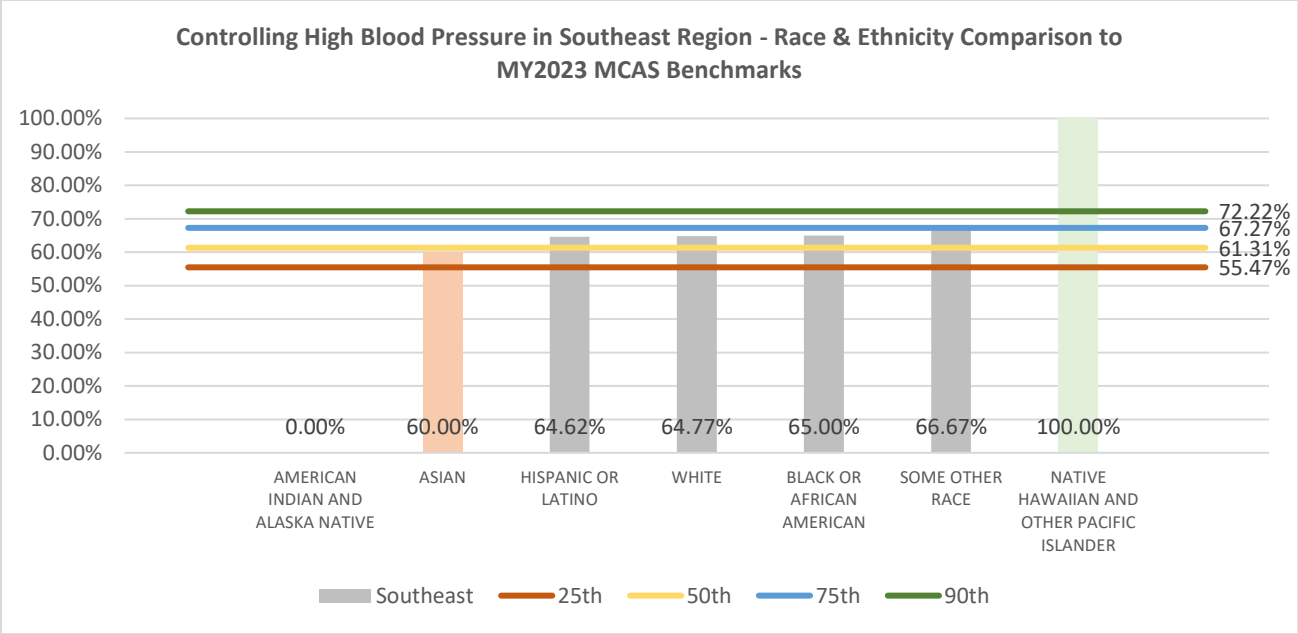
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

5. *Graph III*



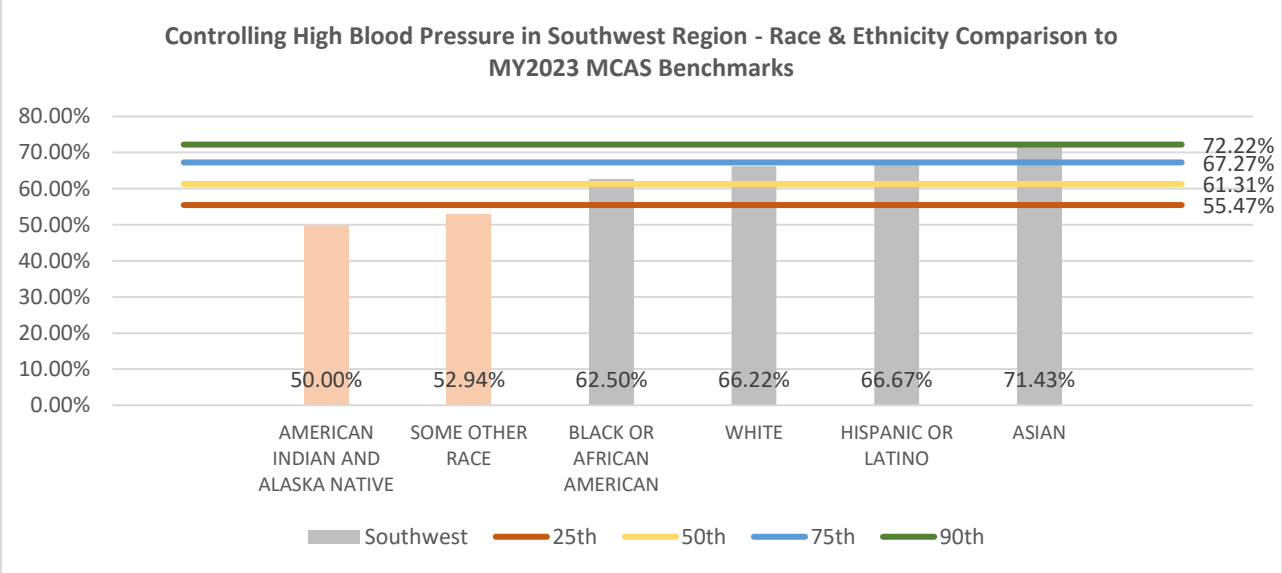
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

6. *Graph IV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

7. *Graph V*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

8. *Table IV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) HPA Statistical Significance Results*

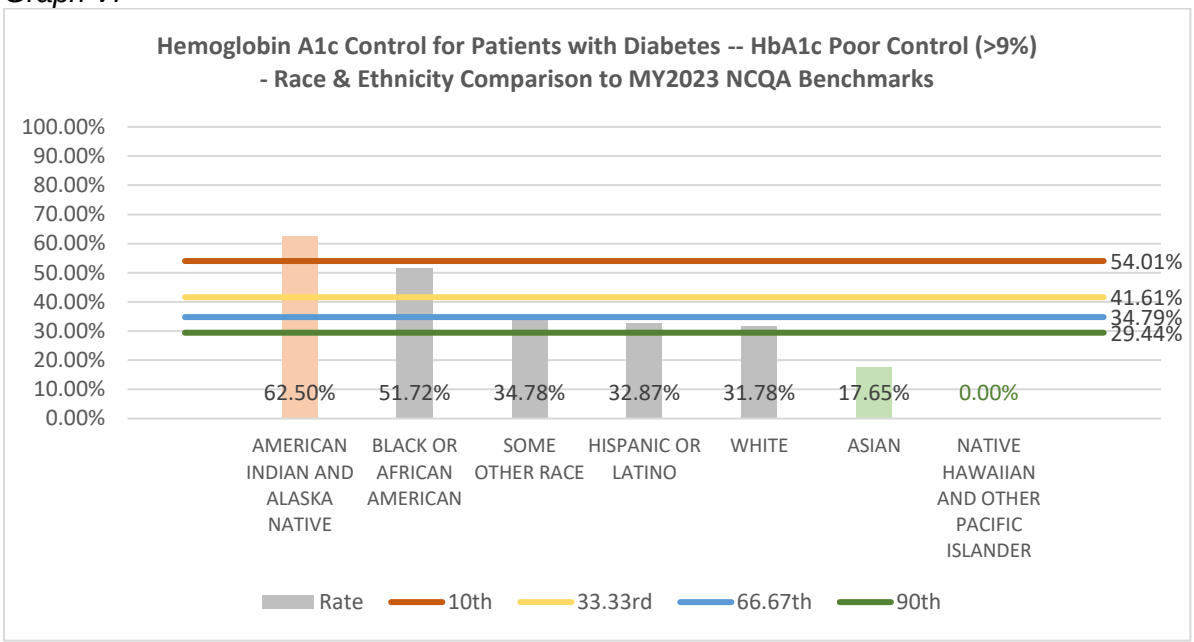
MY 2023, Run Date: 7/24/2024

Sample Size: 405

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	41	129	32%	Reference
HISPANIC OR LATINO	47	143	33%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `HISPANIC OR LATINO` population, (Rate =32.89%, Chi-Square=0.036, p=.8486)
AMERICAN INDIAN AND ALASKA NATIVE	5	8	62%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =62.48%, Chi-Square=0.067, p=.1180)
ASIAN	6	34	18%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `ASIAN` population, (Rate =17.60%, Chi-Square=2.620, p=.1055)
BLACK OR AFRICAN AMERICAN	15	29	52%	The WHITE population had a statistically significantly lower rate, (31.79%), compared to the `BLACK OR AFRICAN AMERICAN` population, (Rate =51.70%, Chi-Square=4.115, p=.0425)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	2	%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.470, p=1.000)
SOME OTHER RACE	8	23	35%	There is no statistically significant difference in rates between the WHITE population, (31.79%), and the `SOME OTHER RACE` population, (Rate =34.76%, Chi-Square=0.080, p=.7768)

9. *Graph VI*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

The Native Hawaiian and Other Pacific Islander group had the lowest rate of HbA1c Poor Control, however the sample size (n=2) was too small for their performance to be

considered statistically significant using Fishers Exact. Therefore, the Asian population was the next group with a lower rate of HbA1c Poor Control (suggesting high rate of good control) when compared to the White population per the NCQA Health Plan Accreditation associated sample (n=405) (Table IV). The White population had a higher rate of poor control when compared to the Asian population, but the American Indian and Alaska Native population was the worst performing group. Specifically, the rate of poor control was 30% higher in the American Indian or Alaska Native population when compared to the White population, however, the sample size (n=8) was too small for their performance to be considered statistically significant. The only group with a statistically significant difference in compliance in comparison to the White group was the Black or African American group, with a rate of 51.72%. The Hispanic or Latino, White, and 'Some Other Race' groups performed above the 66.67th, While the Black or African American population performed at the 10th, and the American Indian and Alaska Native population performed below the 10th.

10. *Table V: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%)MCAS Statistical Significance Results*

    MY 2023, Run Date: 7/24/2024

    Sample Size: 1,352

    Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	94	238	39%	
HISPANIC OR LATINO	21	55	38%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `HISPANIC OR LATINO` population, (Rate =38.17%, Chi-Square=0.032, p=.8573)
AMERICAN INDIAN AND ALASKA NATIVE	6	20	30%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =30.03%, Chi-Square=0.701, p=.4025)
ASIAN	7	19	37%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `ASIAN` population, (Rate =36.85%, Chi-Square=0.052, p=.8197)
BLACK OR AFRICAN AMERICAN	4	13	31%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =30.80%, Chi-Square=0.394, p=.5300)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	1	%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.607, p=1.000)
SOME OTHER RACE	0	4	%	There is no statistically significant difference in rates between the WHITE population, (39.49%), and the `SOME OTHER RACE` population, (Rate =0.000%, Chi-Square=0.138, p=.1596)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	58	198	29%	
HISPANIC OR LATINO	22	60	37%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `HISPANIC OR LATINO` population, (Rate =36.63%, Chi-Square=1.170, p=.2793)
AMERICAN INDIAN AND ALASKA NATIVE	20	46	43%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =43.45%, Chi-Square=3.454, p=.0631)

ASIAN	4	17	24%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `ASIAN` population, (Rate =23.54%, Chi-Square=0.203, p=.7831)
BLACK OR AFRICAN AMERICAN	5	9	56%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =55.55%, Chi-Square=0.075, p=.1346)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.297, p=.2965)
SOME OTHER RACE	2	4	50%	There is no statistically significant difference in rates between the WHITE population, (29.26%), and the `SOME OTHER RACE` population, (Rate =50.05%, Chi-Square=0.263, p=.5837)

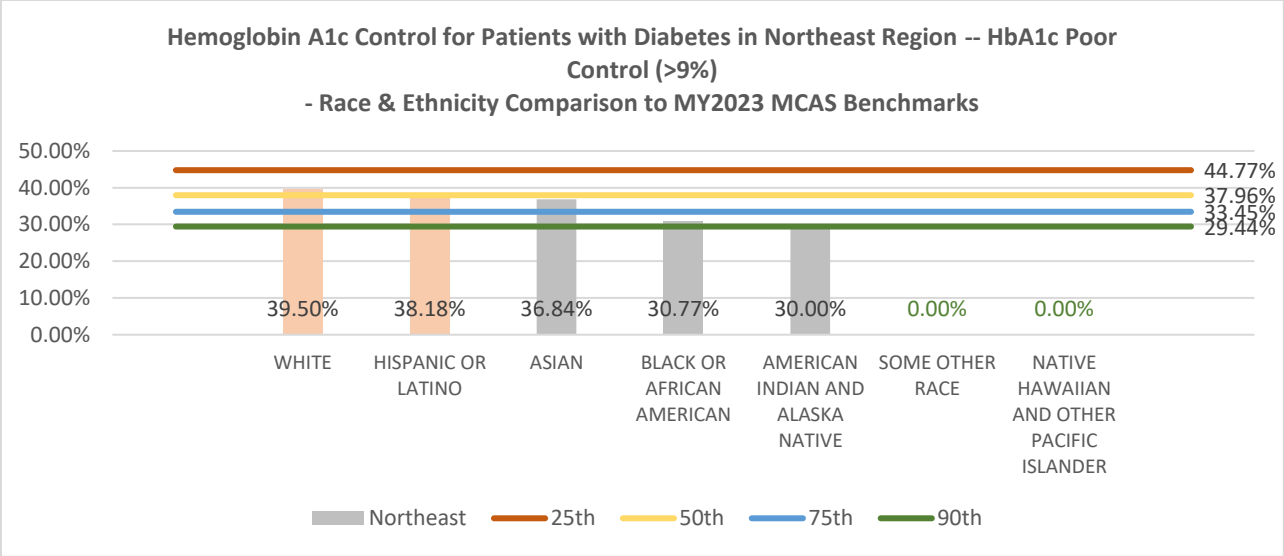
Southeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	23	69	33%	
HISPANIC OR LATINO	46	155	30%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `HISPANIC OR LATINO` population, (Rate =29.70%, Chi-Square=0.299, p=.5843)
AMERICAN INDIAN AND ALASKA NATIVE	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =99.99%, Chi-Square=1.944, p=.1632)
ASIAN	11	62	18%	The WHITE population had a statistically significantly higher rate, (33.33%), compared to the `ASIAN` population, (Rate =17.71%, Chi-Square=4.131, p=.0421)
BLACK OR AFRICAN AMERICAN	14	32	44%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =43.78%, Chi-Square=1.022, p=.3121)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.343, p=.3429)
SOME OTHER RACE	6	16	38%	There is no statistically significant difference in rates between the WHITE population, (33.33%), and the `SOME OTHER RACE` population, (Rate =37.51%, Chi-Square=0.100, p=.7514)

Southwest

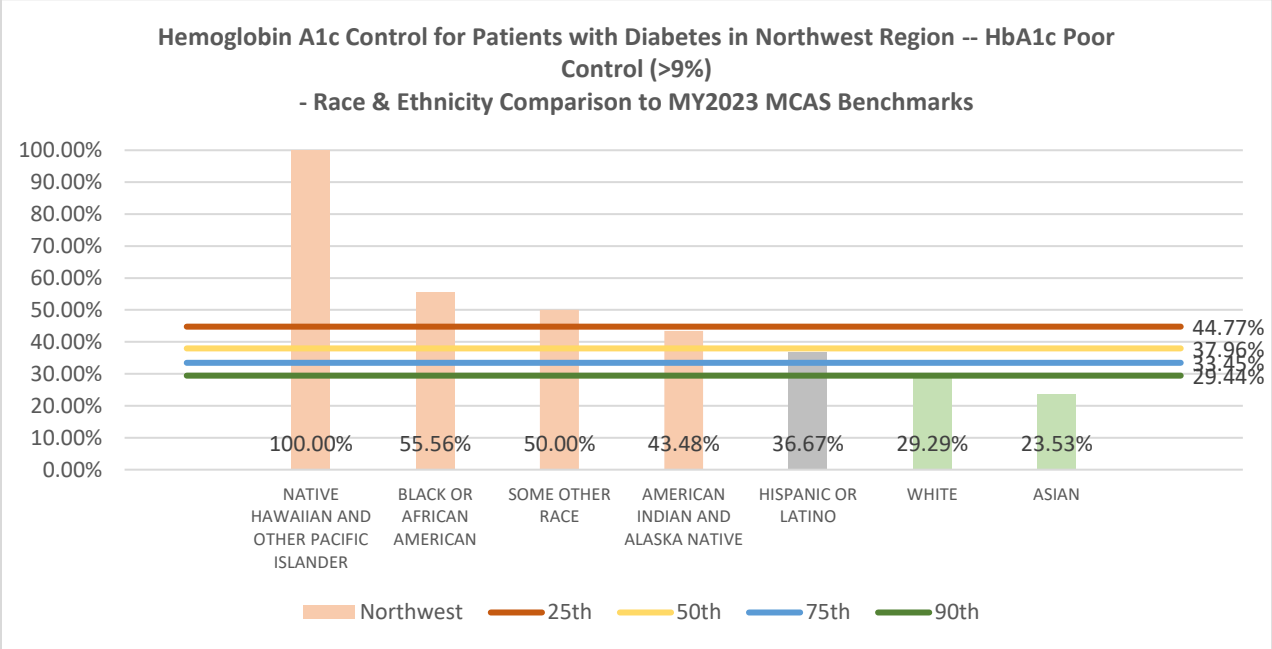
Race	Numerator	Denominator	Rate	Interpretation
WHITE	34	98	35%	
HISPANIC OR LATINO	49	166	29%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `HISPANIC OR LATINO` population, (Rate =29.48%, Chi-Square=0.766, p=.3815)
AMERICAN INDIAN AND ALASKA NATIVE	7	10	70%	The WHITE population had a statistically significantly lower rate, (34.65%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =69.96%, Chi-Square=4.803, p=.0284)
ASIAN	1	8	13%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `ASIAN` population, (Rate =12.54%, Chi-Square=0.154, p=.2662)
BLACK OR AFRICAN AMERICAN	3	11	27%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =27.28%, Chi-Square=0.242, p=.7464)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	1	%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.657, p=1.000)
SOME OTHER RACE	13	37	35%	There is no statistically significant difference in rates between the WHITE population, (34.65%), and the `SOME OTHER RACE` population, (Rate =35.09%, Chi-Square=0.002, p=.9617)

11. *Graph VII*



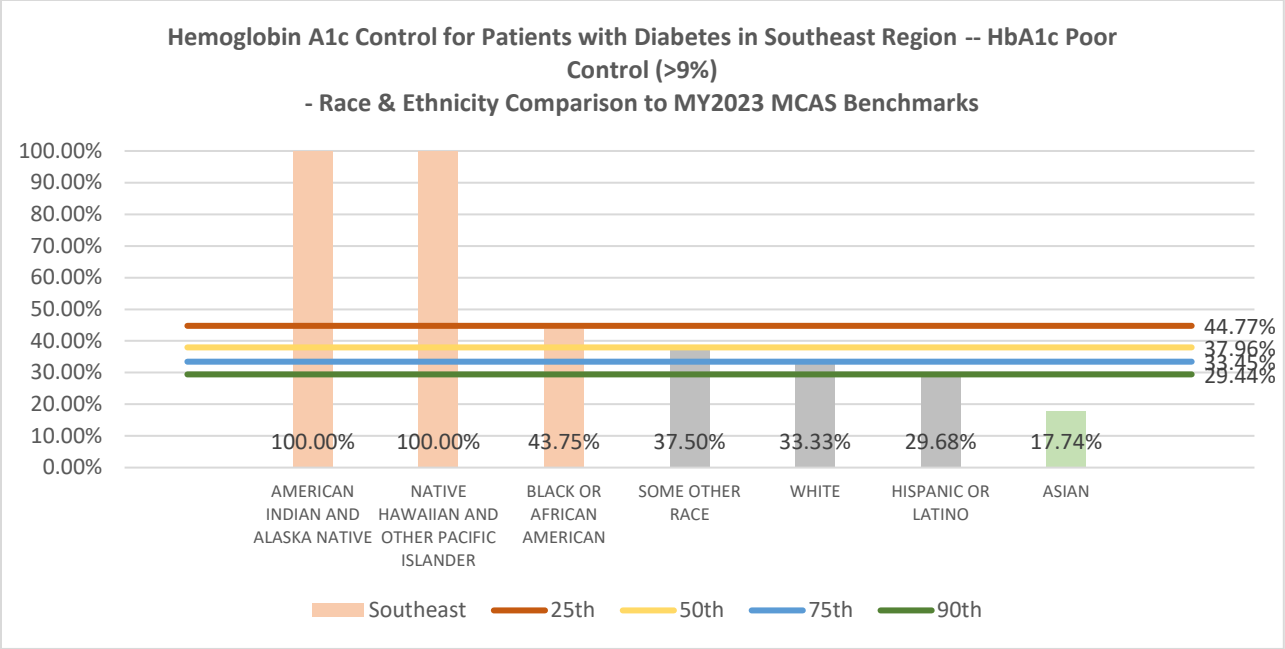
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

12. *Graph VIII*



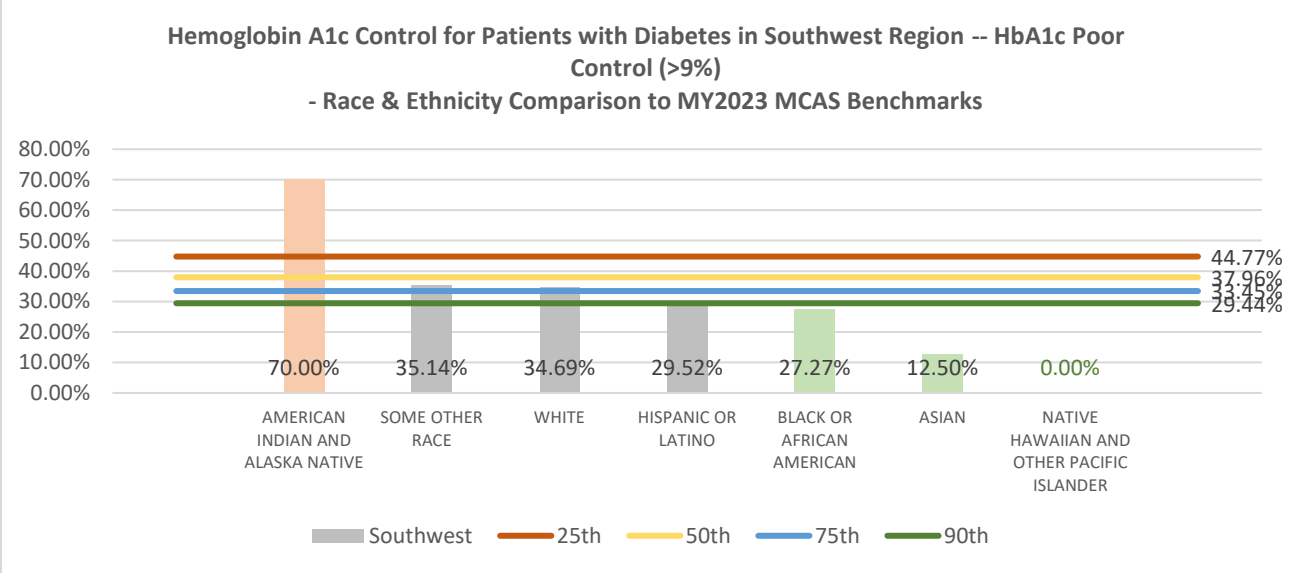
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

13. *Graph IX*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

14. *Graph X*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

15. *Table VI: Timeliness of Prenatal Care (PPC – Pre) HPA Statistical Significance Results*

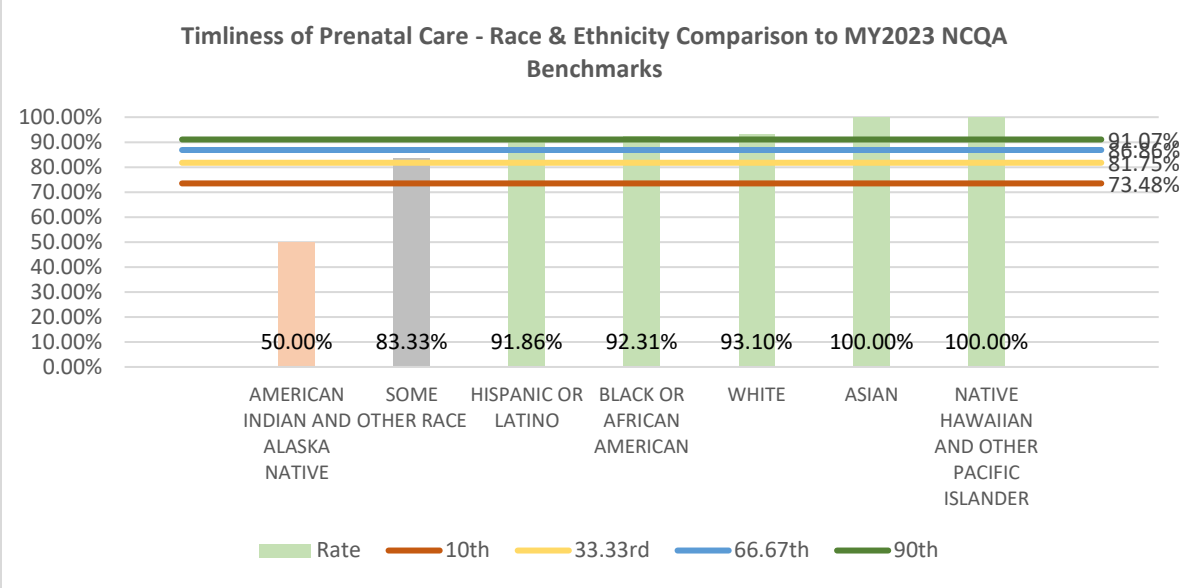
MY 2023, Run Date: 7/24/2024

Sample Size: 186

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	54	58	93%	Reference
HISPANIC OR LATINO	79	86	92%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `HISPANIC OR LATINO` population, (Rate =91.85%, Chi-Square=0.244, p=1.000)
AMERICAN INDIAN AND ALASKA NATIVE	4	8	50%	The WHITE population had a statistically significantly higher rate, (93.06%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =50.05%, Chi-Square=0.005, p=.0055)
ASIAN	8	8	100%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.589, p=1.000)
BLACK OR AFRICAN AMERICAN	12	13	92%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =92.29%, Chi-Square=0.424, p=1.000)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.932, p=1.000)
SOME OTHER RACE	10	12	83%	There is no statistically significant difference in rates between the WHITE population, (93.06%), and the `SOME OTHER RACE` population, (Rate =83.38%, Chi-Square=0.214, p=.2719)

16. *Graph XI*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

Partnership found the American Indian and Alaska Native group performed significantly worse when compared to the White group in PPC – Pre rates per the Health Plan Accreditation Timeliness of Prenatal Care sample (n=207) (Table VI). When comparing each group's performance to the NCQA benchmarks (Graph XI), all groups achieved at least the 33.33rd percentile or greater, except the American Indian and Alaska Native population (n=8). The Native Hawaiian and Other Pacific Islander and Asian populations had the highest rates, surpassing the 90th percentile with 100% compliance, indicating all members

included in the Health Plan Accreditation sample for this measure within these groups successfully completed a timely prenatal care visit during the measurement year.

17. *Table VII: Timeliness of Prenatal Care (PPC – Pre) MCAS Statistical Significance Results*

MY 2023, Run Date: 7/24/2024

Sample Size: 812

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	157	182	86%	
HISPANIC OR LATINO	49	58	84%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `HISPANIC OR LATINO` population, (Rate =84.48%, Chi-Square=0.115, p=.7348)
AMERICAN INDIAN AND ALASKA NATIVE	6	8	75%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =75.02%, Chi-Square=0.797, p=.3718)
ASIAN	7	9	78%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `ASIAN` population, (Rate =77.77%, Chi-Square=0.254, p=.6173)
BLACK OR AFRICAN AMERICAN	3	4	75%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =75.02%, Chi-Square=0.361, p=.4553)
SOME OTHER RACE	4	5	80%	There is no statistically significant difference in rates between the WHITE population, (86.24%), and the `SOME OTHER RACE` population, (Rate =79.97%, Chi-Square=0.388, p=.5311)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	92	115	80%	
HISPANIC OR LATINO	41	47	87%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `HISPANIC OR LATINO` population, (Rate =87.23%, Chi-Square=1.188, p=.2757)
AMERICAN INDIAN AND ALASKA NATIVE	15	24	62%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =62.48%, Chi-Square=3.431, p=.0640)
ASIAN	6	7	86%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `ASIAN` population, (Rate =85.69%, Chi-Square=0.377, p=1.000)
BLACK OR AFRICAN AMERICAN	1	3	33%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =33.33%, Chi-Square=0.105, p=.1131)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.802, p=1.000)
SOME OTHER RACE	3	4	75%	There is no statistically significant difference in rates between the WHITE population, (79.97%), and the `SOME OTHER RACE` population, (Rate =75.02%, Chi-Square=0.418, p=1.000)

Southeast

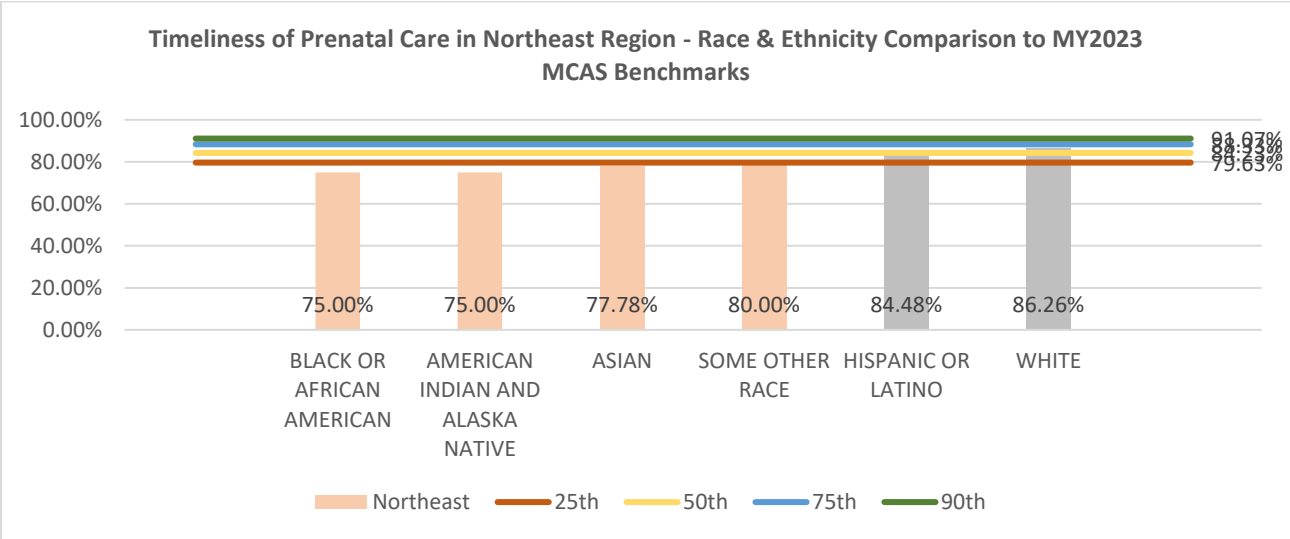
Race	Numerator	Denominator	Rate	Interpretation
WHITE	31	36	86%	

HISPANIC OR LATINO	110	123	89%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `HISPANIC OR LATINO` population, (Rate =89.43%, Chi-Square=0.191, p=.5591)
ASIAN	16	16	100%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.145, p=.3077)
BLACK OR AFRICAN AMERICAN	22	25	88%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =88.00%, Chi-Square=0.294, p=1.000)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	0	1	%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =0.000%, Chi-Square=0.162, p=.1622)
SOME OTHER RACE	11	13	85%	There is no statistically significant difference in rates between the WHITE population, (86.13%), and the `SOME OTHER RACE` population, (Rate =84.59%, Chi-Square=0.342, p=1.000)

Southwest

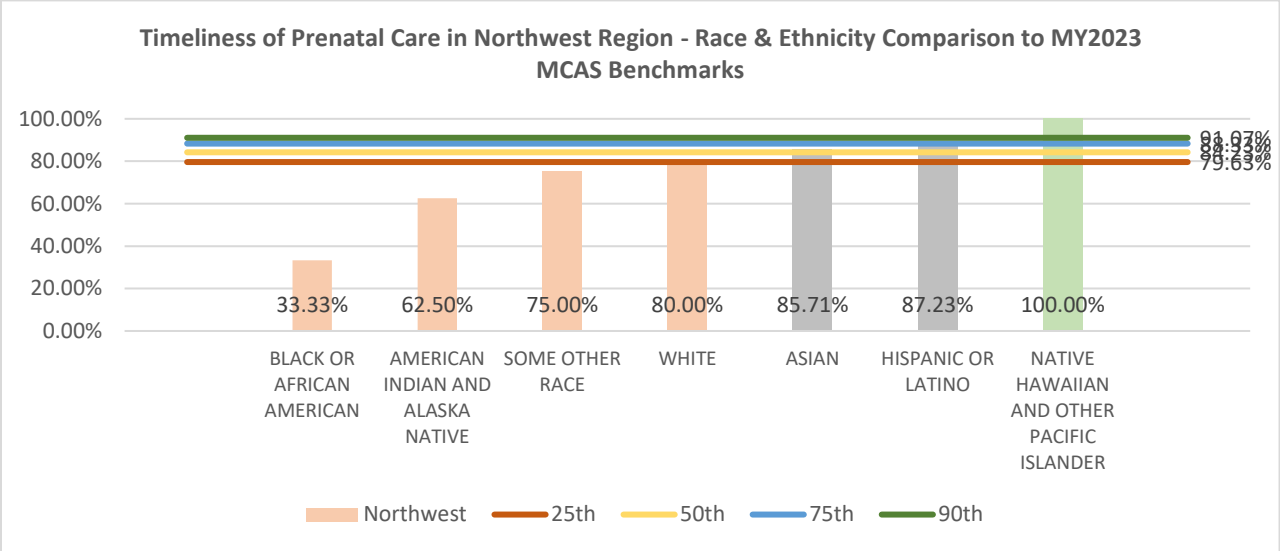
Race	Numerator	Denominator	Rate	Interpretation
WHITE	26	29	90%	
HISPANIC OR LATINO	76	80	95%	There is no statistically significant difference in rates between the WHITE population, (89.65%), and the `HISPANIC OR LATINO` population, (Rate =95.04%, Chi-Square=0.194, p=.3800)
AMERICAN INDIAN AND ALASKA NATIVE	2	4	50%	The WHITE population had a statistically significantly higher rate, (89.65%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =50.05%, Chi-Square=4.300, p=.0381)
ASIAN	4	4	100%	There is no statistically significant difference in rates between the WHITE population, (89.65%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.670, p=1.000)
BLACK OR AFRICAN AMERICAN	3	3	100%	There is no statistically significant difference in rates between the WHITE population, (89.65%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =99.99%, Chi-Square=0.737, p=1.000)
SOME OTHER RACE	11	11	100%	There is no statistically significant difference in rates between the WHITE population, (89.65%), and the `SOME OTHER RACE` population, (Rate =99.99%, Chi-Square=0.370, p=.5480)

18. *Graph XII*



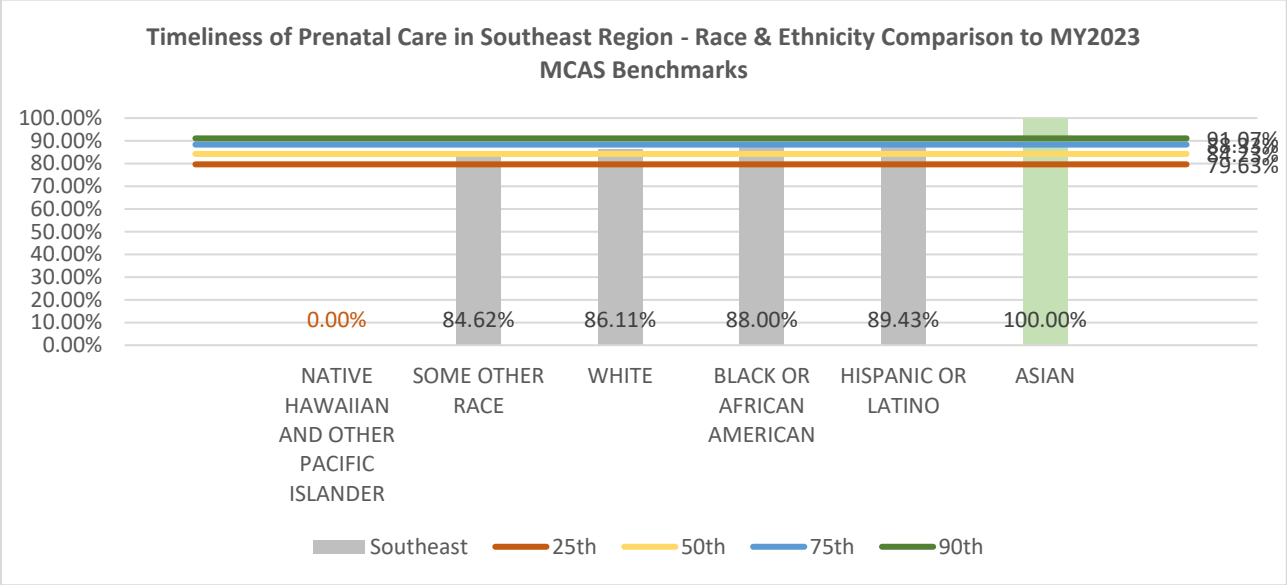
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

19. *Graph XIII*



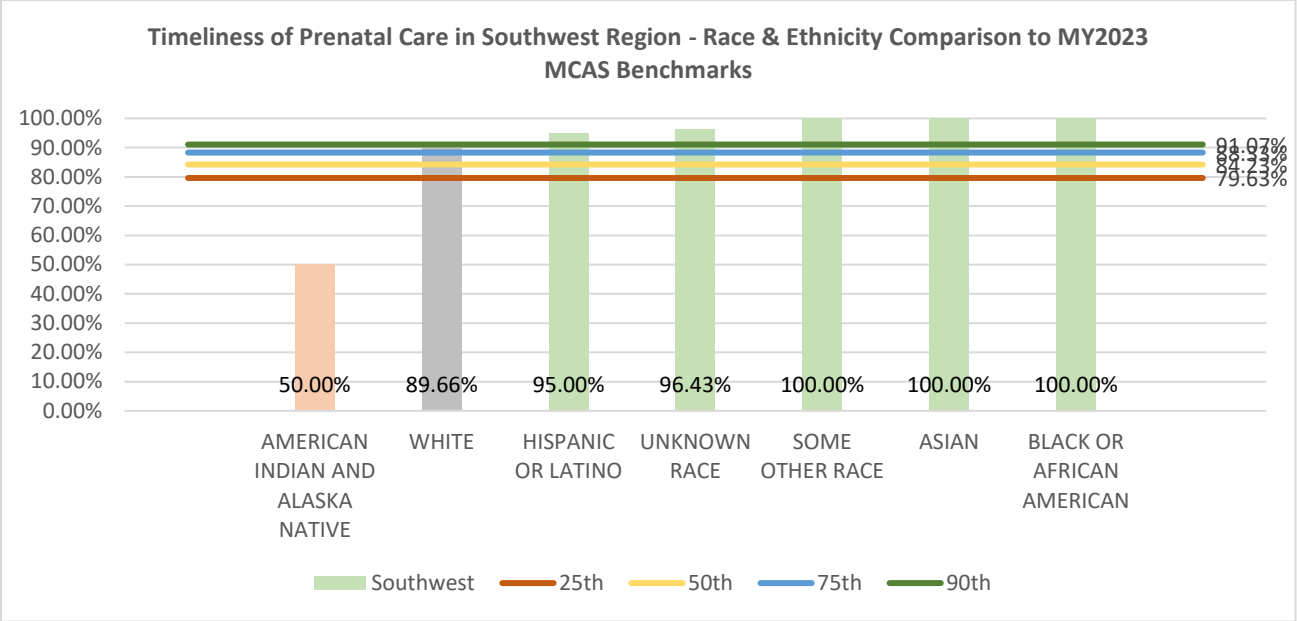
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

20. *Graph XIV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

21. *Graph XV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

22. *Table VII: Postpartum Care (PPC – Post) HPA Statistical Significance Results*

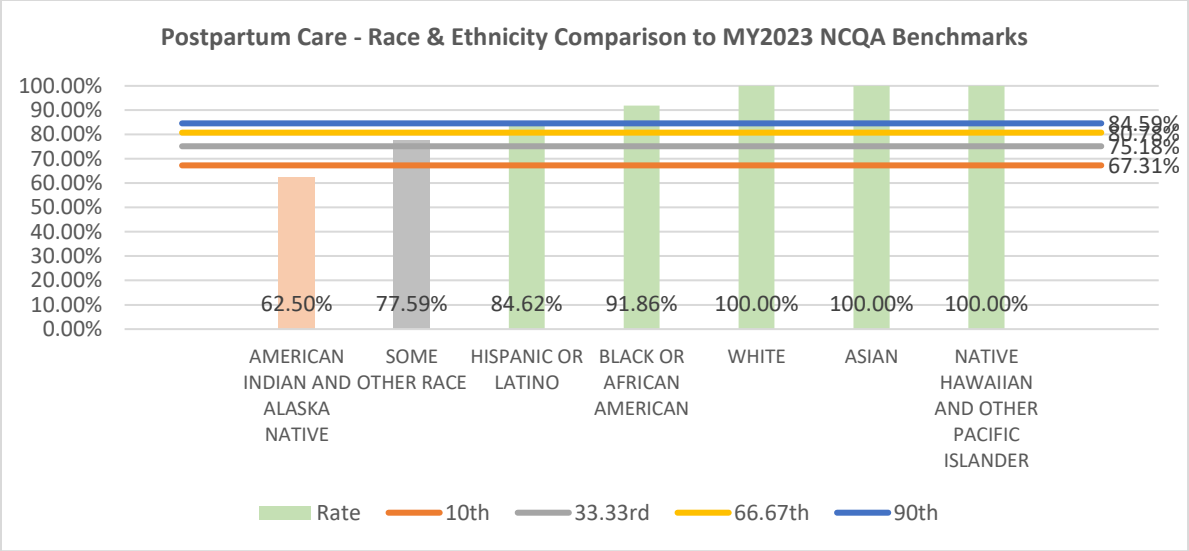
MY 2023, Run Date: 7/24/2024

Sample Size: 186

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	45	58	78%	Reference
HISPANIC OR LATINO	79	86	92%	The WHITE population had a statistically significantly lower rate, (77.55%), compared to the `HISPANIC OR LATINO` population, (Rate =91.85%, Chi-Square=5.901, p=.0151)
AMERICAN INDIAN AND ALASKA NATIVE	5	8	62%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =62.48%, Chi-Square=0.207,p=.3897)
ASIAN	8	8	100%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.154, p=.3393)
BLACK OR AFRICAN AMERICAN	11	13	85%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =84.59%, Chi-Square=0.269, p=.7212)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.780, p=1.000)
SOME OTHER RACE	12	12	100%	There is no statistically significant difference in rates between the WHITE population, (77.55%), and the `SOME OTHER RACE` population, (Rate =99.99%, Chi-Square=0.067, p=.1050)

23. *Graph XVI*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile.

Researchers found no group performed statistically significantly worse than the White group, although the Hispanic or Latino group performed significantly better than the White population in Postpartum care rates in the Health Plan Accreditation Postpartum Care sample (n=207) (Table VIII). When comparing groups to the NCQA benchmarks (Graph XVI), only the American Indian and Alaska Native and 'Some Other Race' groups did not surpass the 90th percentile benchmark as all other groups, with the American Indian and Alaska Native being the only group below the 10th.

24. *Table VIV: Postpartum Care (PPC – Post) MCAS Statistical Significance Results*

MY 2023, Run Date: 7/24/2024

Sample Size: 812

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	145	182	80%	
HISPANIC OR LATINO	50	58	86%	There is no statistically significant difference in rates between the WHITE population, (79.64%), and the `HISPANIC OR LATINO` population, (Rate =86.24%, Chi-Square=1.234, p=.2667)
AMERICAN INDIAN AND ALASKA NATIVE	4	8	50%	The WHITE population had a statistically significantly higher rate, (79.64%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =50.05%, Chi-Square=3.986, p=.0459)
ASIAN	7	9	78%	There is no statistically significant difference in rates between the WHITE population, (79.64%), and the `ASIAN` population, (Rate =77.77%, Chi-Square=0.311, p=1.000)
BLACK OR AFRICAN AMERICAN	4	4	100%	There is no statistically significant difference in rates between the WHITE population, (79.64%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =99.99%, Chi-Square=0.409, p=.5859)

SOME OTHER RACE	5	5	100%	There is no statistically significant difference in rates between the WHITE population, (79.64%), and the `SOME OTHER RACE` population, (Rate =99.99%, Chi-Square=0.328, p=.5848)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	94	115	82%	
HISPANIC OR LATINO	41	47	87%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `HISPANIC OR LATINO` population, (Rate =87.23%, Chi-Square=0.725, p=.3944)
AMERICAN INDIAN AND ALASKA NATIVE	18	24	75%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =75.02%, Chi-Square=0.576, p=.4478)
ASIAN	5	7	71%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `ASIAN` population, (Rate =71.39%, Chi-Square=0.270, p=.6152)
BLACK OR AFRICAN AMERICAN	3	3	100%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =99.99%, Chi-Square=0.552, p=1.000)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.819, p=1.000)
SOME OTHER RACE	4	4	100%	There is no statistically significant difference in rates between the WHITE population, (81.73%), and the `SOME OTHER RACE` population, (Rate =99.99%, Chi-Square=0.455, p=1.000)

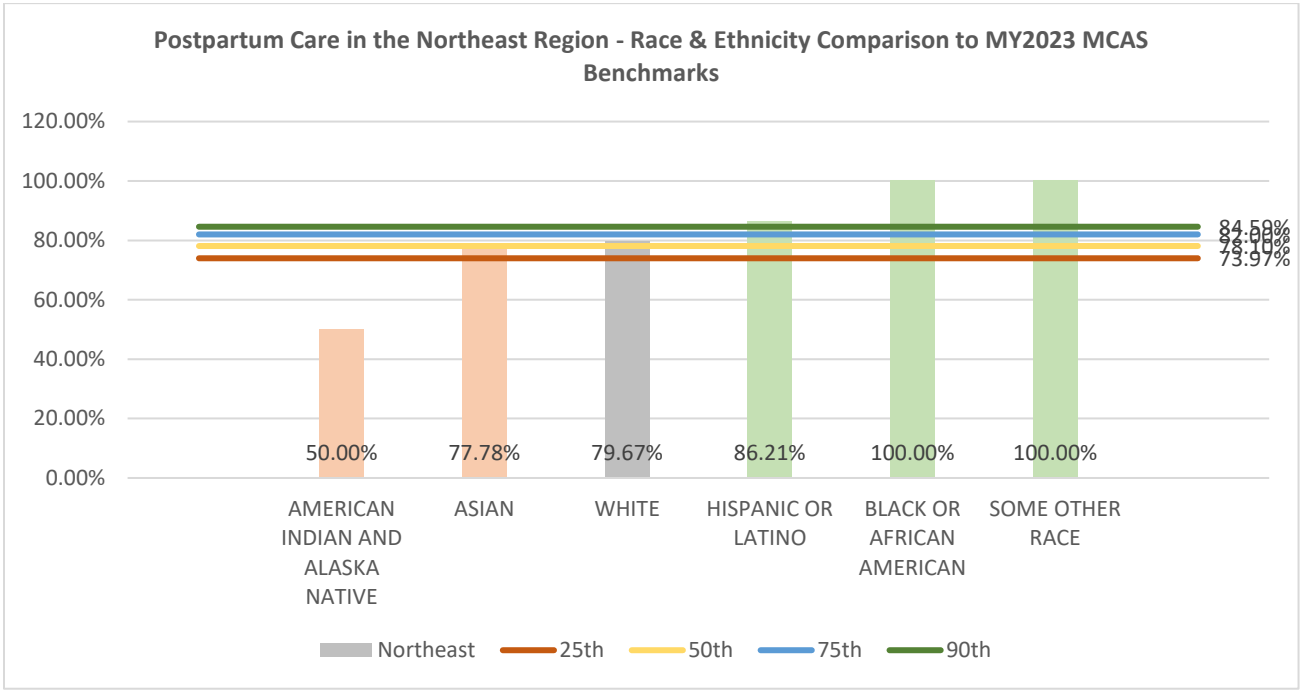
Southeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	30	36	83%	
HISPANIC OR LATINO	111	123	90%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `HISPANIC OR LATINO` population, (Rate =90.20%, Chi-Square=0.116, p=.2452)
ASIAN	15	16	94%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `ASIAN` population, (Rate =93.72%, Chi-Square=0.233, p=.4153)
BLACK OR AFRICAN AMERICAN	22	25	88%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =88.00%, Chi-Square=0.258, p=.7250)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	1	1	100%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =99.99%, Chi-Square=0.838, p=1.000)
SOME OTHER RACE	10	13	77%	There is no statistically significant difference in rates between the WHITE population, (83.38%), and the `SOME OTHER RACE` population, (Rate =76.89%, Chi-Square=0.271, p=.6831)

Southwest

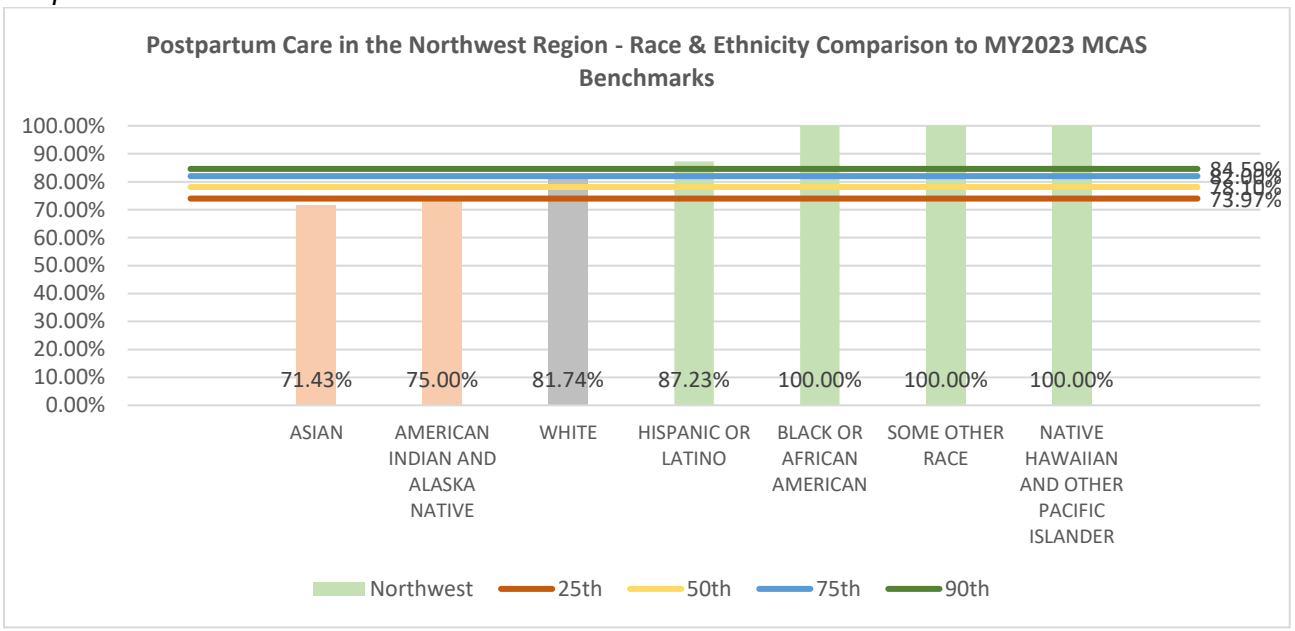
Race	Numerator	Denominator	Rate	Interpretation
WHITE	24	29	83%	
HISPANIC OR LATINO	79	80	99%	The WHITE population had a statistically significantly lower rate, (82.72%), compared to the `HISPANIC OR LATINO` population, (Rate =98.78%, Chi-Square=0.005, p=.0049)
AMERICAN INDIAN AND ALASKA NATIVE	3	4	75%	There is no statistically significant difference in rates between the WHITE population, (82.72%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =75.02%, Chi-Square=0.142, p=.7061)
ASIAN	4	4	100%	There is no statistically significant difference in rates between the WHITE population, (82.72%), and the `ASIAN` population, (Rate =99.99%, Chi-Square=0.500, p=1.000)
BLACK OR AFRICAN AMERICAN	3	3	100%	There is no statistically significant difference in rates between the WHITE population, (82.72%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =99.99%, Chi-Square=0.590, p=1.000)
SOME OTHER RACE	10	11	91%	There is no statistically significant difference in rates between the WHITE population, (82.72%), and the `SOME OTHER RACE` population, (Rate =90.86%, Chi-Square=0.340, p=1.000)

25. *Graph XVII*



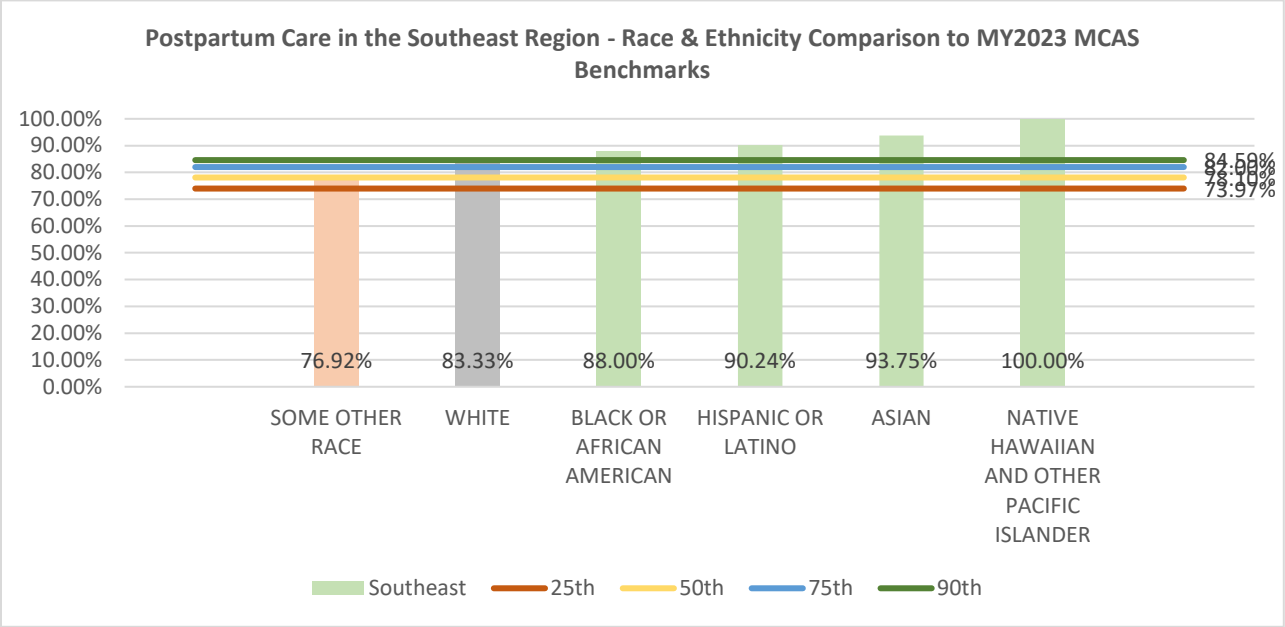
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

26. *Graph XVIII*



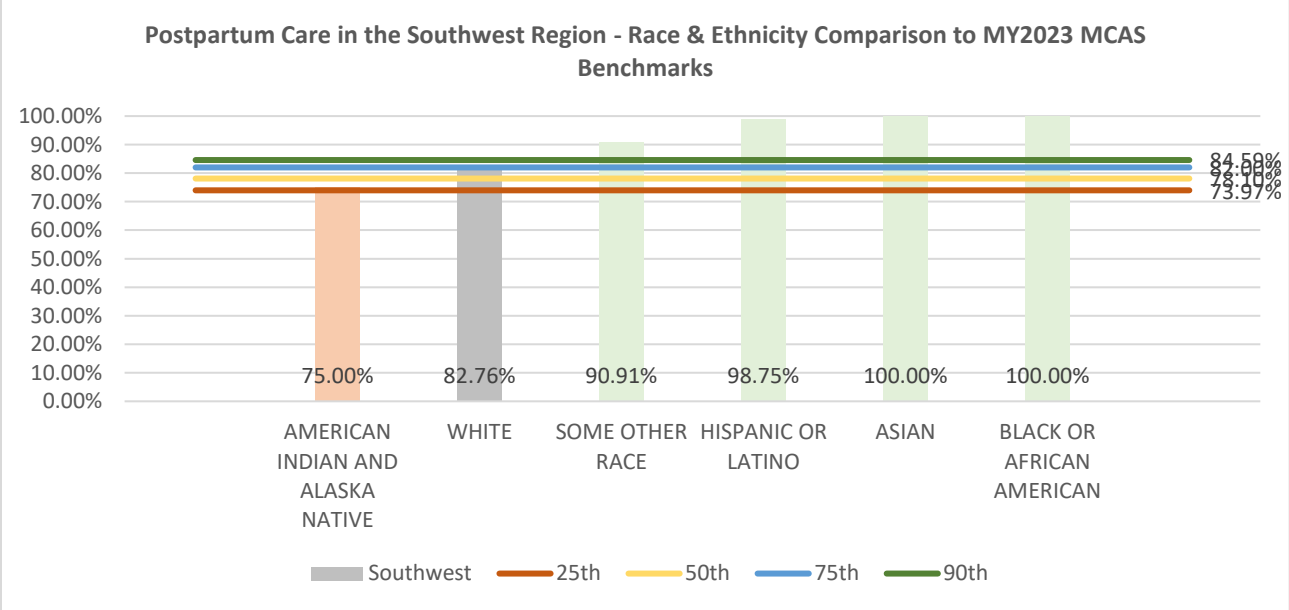
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

27. *Graph XIX*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

28. *Graph XX*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

29. *Table VIV: Child and Adolescent Well Care Visits (WCV) HPA Statistical Significance Results*

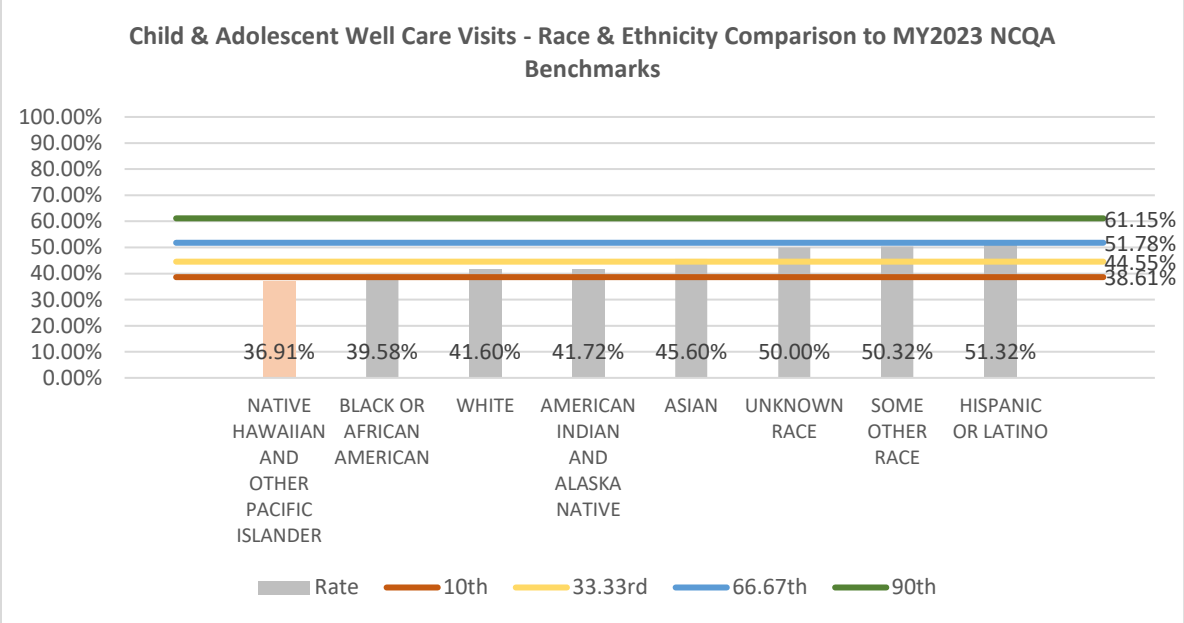
MY 2023, Run Date: 7/24/2024

Sample Size: 167,450

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Race	Numerator	Denominator	Rate	Interpretation
WHITE	22119	53167	42%	Reference
HISPANIC OR LATINO	44145	86027	51%	The WHITE population had a statistically significantly lower rate, (41.58%), compared to the `HISPANIC OR LATINO` population, (Rate =51.37%, Chi-Square=1242.7, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	1853	4442	42%	There is no statistically significant difference in rates between the WHITE population, (41.58%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =41.69%, Chi Square=0.021, p=.8837)
ASIAN	2998	6574	46%	The WHITE population had a statistically significantly lower rate, (41.58%), compared to the `ASIAN` population, (Rate =45.65%, Chi-Square=38.436, p=.0000)
BLACK OR AFRICAN AMERICAN	3256	8226	40%	The WHITE population had a statistically significantly higher rate, (41.58%), compared to the `BLACK OR AFRICAN AMERICAN` population, (Rate =39.60%, Chi-Square=12.000, p=.0005)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	148	401	37%	There is no statistically significant difference in rates between the WHITE population, (41.58%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =36.96%, Chi-Square=3.612, p=.0574)
SOME OTHER RACE	4334	8613	50%	The WHITE population had a statistically significantly lower rate, (41.58%), compared to the `SOME OTHER RACE` population, (Rate =50.27%, Chi-Square=230.01, p=.0000)

30. *Graph XXI*



Note: Bars highlighted orange indicate a group had lowest percentile performance of all groups included in measure sample, and were only group to fall into the percentile. Bars highlighted green indicate groups performed above the 90th percentile

The Hispanic/Latino, Asian, and 'Some Other Race' groups had a significantly higher rate of Child and Adolescent Well Care Visits (WCV) completions when compared to the White population per the HPA sample. Specifically, the Hispanic/Latino group had the highest rate

of completion with a rate of 51.32%. The Black/African American had a statistically significantly lower rate of completed WCV in comparison to the White group, and numerically had the lowest rate of completion. They were also the only group below the 10th percentile (Graph XXI) (n=167,450) (Table X).

31. *Table VIV: Child and Adolescent Well Care Visits (WCV) MCAS Statistical Significance Results*

    MY 2023, Run Date: 7/24/2024

    Sample Size: 167,450

    Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	7084	18461	38%	
HISPANIC OR LATINO	2245	4986	45%	The WHITE population had a statistically significantly lower rate, (38.39%), compared to the `HISPANIC OR LATINO` population, (Rate=44.99%, Chi-Square=72.537, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	441	1079	41%	There is no statistically significant difference in rates between the WHITE population, (38.39%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =40.92%, Chi-Square=2.687, p=.1012)
ASIAN	398	926	43%	The WHITE population had a statistically significantly lower rate, (38.39%), compared to the `ASIAN` population, (Rate =43.01%, Chi-Square=7.900, p=.0049)
BLACK OR AFRICAN AMERICAN	160	428	37%	There is no statistically significant difference in rates between the WHITE population, (38.39%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =37.40%, Chi-Square=0.173, p=.6772)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	9	33	27%	There is no statistically significant difference in rates between the WHITE population, (38.39%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =27.28%, Chi-Square=1.717, p=.1901)
SOME OTHER RACE	237	498	48%	The WHITE population had a statistically significantly lower rate, (38.39%), compared to the `SOME OTHER RACE` population, (Rate =47.63%, Chi-Square=17.381, p=.0000)

Northwest

Race	Numerator	Denominator	Rate	Interpretation
WHITE	4261	9519	45%	
HISPANIC OR LATINO	1919	3733	51%	The WHITE population had a statistically significantly lower rate, (44.77%), compared to the `HISPANIC OR LATINO` population, (Rate=51.37%, Chi-Square=47.551, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	779	1813	43%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =43.01%, Chi-Square=1.988, p=.1585)
ASIAN	257	552	47%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `ASIAN` population, (Rate =46.53%, Chi-Square=0.680, p=.4098)
BLACK OR AFRICAN AMERICAN	103	224	46%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =45.98%, Chi-Square=0.132, p=.7169)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	12	30	40%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =40.04%, Chi-Square=0.274, p=.6004)
SOME OTHER RACE	158	315	50%	There is no statistically significant difference in rates between the WHITE population, (44.77%), and the `SOME OTHER RACE` population, (Rate =50.16%, Chi-Square=3.588, p=.0582)

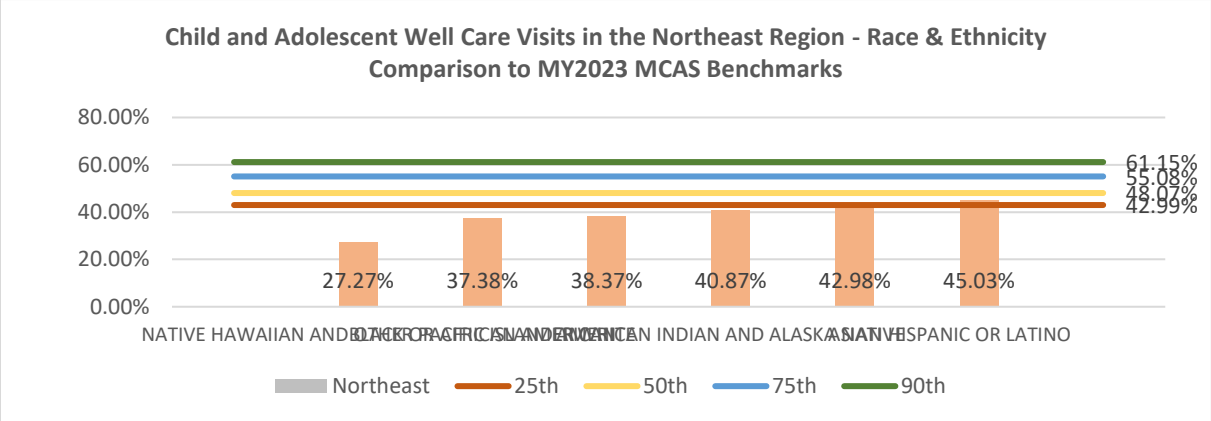
Southeast

Race	Numerator	Denominator	Rate	Interpretation
WHITE	3327	7949	42%	
HISPANIC OR LATINO	17716	34611	51%	The WHITE population had a statistically significantly lower rate, (41.80%), compared to the `HISPANIC OR LATINO` population, (Rate=51.15%, Chi-Square=225.20, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	79	178	44%	There is no statistically significant difference in rates between the WHITE population, (41.80%), and the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =44.33%, Chi-Square=0.457, p=.4991)
ASIAN	1760	3809	46%	The WHITE population had a statistically significantly lower rate, (41.80%), compared to the `ASIAN` population, (Rate =46.20%, Chi-Square=19.870, p=.0000)
BLACK OR AFRICAN AMERICAN	2508	6469	39%	The WHITE population had a statistically significantly higher rate, (41.80%), compared to the `BLACK OR AFRICAN AMERICAN` population, (Rate =38.72%, Chi-Square=14.087, p=.0002)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	86	249	35%	The WHITE population had a statistically significantly higher rate, (41.80%), compared to the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =34.54%, Chi-Square=5.318, p=.0211)
SOME OTHER RACE	1526	3094	49%	The WHITE population had a statistically significantly lower rate, (41.80%), compared to the `SOME OTHER RACE` population, (Rate=49.28%, Chi-Square=50.409, p=.0000)

Southwest

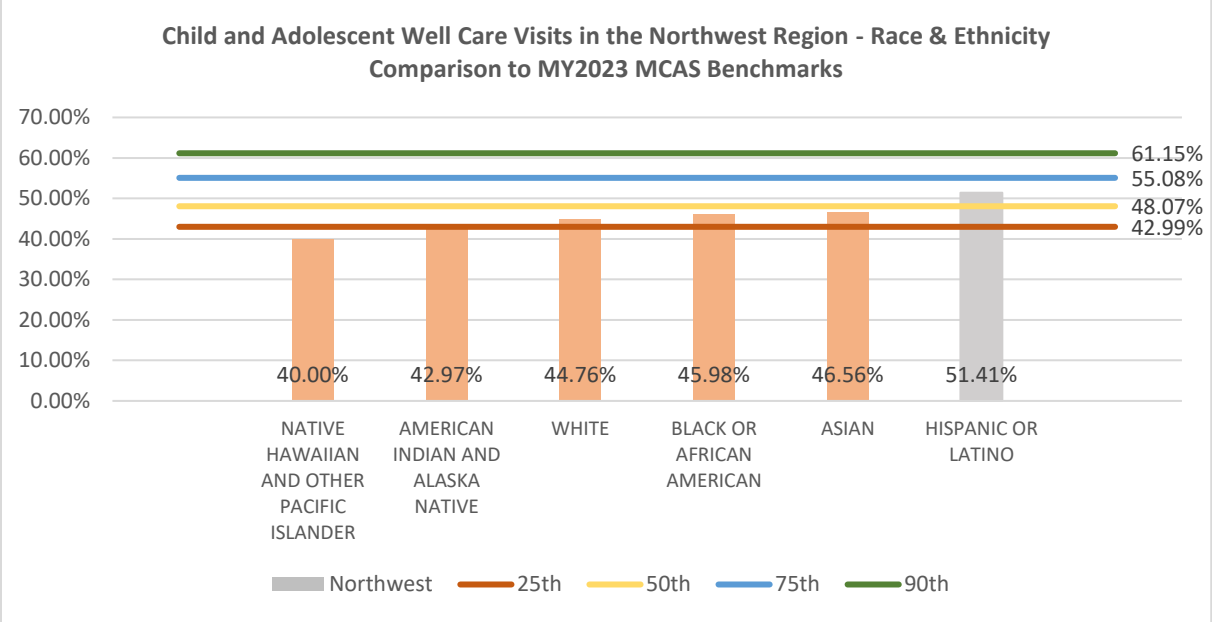
Race	Numerator	Denominator	Rate	Interpretation
WHITE	7447	17238	43%	
HISPANIC OR LATINO	22265	42697	52%	The WHITE population had a statistically significantly lower rate, (43.23%), compared to the `HISPANIC OR LATINO` population, (Rate=52.14%, Chi-Square=393.10, p=.0000)
AMERICAN INDIAN AND ALASKA NATIVE	554	1372	40%	The WHITE population had a statistically significantly higher rate, (43.23%), compared to the `AMERICAN INDIAN AND ALASKA NATIVE` population, (Rate =40.37%, Chi-Square=4.130, p=.0421)
ASIAN	583	1287	45%	There is no statistically significant difference in rates between the WHITE population, (43.23%), and the `ASIAN` population, (Rate =45.32%, Chi-Square=2.147, p=.1429)
BLACK OR AFRICAN AMERICAN	485	1105	44%	There is no statistically significant difference in rates between the WHITE population, (43.23%), and the `BLACK OR AFRICAN AMERICAN` population, (Rate =43.89%, Chi-Square=0.202, p=.6534)
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER	41	89	46%	There is no statistically significant difference in rates between the WHITE population, (43.23%), and the `NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER` population, (Rate =46.09%, Chi-Square=0.296, p=.5861)
SOME OTHER RACE	2413	4706	51%	The WHITE population had a statistically significantly lower rate, (43.23%), compared to the `SOME OTHER RACE` population, (Rate=51.26%, Chi-Square=97.394, p=.0000)

32. *Graph XXII*



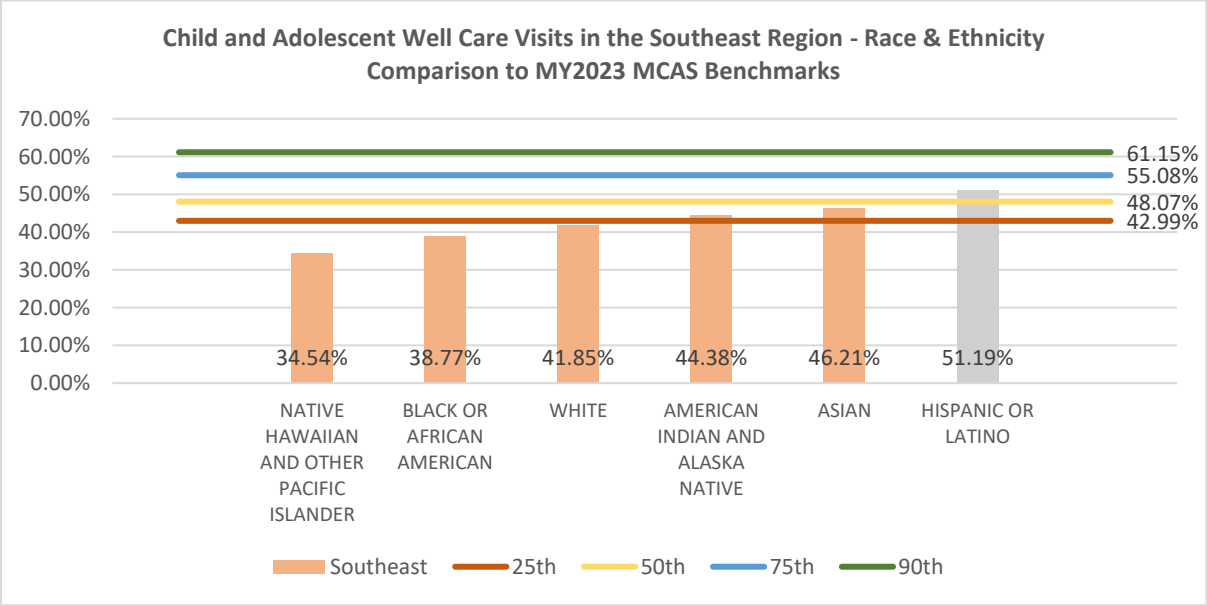
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

33. *Graph XXIII*



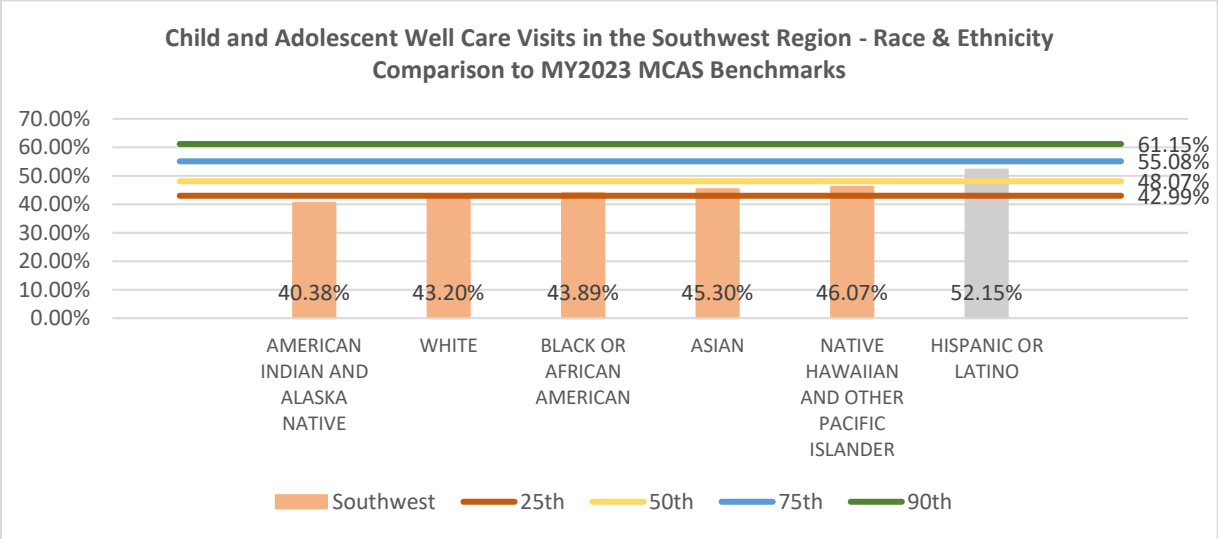
Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

34. *Graph XXIV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

35. *Graph XXV*



Note: Bars highlighted orange indicate group performed below the MPL (50th percentile). Bars highlighted green indicate groups performed above the 90th percentile.

36. *Table XII: Controlling High Blood Pressure (CBP) Language HPA Statistical Significance Testing*

Sample Size: 392

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	204	289	71%	Reference
SPANISH	70	95	74%	There is no statistically significant difference in rates between the ENGLISH population, (70.62%), and the `SPANISH` population, (Rate=73.70%, Chi-Square=0.335, p=.5626)
TAGALOG	3	6	50%	There is no statistically significant difference in rates between the ENGLISH population, (70.62%), and the `TAGALOG` population, (Rate=50.05%, Chi-Square=0.184, p=.3677)
RUSSIAN	1	2	50%	There is no statistically significant difference in rates between the ENGLISH population, (70.62%), and the `RUSSIAN` population, (Rate=50.05%, Chi-Square=0.418, p=.5044)

37. *Table XIII: Controlling High Blood Pressure (CBP) Language MCAS Statistical Significance Testing*

Sample Size: 1,489

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	223	359	62%	
SPANISH	10	18	56%	There is no statistically significant difference in rates between the ENGLISH population, (62.15%), and the `SPANISH` population, (Rate=55.55%, Chi-Square=0.313, p=.5761)

Northwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	234	366	64%	
SPANISH	6	12	50%	There is no statistically significant difference in rates between the ENGLISH population, (63.91%), and the `SPANISH` population, (Rate=50.05%, Chi-Square=0.144, p=.3675)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	166	265	63%	
SPANISH	66	98	67%	There is no statistically significant difference in rates between the ENGLISH population, (62.59%), and the `SPANISH` population, (Rate=67.32%, Chi-Square=0.687, p=.4073)
TAGALOG	6	11	55%	There is no statistically significant difference in rates between the ENGLISH population, (62.59%), and the `TAGALOG` population, (Rate=54.56%, Chi-Square=0.209, p=.7523)
RUSSIAN	3	5	60%	There is no statistically significant difference in rates between the ENGLISH population, (62.59%), and the `RUSSIAN` population, (Rate=59.95%, Chi-Square=0.346, p=1.000)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	150	237	63%	
SPANISH	76	116	66%	There is no statistically significant difference in rates between the ENGLISH population, (63.25%), and the `SPANISH` population, (Rate=65.56%, Chi-Square=0.168, p=.6823)
TAGALOG	1	2	50%	There is no statistically significant difference in rates between the ENGLISH population, (63.25%), and the `TAGALOG` population, (Rate=50.05%, Chi-Square=0.467, p=1.000)

38. *Table XIV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Language HPA Statistical Significance Testing*

    Sample Size: 394

    Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	97	276	35%	Reference
SPANISH	34	114	30%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `SPANISH` population, (Rate=29.81%, Chi-Square=1.024, p=.3116)
TAGALOG	0	2	%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `TAGALOG` population, (Rate=0.000%, Chi-Square=0.423, p=.5440)
RUSSIAN	2	2	100%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `RUSSIAN` population, (Rate=99.99%, Chi-Square=0.126, p=.1260)

39. *Table XV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Language MCAS Statistical Significance Testing*

Sample Size: 1,441

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	138	338	41%	
SPANISH	4	21	19%	The ENGLISH population had a statistically significantly higher rate, (40.81%), compared to the `SPANISH` population, (Rate =19.03%, Chi-Square=3.923, p=.0476)

Northwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	116	346	34%	
SPANISH	5	14	36%	There is no statistically significant difference in rates between the ENGLISH population, (33.55%), and the `SPANISH` population, (Rate =35.75%, Chi-Square=0.220, p=1.000)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	87	248	35%	
SPANISH	29	112	26%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `SPANISH` population, (Rate =25.85%, Chi-Square=2.982, p=.0842)
TAGALOG	0	7	%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `TAGALOG` population, (Rate =0.000%, Chi-Square=0.052, p=.0991)
RUSSIAN	0	1	%	There is no statistically significant difference in rates between the ENGLISH population, (35.09%), and the `RUSSIAN` population, (Rate =0.000%, Chi-Square=0.651, p=1.000)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	82	214	38%	
SPANISH	36	139	26%	The ENGLISH population had a statistically significantly higher rate, (38.28%), compared to the `SPANISH` population, (Rate =25.85%, Chi-Square=5.840, p=.0157)
TAGALOG	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (38.28%), and the `TAGALOG` population, (Rate =99.99%, Chi-Square=0.386, p=.3860)

40. *Table XVI: Timeliness of Prenatal Care (PPC – Pre) Language HPA Statistical Significance Testing*

Sample Size: 205

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	143	158	91%	Reference
SPANISH	42	47	89%	There is no statistically significant difference in rates between the ENGLISH population, (90.53%), and the `SPANISH` population, (Rate=89.32%, Chi-Square=0.208, p=.7837)

41. *Table XVII: Timeliness of Prenatal Care (PPC – Pre) Language MCAS Statistical Significance Testing*

Sample Size: 885

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	224	265	84%	
SPANISH	12	12	100%	There is no statistically significant difference in rates between the ENGLISH population, (84.48%), and the `SPANISH` population, (Rate =99.99%, Chi-Square=0.140, p=.2243)

Northwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	163	208	78%	
SPANISH	8	9	89%	There is no statistically significant difference in rates between the ENGLISH population, (78.32%), and the `SPANISH` population, (Rate =88.88%, Chi-Square=0.284, p=.6880)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	159	177	90%	
SPANISH	44	52	85%	There is no statistically significant difference in rates between the ENGLISH population, (89.87%), and the `SPANISH` population, (Rate =84.59%, Chi-Square=1.086, p=.2973)
TAGALOG	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (89.87%), and the `TAGALOG` population, (Rate =99.99%, Chi-Square=0.899, p=1.000)
RUSSIAN	2	2	100%	There is no statistically significant difference in rates between the ENGLISH population, (89.87%), and the `RUSSIAN` population, (Rate =99.99%, Chi-Square=0.809, p=1.000)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	100	108	93%	
SPANISH	48	50	96%	There is no statistically significant difference in rates between the ENGLISH population, (92.62%), and the `SPANISH` population, (Rate =96.03%, Chi-Square=0.216, p=.5059)
RUSSIAN	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (92.62%), and the `RUSSIAN` population, (Rate =99.99%, Chi-Square=0.927, p=1.000)

42. *Table XVIII: Postpartum Care (PPC – Post) Language HPA Statistical Significance Testing*

Sample Size: 205

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation

ENGLISH	134	158	85%	Reference
SPANISH	44	47	94%	There is no statistically significant difference in rates between the ENGLISH population, (84.81%), and the `SPANISH` population, (Rate=93.61%, Chi-Square=2.457, p=.1170)

43. *Table XIX: Postpartum Care (PPC – Post) Language MCAS Statistical Significance Testing*

Sample Size: 885

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	213	265	80%	
SPANISH	12	12	100%	There is no statistically significant difference in rates between the ENGLISH population, (80.41%), and the `SPANISH` population, (Rate=99.99%, Chi-Square=0.078, p=.1312)

Notheast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	169	208	81%	
SPANISH	9	9	100%	There is no statistically significant difference in rates between the ENGLISH population, (81.29%), and the `SPANISH` population, (Rate=99.99%, Chi-Square=0.162, p=.3684)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	154	177	87%	
SPANISH	46	52	88%	There is no statistically significant difference in rates between the ENGLISH population, (87.01%), and the `SPANISH` population, (Rate=88.44%, Chi-Square=0.077, p=.7814)
TAGALOG	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (87.01%), and the `TAGALOG` population, (Rate=99.99%, Chi-Square=0.871, p=1.000)
RUSSIAN	2	2	100%	There is no statistically significant difference in rates between the ENGLISH population, (87.01%), and the `RUSSIAN` population, (Rate=99.99%, Chi-Square=0.759, p=1.000)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	98	108	91%	
SPANISH	50	50	100%	The ENGLISH population had a statistically significantly lower rate, (90.75%), compared to the `SPANISH` population, (Rate =99.99%, Chi-Square=0.019, p=.0313)
RUSSIAN	1	1	100%	There is no statistically significant difference in rates between the ENGLISH population, (90.75%), and the `RUSSIAN` population, (Rate=99.99%, Chi-Square=0.908, p=1.000)

44. *Table XX: Child and Adolescent Well Care Visits (WCV) Language HPA Statistical Significance Testing*

Sample Size: 187,458

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	59368	131999	45%	Reference
SPANISH	28864	54051	53%	The ENGLISH population had a statistically significantly lower rate, (44.99%), compared to the `SPANISH` population, (Rate =53.35%, Chi-Square=1091.8, p=.0000)
TAGALOG	61	155	39%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `TAGALOG` population, (Rate=39.38%, Chi-Square=1.977, p=.1597)
RUSSIAN	197	424	46%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `RUSSIAN` population, (Rate=46.42%, Chi-Square=0.377, p=.5391)
FARSI	121	172	70%	The ENGLISH population had a statistically significantly lower rate, (44.99%), compared to the `FARSI` population, (Rate =70.40%, Chi-Square=44.679, p=.0000)
HMONG	45	125	36%	The ENGLISH population had a statistically significantly higher rate, (44.99%), compared to the `HMONG` population, (Rate =35.97%, Chi-Square=4.066, p=.0438)
MANDARIN	51	123	41%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `MANDARIN` population, (Rate=41.47%, Chi-Square=0.613, p=.4338)
PORTUGUESE	50	102	49%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `PORTUGUESE` population, (Rate =49.06%, Chi-Square=0.673, p=.4119)
VIETNAMESE	131	307	43%	There is no statistically significant difference in rates between the ENGLISH population, (44.99%), and the `VIETNAMESE` population, (Rate =42.68%, Chi-Square=0.658, p=.4174)

45. Table XXI: Child and Adolescent Well Care Visits (WCV) Language MCAS Statistical Significance Testing

Sample Size: 187,070

Contact: Shivani Sivasankar, Sr. Health Data Analyst II

Northeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	12748	31029	41%	
SPANISH	658	1179	56%	The ENGLISH population had a statistically significantly lower rate, (41.03%), compared to the `SPANISH` population, (Rate =55.77%, Chi-Square=101.37, p=.0000)
RUSSIAN	4	8	50%	There is no statistically significant difference in rates between the ENGLISH population, (41.03%), and the `RUSSIAN` population, (Rate =50.05%, Chi-Square=0.240, p=.7243)

Northwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	9087	19045	48%	
SPANISH	662	1233	54%	The ENGLISH population had a statistically significantly lower rate, (47.74%), compared to the `SPANISH` population, (Rate =53.68%, Chi-Square=16.572, p=.0000)
TAGALOG	3	4	75%	There is no statistically significant difference in rates between the ENGLISH population, (47.74%), and the `TAGALOG` population, (Rate =75.02%, Chi-Square=0.227, p=.3538)

Southeast

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	17893	39571	45%	
SPANISH	10631	20118	53%	The ENGLISH population had a statistically significantly lower rate, (45.21%), compared to the `SPANISH` population, (Rate =52.80%, Chi-Square=310.85, p=.0000)
TAGALOG	52	135	39%	There is no statistically significant difference in rates between the ENGLISH population, (45.21%), and the `TAGALOG` population, (Rate =38.50%, Chi-Square=2.438, p=.1185)
RUSSIAN	170	372	46%	There is no statistically significant difference in rates between the ENGLISH population, (45.21%), and the `RUSSIAN` population, (Rate =45.65%, Chi-Square=0.034, p=.8527)
FARSI	113	160	71%	The ENGLISH population had a statistically significantly lower rate, (45.21%), compared to the `FARSI` population, (Rate =70.62%, Chi-Square=41.512, p=.0000)
VIETNAMESE	56	156	36%	The ENGLISH population had a statistically significantly higher rate, (45.21%), compared to the `VIETNAMESE` population, (Rate =35.86%, Chi-Square=5.450, p=.0196)

Southwest

Language	Numerator	Denominator	Rate	Interpretation
ENGLISH	19639	42354	46%	
SPANISH	16914	31521	54%	The ENGLISH population had a statistically significantly lower rate, (46.42%), compared to the `SPANISH` population, (Rate =53.68%, Chi-Square=384.28, p=.0000)
TAGALOG	6	16	38%	There is no statistically significant difference in rates between the ENGLISH population, (46.42%), and the `TAGALOG` population, (Rate =37.51%, Chi-Square=0.506, p=.4769)
RUSSIAN	23	44	52%	There is no statistically significant difference in rates between the ENGLISH population, (46.42%), and the `RUSSIAN` population, (Rate =52.25%, Chi-Square=0.616, p=.4325)
VIETNAMESE	61	125	49%	There is no statistically significant difference in rates between the ENGLISH population, (46.42%), and the `VIETNAMESE` population, (Rate =48.84%, Chi-Square=0.296, p=.5862)

46. *Table XXII: Controlling High Blood Pressure (CBP) Gender HPA Statistical Significance Testing*

Gender	Numerator	Denominator	Rate	Interpretation
MALE	133	178	75%	Reference
FEMALE	150	223	67%	There is no statistically significant difference in rates between the Male population, (74.69%), and the Female population, (Rate =67.21%, Chi-Square=2.649, p=.1036)

Partnership found no statistically significant difference when comparing each gender identity group to the Male gender identity group while using the NCQA Health Plan Accreditation generated sample (drawn from the eligible population) for Controlling High Blood Pressure (n=401) (Table XXII).

47. *Table XXIII: Controlling High Blood Pressure (CBP) Gender Identity MCAS Statistical Significance Results*

Northeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	99	173	57%	
FEMALE	139	215	65%	There is no statistically significant difference in rates between the Male population, (57.20%), and the Female population, (Rate =64.68%, Chi-Square=2.229, p=.1354)

Northwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	133	209	64%	
FEMALE	112	179	63%	There is no statistically significant difference in rates between the Male population, (63.69%), and the Female population, (Rate =62.59%, Chi-Square=0.047, p=.8281)

Southeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	104	161	65%	
FEMALE	148	231	64%	There is no statistically significant difference in rates between the Male population, (64.57%), and the Female population, (Rate =64.02%, Chi-Square=0.011, p=.9147)

Southwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	106	167	63%	
FEMALE	131	199	66%	There is no statistically significant difference in rates between the Male population, (63.47%), and the Female population, (Rate =65.78%, Chi-Square=0.221, p=.6384)

48. *Table XXIV: Hemoglobin A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Gender HPA Statistical Significance Testing*

Gender	Numerator	Denominator	Rate	Interpretation
MALE	68	189	36%	Reference
FEMALE	66	216	31%	There is no statistically significant difference in rates between the Male population, (35.97%), and the Female population, (Rate=30.58%, Chi-Square=1.339, p=.2472)

Partnership found no statistically significant difference when comparing each gender identity group to the Male gender identity group while using the NCQA Health Plan Accreditation generated sample (drawn from the eligible population) for HbA1c Poor Control (n=405) (Table XXIV).

49. *Table XXV: A1c Control for Patients with Diabetes (HBD) HbA1c Poor Control (>9.0%) Gender Identity MCAS Statistical Significance Results*

Northeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	71	170	42%	
FEMALE	73	201	36%	There is no statistically significant difference in rates between the Male population, (41.80%), and the Female population, (Rate =36.30%, Chi-Square=1.150, p=.2835)

Northwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	60	156	39%	
FEMALE	63	215	29%	There is no statistically significant difference in rates between the Male population, (38.50%), and the Female population, (Rate =29.26%, Chi-Square=3.422, p=.0643)

Southeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	66	171	39%	
FEMALE	53	209	25%	The Male population had a statistically significantly higher rate, (38.61%), compared to the Female population, (Rate =25.41%, Chi-Square=7.662, p=.0056)

Southwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	57	172	33%	
FEMALE	62	188	33%	There is no statistically significant difference in rates between the Male population, (33.11%), and the Female population, (Rate =33.00%, Chi-Square=0.001, p=.9742)

50. *Table XXVI: Child and Adolescent Well Care Visits (WCV) Gender Identity HPA Statistical Significance Testing*

Gender	Numerator	Denominator	Rate	Interpretation
MALE	45513	96466	47%	Reference
FEMALE	43714	91730	48%	The Female population had a statistically significantly higher rate, (47.63%), compared to the Male population, (Rate =47.19%, Chi-Square=4.250, p=.0393)

Partnership found that the Female gender identity significantly performed better to the Male-group while using the NCQA Health Plan Accreditation generated sample (drawn from the eligible population) for Child and Adolescent Well Care Visits (n=188,196, Table XXVI). Specifically, the Female population had a 1% higher rate of Child and Adolescent Well Care when compared to the Male population.

51. *Table XXVII: Child and Adolescent Well Care Visits (WCV) Gender Identity MCAS Statistical Significance Results*

Northeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	6964	16665	42%	
FEMALE	6520	15719	41%	There is no statistically significant difference in rates between the Male population, (41.80%), and the Female population, (Rate =41.47%, Chi-Square=0.319, p=.5720)

Northwest

Gender	Numerator	Denominator	Rate	Interpretation

MALE	4952	10440	47%	
FEMALE	4840	9948	49%	There is no statistically significant difference in rates between the Male population, (47.41%), and the Female population, (Rate =48.62%, Chi-Square=3.038, p=.0813)

Southeast

Gender	Numerator	Denominator	Rate	Interpretation
MALE	14866	31164	48%	
FEMALE	14320	29908	48%	There is no statistically significant difference in rates between the Male population, (47.74%), and the Female population, (Rate =47.85%, Chi-Square=0.193, p=.6603)

Southwest

Gender	Numerator	Denominator	Rate	Interpretation
MALE	18731	38198	49%	
FEMALE	18034	36154	50%	The Female population had a statistically significantly higher rate, (49.83%), compared to the Male population, (Rate =49.06%, Chi-Square=5.299, p=.0213)

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Cultural & Linguistic Program Description / Quality Improvement Health Equity Transformation Program (C&L/QIHEPT) Work Plan - 2024-2025 Goals

Goal #	Project/Program	Continuation or New Goal	Goal	Outcome Measure(s)	Deliverables	Start Date	Due Date	Sponsor	Business Owner	Deliverable Evaluation Status				Goal Met (Yes No)
										Jan 1 - Mar 31	Apr 1 - June 30	July 1 - Sep 30	Oct 1 - Dec 31	
1	Health Equity Strategic Plan Development and Health Disparities Analysis (HE6)	Continued from 2024	By Aug 31, 2024, define the framework and processes by which the QIHETP Program Description, C&L/QIHETP Work Plan, and QIHETP Evaluation will be initiated in 2024 and maintained through approval of corresponding 2025 versions needed for HEA Initial Survey in June 2025	**Measure:** Disparity Analysis Report and Health Equity Strategic Plan Completion (QIHETP Program Description)	**Deliverable 1:** Submit 2023 HE 6 Disparity Analysis to External Consultant (Diane Williams)	1/1/2024	2/24/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Improvement Advisor (QI) Name: Dorian Roberts	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Submit updated 2024 C&L/QIHETP Work Plan for QIHEC approval	1/1/2024	2/20/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Health Disparities Statistical Analysis for 2024 data (2025 HE 6 Analysis)	7/1/2024	7/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Senior Health Data Analyst II Name: Shivani Sivasankar	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Submit 2025 HE 6 Disparity Analysis to External Consultant (Diane Williams)	9/1/2024	9/15/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Improvement Advisor (QI) Name: Dorian Roberts	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #5: Submit Final 2024 C&L/QIHETP Work Plan and proposed 2025 C&L/QIHETP Work Plan for IQI / QUAC review and approval for HEA Initial Survey in 2025	9/1/2024	10/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
2	Providing DEI Training Development for Staff and Network Providers, Subcontractors, etc. to fulfill DHCS All Plan Letter (APL) Requirements. Training will be tailored per Network Cultural Responsiveness and Community Needs	Continued from 2024	By December 31, 2024, submit DEI training to DHCS for review to fulfill Phase I APL deliverables	**Measure:** DEI Training Submission Receipt from DHCS	**Deliverable #1:** Create and submit RFP for DEI training	1/1/2024	3/1/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Execute Contract for RFP after decision from Exec Team and PRB	3/1/2024	9/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Project Manager I Name: Anabel Castro	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Review and Update DEI training Content Submitted by Vendor	9/30/2024	10/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Submit training to DHCS for review and approval to fulfill Phase I of APL	11/012024	12/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
3	Providing materials to members in large print, Braille, audio format, or other, per member request	Continued from 2024	By Dec 31, 2024, 90% of members who have requested materials in an alternate format will receive one or more mailings in their preferred format	**Measure:** Percentage of members requesting materials in an alternate format who received a mailing in their preferred format **Numerator:** Number of members who have been sent one (1) or more mailings of materials in their preferred format **Denominator:** Number of members who have requested an alternate format	**Deliverable #1:** Complete draft 2024 C&L Program Evaluation based on 2024 C&L Program Description and Final 2024 C&L/QIHETP Work Plan in preparation for submission to the NCQA Consultant for review in January 2025	11/1/2024	12/31/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Manager of Population Health Name: Hannah O'Leary, MPH, CHES Title: Sr. Manager of Member Services Name: Cyress Mendiola (MS)	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
4	Hiring of bilingual member services representatives	Continued from 2024	By Dec 31, 2024, increase the number of bilingual Member Service Representative (MSR) staff hired by 1% to move closer to organizational goal of 75% of bilingual MSR staff.	**Measure:** Percentage of members who are considered bilingual **Numerator:** Number of bilingual MSR department staff that have passed Partnership bilingual competency examination with a minimum rating of "Advanced" **Denominator:** Total number of MSR department staff	**Deliverable #1:** Conduct baseline assessment of number of bilingual representatives needed to reach 1% increase	1/1/2024	2/24/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Conduct internal evaluation of bilingual salary adjustment recommendations to promote MSR retention in the MS department	3/1/2024	6/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Sr. Manager of Member Services Name: Cyress Mendiola (MS) Title: Supervisor of Member Services Name: Maria Cabrera (MS)	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Conduct internal focus group to discuss strategies for recruiting bilingual staff members	3/1/2024	6/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Sr. Manager of Member Services Name: Cyress Mendiola (MS) Title: Supervisor of Member Services Name: Maria Cabrera (MS)	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Complete draft 2025 C&L/QIHETP Work Plan	7/1/2024	8/1/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
5	Controlling Blood Pressure	Continued from 2024	By Dec 31, 2024, improve controlled blood pressure rate among American Indian/Alaska Native members by 5%	**Measure:** Percentage of members with controlled blood pressure per HEDIS- **Numerator:** Number of members who are considered controlled for blood pressure **Denominator:** Total number of eligible members with essential hypertension diagnosis	**Deliverable #1:** Conduct Root Cause Analysis to identify sites that have largest number of American Indian/Alaska Native Members with lowest blood pressure control per region	3/1/2024	3/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Conduct coordinated site visit with Performance Improvement and/or Equity Transformation Project teams to at least 60 to 80% of previously identified sites to provide education and solicit feedback	4/1/2024	6/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Provide recommendations to QIP workgroup to incentivize blood pressure reduction in specific target community to model other health plans	4/1/2024	6/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	

					Deliverable #4: Execute PHM campaign to prioritize group during outreach calls and identify community events to conduct hypertension community outreach	4/1/2024	12/31/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Associate Director of Population Health Name: Monika Brunkal, RPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
6	Timely Translation Fulfillment	New	By Dec 31, 2025, improve the rate of timely translations in the Utilization Management department to achieve the threshold of at least 90%.	**Measure**: percentage of translations fulfilled in a timely manner **Numerator**: translations completed in 48 hours **Denominator**: total translations in either department	**Deliverable #1:** Generate a report showing the rate of timely translations for UM	1/1/2025	12/31/2025	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Program Manager I, Utilization Management Name: Kandice Dixon	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
								Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN		**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated				
								Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN		**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed				
7	Prenatal Care	New	By Dec 31, 2025, Improve prenatal visits by at least 5% in the NE or NW region in the American Indian/Alaska Native Member Population within 12 months with the global goal of improvement by 22% in the next 5 years.	**Measure:** The percentage of deliveries in which women had a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. **Numerator:** The total number of deliveries a woman had in the first first trimester **Denominator:** The total number of eligible deliveries, such as all live births between certain dates or all women who meet certain enrollment criteria.	**Deliverable #1:** Conduct Root Cause Analysis to identify sites and zipcodes with highest likelihood of not completing prenatal care visits	10/1/2024	10/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Interview at least 10 members per Northern Region to identify barriers for conducting prenatal visits	10/30/2024	11/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Identify interventions for QMSI workgroup in collaboration with other depts and teams	1/1/2025	3/30/2025	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Execute internal PHM campaign, QMSI generated intervention, and/or Population Health Community event to address disparity	6/1/2025	12/312025	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Associate Director of Population Health Name: Monika Brunkal, RPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
8	Well Care Visits	New	By Dec 31, 2025, improve Well Care Visits rate among Black, White, and/or American Indian/Alaska native members by 5% overall or in at least 1.25% in at least one region	**Measure:** Percentage of members 3–21 years of age who received one or more well-care visit with a primary care practitioner or an OB/GYN practitioner during the measurement year **Numerator:** Number of members who attend at least one well-care visit witha primary care practitioner **Denominator:** Total number of eligible members in age range	**Deliverable #1:** Conduct Root Cause Analysis to identify sites that have largest number of members who are not attending WCVs	10/1/2024	10/30/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #2: Interview available pediatricians to assess current workload of seeing members for well care visits and interview at least 10 parents to identify barriers for going to well-care visits	11/30/2024	12/021/2024	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #3: Identify interventions for QMSI workgroup in collaboration with other depts and teams (Conduct in-service presentation on benefit of group WCV and mother-child dyadic appointments to clinical sites	1/1/2025	3/30/2025	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Director of Health Equity Name: Mohamed Jalloh, PharmD	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	
					Deliverable #4: Execute internal PHM campaign, QMSI generated intervention, and/or Population Health Community event to address disparity	6/1/2025	12/312025	Title: Chief Health Services Officer Name: Katherine Barresi, RN, MSN	Title: Associate Director of Population Health Name: Monika Brunkal, RPH	**Jan 1 - Mar 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Apr 1 - June 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**July 1 - Sep 30** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	**Oct 1 - Dec 31** ☐ Complete ☐ On Track ☐ Delayed ☐ Terminated	

Cultural and Linguistics Work Plan										
Topic	**Department(s) Involved**	**Service Description / Member Notification**	**Outcome Measures**	**Denominator**	**Number**	**Start Date**	**Due Date**	**Project/Program Lead / Analytics**	**Project/Program Update Contact**	**Ongoing Issues to Monitor**
Vision-Impaired Members (Disability)	Member Services, Care Coordination, Communications, Grievance, Population Health, Utilization Management	Providing materials to members in large print, Braille, audio format or other, per member request	* percentage of members requesting materials in an alternate format who received a mailing in their preferred format - Goal: 90% of members who have requested materials in an alternate format will receive one or more mailings in their preferred format	Number of members who have requested an alternate format	Number of members who have been sent one or more mailings of materials in their preferred format	1/1/2024	Ongoing	Anna Hernandez (MS) & Greg Friedman (PHM)	Greg Friedman	Yearly report to evaluate compliance