PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

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Business Unit: Quality Improvement</td></tr>
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<tr><td colspan="4">Approval Signature: Robert Moore, MD, MPH, MBA</td><td colspan="2">Approval Date: 10/14/26</td></tr>
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I. RELATED POLICIES:

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

II. IMPACTED DEPTS:

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

III. DEFINITIONS:

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

A.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

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

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

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

VI. POLICY / PROCEDURE:

A. Committee Structure

1. Composition

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

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

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

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

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

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

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

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

appropriateness of medical care. Advises staff on selection and prioritization of quality improvement activities.

11. Develops and/or approves clinical criteria used by UM staff to perform prospective and concurrent inpatient, ambulatory review or other utilization activities.
12. Reviews utilization, financial, and other staff reports that display the utilization of services and outcomes of quality within the delivery system.
13. Serves as a review body to assist in the interpretation of medical benefit coverage based on medical necessity and appropriateness issues.
14. Provides oversight of delegated utilization management and quality improvement activities.
15. Reviews performance dashboards and make recommendations for corrective action on indicators that fall below established thresholds; ensures follow-up on corrective actions where identified.
16. Reviews and provides recommendations for member-related activities including Consumer Assessment of Healthcare Providers and Systems (CAHPS®), grievances, telephone access, appointment access, availability and other member satisfaction surveys.

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

D. Delegation Oversight and Monitoring
   1. Partnership may delegate quality improvement activities, responsibilities and committee structure.
   2. A formal agreement is maintained and inclusive of all delegated functions.
   3. Partnership conducts oversight and monitoring activities, including audits no less than annually, to ensure appropriate policy and procedures are maintained.
   4. Results from Oversight and Monitoring activities shall be presented to DORS for review and approval.

VII. REFERENCES:
N/A

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

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

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

Partnership Advantage (effective January 1, 2028)
N/A

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

PREVIOUSLY APPLIED TO:

Policy/Procedure Number: MPQP1002 (previously QP100102)			**Lead Department: Health Services** Business Unit: Quality Improvement
Policy/Procedure Title: Quality/Utilization Advisory Committee			☒**External Policy** ☐**Internal Policy**
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PartnershipAdvantage
MPQP1002 - 03/21/2007 to 01/01/2015

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

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