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

MCED6001

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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

AUTHORITY AND RESPONSIBILITY

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 Quality Improvement and Performance Improvement (QI/PI) programs. The Commission is ultimately accountable for the quality of care and services provided to members. The Commission has delegated direct supervision, coordination, and oversight of the QI/PI program to the Physician Advisory Committee (PAC), which serves as the main Quality Improvement committee. PAC is supported by two other quality committees – the Quality and Utilization Advisory Committee (Q/UAC) and the Internal Quality Improvement Committee (IQI), which are described in more detail below. The county Boards of Supervisors for each geographic area appoints members of the Commission, which include representation from the community: consumers, businesses, physicians, providers, hospitals, community clinics, HMOs, local government, and County Health departments. The Commission meets six times per year.

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

Key Roles

The following leadership roles carry authority and responsibility to ensure the QIHETP Program is fully implemented and maintained. The qualifications of staff presently fulfilling these roles are detailed in Appendix D (included with QI Trilogy submission) which includes documented evidence corresponding to that collected annually on behalf of DHCS. Given the personal details included, this appendix is not posted publicly.

PROGRAM STAFF

Chief Medical Officer

The Chief Medical Officer (CMO), with the assistance of the members of PAC, Q/UAC, and IQI, as well as the other medical directors of Partnership, is responsible for providing professional judgment regarding matters of quality of care, peer review, clinical, and medical procedures. The CMO is the chair of IQI and Q/UAC and has significant involvement in all QI/PI, Pharmacy, and Health Services activities as well as providing oversight to these programs on a day-to-day basis. The CMO is a Medical Doctor (MD) or Doctor of Osteopathy (DO) with an unrestricted license in the State of California.

Chief Health Services Officer

The Chief Health Services Officer (CHSO) works closely with leaders in Utilization Management to provide accountability for delegates to meet necessary National committee for Quality Assurance (NCQA) accreditation requirements and provide strategic leadership and guidance in the review and revision of provider contracts to ensure QI reporting requirements and value-based program contingencies are met. The CHSO also has purview over the Care Coordination, Utilization Management, Enhanced Health Services, Behavioral Health and Health Equity departments and ensures that these departments incorporate and prioritize quality improvement work and processes in coordination with standing work. The CHSO's level of involvement fulfills the need for executive

support and accountability for improvements with data quality, and coordination of activities between QI and these departments. Collaborates with the Chief Medical Officer and members of PAC, Q/UAC, and IQI in matters involving quality of care, clinical, and medical procedures.

Director of Health Equity (Health Equity Officer)
The Director of Health Equity serves as the Health Equity Officer (HEO) for Partnership. In collaboration with Partnership leaders, the Director of Health Equity leads the development and implementation of strategies that advance health equity across our network diversity, equity, and inclusion across the organization. This role drives systemic change to enhance representation and cultivates programs that foster a culture of belonging. This role provides oversight, strategic direction, and support for improving quality measure performance and member experience in specified cultural, linguistic, economic, educational, etc. groups in our community and workforce. In collaboration with the CMO, oversees the Quality Improvement and Health Equity Transformation Program (QIHETP) program operations and assists in the development and coordination of QIHETP policies and procedures. This role also leads the development and management of the diversity, equity, and inclusion and gender-affirming care training programs.

Medical Director for Quality
Assists CMO by providing physician support for varying activities within the QI/PI department, including Performance Improvement, Member Safety, Peer Review, and the Quality Incentive Programs, as well as assists with utilization management review activities. This role also serves as management oversight for the Member Safety teams within the QI/PI department.

Senior Director of Quality and Performance Improvement
This role works collaboratively with the CMO to define strategy, develop programs and services, and to evaluate the effectiveness of the QI/PI Program. Together with the QI management team, including the Medical Director for Quality, provides oversight of Facility Site Reviews, investigation of potential quality issues, compliance with NCQA standards, Healthcare Effectiveness and Data Information Set (HEDIS®) and other performance measure data collection and performance reporting, value-based payment programs (QIPs), performance improvement initiatives and programs, external and internal QI training, provider education on the QIPs and HEDIS®, grant application and grant management. This role works to foster greater cross collaboration of QI staff and strategic involvement of other departments to support the execution of tactics defined and maintained under Partnership's 5-Star Quality Strategy.

Director of Population Health Management
The Director of Population Health Management works collaboratively with leaders across the organization, to execute the organization's Population Health Management strategy. This role provides oversight, strategic direction, and support for related initiatives, including those essential to improving quality measure performance and member experience. This role offers guidance and ensures alignment with health care policies, financing, accreditation requirements, and regulations to drive optimal health outcomes for members.

Behavioral Health Clinical Director
The Behavioral Health Clinical Director holds an MD/DO, PhD or PsyD credential. With the assistance of the Behavioral Health team, this individual is responsible for providing professional judgment regarding matters of quality of care, peer review, and clinical policies and procedures through oversight

of Partnership activities in the areas of mental health and substance use disorder services as provided by Partnership's delegated behavioral health providers.

Administrative Assistant
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

Project Coordinator I

Oversees timelines and deliverables for department projects. Provides routine and ad hoc reporting for key Population Health activities and initiatives. Works closely with designated department staff and leadership to gather, compile, and distribute reports, and facilitates structured file and record management. Supports ongoing audit readiness activities by maintaining structures around audit deliverables, meeting minutes, and the file retrieval system.

- Uploads and maintains policy documents in PowerDMS

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., Community 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

Community Advisory Committee (CAC)
The Community 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) (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 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) and Community Health Improvement Plan (CHIP) 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 Contributors
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.

Community Reinvestment Management
The Health Equity department will work with the Finances, Population Health, Behavioral Health, Project Management Operations departments to ensure the health plan reinvests a minimum level of our net income into our local communities. Community reinvestment planning will start in calendar year 2025, with community reinvestment activities starting in 2026 and follow a 3 year cycle to align with other DHCS-related initiatives (Community Health Assessment, Behavioral Health Transformation, etc.)

Partnership's Health Equity Officer and Health Equity team, will lead the management of the community reinvestment planning process to ensure all community reinvestment plans align with overall health equity needs and priorities. Also, the health equity team will ensure that the health plan and qualifying subcontractors' activities are based upon engagement with the community and community-identified priorities, with investments in health quality improvement and equity outcomes.

Data
Every 3 years, Partnership will review the following to make a preliminary assessment of community reinvestment landscape in our counties:

- PNA
- CHA/CHIP for each corresponding county
- Behavioral Health Transformation assessment for each county
- Health Equity Grand Analysis per QIHETP workplan

Funding Requirements
Partnership and qualifying subcontractors will define the base Community Reinvestment as the minimum level of net income that, if with positive net income, is required to invest into initiatives that serve the communities in which the Partnership operates, starting with net income based on Calendar year (CY) 2024 Contract Revenues for Community Reinvestment activities initiated in CY 2026.

- Partnership, since in multiple counties, will calculate the Base Community Reinvestment funding obligations with the following allocation methodology:
  - 5% of Base Community Reinvestment Funds equally across counties in which Partnership operates + 95% of Base Community reinvestment Funds in Proportion to Medi-Cal membership by county
- Partnership will allocate the base community reinvestment funds = (5% of the Partnership's or Qualifying Subcontractors annual net income that is less than or equal to 7.5% of Medi-Cal Contract Revenues/Subcontractor agreement for the year**) +** (7.5% of the Partnership's or Qualifying Subcontractor's annual net income that is greater than 7.5% of Medi-Cal Contract Revenues/subcontractor agreement for the year)
- The approved net income from Partnership will invest into initiatives in counties that do not meet minimum quality measure performance thresholds for the applicable year
- Partnership receives an Enforcement Tier 2 or Tier 3 assignment for the applicable calendar year for any county, it will reinvest at minimum an additional 7.5% of their annual net income into Community Reinvestment initiatives
  - ** For any county in which the Partnership is assigned to Enforcement Tier 2 or Tier 3, it will allocate 100% of our Quality Achievement Community Reinvestment funds toward investments in the "Cultivating Improved Health" category per the discretion of the corresponding public health and behavioral health officers
- Partnership will notify our Qualifying Subcontractors of their minimum Community Reinvestment funding obligations, and any corrections to such obligations, within 7 calendar days of notice from DHCS?
- Partnership and its Qualifying Subcontractors as applicable, will initiate investments in Community Reinvestment activities by no later than the close of the CY in which DHCS approves the initial Community Reinvestment Plan for the applicable investment period, and that Community Reinvestment funding obligations for each three-year investment period will be spent on specific activities included in the initial Community Reinvestment Plan by the end of the three-year period

Community Reinvestment Spending Categories (Inclusion/Exclusion Criteria)
Partnership's investments will be targeted toward reducing existing health disparities and/or promoting health outcomes for Medi-Cal populations through investments primarily focused on upstream causes of poor health such as housing instability, food insecurity, poverty, barriers to access to health and social services, and environments that negatively impact health.

Reinvestment spending may fall into at least one of the following categories but will be specific to each county's needs

- Cultivating Neighborhoods and Built Environment.
- Cultivating a Health Care Workforce.
- Cultivating Well-Being for Priority Populations.
- Cultivating Local Communities
- Cultivating Improved Health

Reinvestment spending may NOT fall into any of the following categories, regardless of the needs of the counties:

- Partnership Contract or Services carved out of the contract but covered under Medi-Cal (e.g. Pharmacy Benefit)
- Health care services inclusive of activities that improve health care quality or within the scope of Medi-Cal benefits or state-funded services
- Administrative activities of Partnership Health Plan (e.g. Employment, Meeting Scheduling, etc.)
- Administrative activities related to community reinvestment planning, implementation
- Member incentives or Grants
- Contract Activities

Local Health Jurisdiction (LHJ) and Behavioral Health Transformation Engagement
Partnership will engage with the community to ensure alignment with community reinvestment principles. Specifically, Partnership will engage at least quarterly meetings with corresponding public health and behavioral health officers in collaboration with the Population Health team to ensure alignment with community health assessment activities. Also, this will be implemented to ensure that local health jurisdiction and county behavioral health are included in community reinvestment planning and decision-making processes. Each reinvestment plan will solicit attestation from public health and county health directors to confirm that the investment strategy is generally agreeable to the LHJ and County Behavioral Health Department and aligns with community needs identified in the CHA / CHIP.

Community Engagement
Partnership will engage with the community to ensure alignment with community reinvestment principles. Specifically, Partnership will annually consult with our Community Advisory Committees (CACs), Quality/Utilization Advisory Committee (Q/UAC), and Quality Improvement and Health Equity Committee (QIHEC) to solicit Community Reinvestment recommendations. Also, Partnership may intermittently solicit feedback and insight from Members, community residents, community-based organizations, tribal organizations, providers, and other external stakeholders to ensure that Community Reinvestment decisions are rooted in the needs of the community.

Health Plan Engagement
Partnership will engage and coordinate with Kaiser Permanente to align investment planning processes and maximize the collective impact of our corresponding funds.

Initial Community Reinvestment Plan
Every three-year investment period, Partnership will detail the composite set of proposed community reinvestment activities including (but not limited to):

- A detailed description of the anticipated Community Reinvestment activities and their related use category or categories.
- A description of how activities are directly informed by community need identified through the LHJ CHA process.
- If applicable, identification of the LHJ CHIP activity that each Community Reinvestment activity matches.
- If applicable, a description of community needs identified through the Behavioral Health Transformation community planning process that the Community Reinvestment activity addresses.

- Anticipated benefits of Community Reinvestment activities (in alignment with criteria described in the "Guiding Principles" and "Community Reinvestment Categories" sections above).
- A description of the approach taken to engage the CAC in the Community Reinvestment planning process, including a summary of the CAC recommendations.
- A description of the approach taken to engage other interested stakeholders in the Community Reinvestment planning process, if any, and identification of those stakeholders.
- A description of any investments recommended by CACs not included in the Community Reinvestment Plan.
- A summary of input provided by Chief Health Equity Officers, and the QIHEC if applicable.
- The expected dollar amount allocated for each Community Reinvestment activity, based on the overall funding obligation for the applicable CY.
- The expected populations that will benefit from or participate in each Community Reinvestment activity.
- A description of how the impact of Community Reinvestment activities will be measured and evaluated.
- A signed attestation from local Public Health and County Behavioral Health Directors.

Subsequent Community Reinvestment Plan Submissions
Each subsequent community reinvestment plan within the investment period will indicate the allocation of additional investments for each activity documented in the initial community reinvestment plan for funding obligations resulting from positive net income for the applicable year. Every future three-year investment period, Partnership will detail the composite set of proposed community reinvestment activities including (but not limited to):

- The expected dollar amount allocated for each Community Reinvestment activity in the initial Community Reinvestment Plan approved by DHCS based on funding obligations for the applicable CY.
- A signed attestation from local Public Health and County Behavioral Health Directors.

Communication
The DHCS-approved Community Reinvestment Plan will be posted on the websites and use DHCS-recommended use templates. Also, Partnership will post a Community Reinvestment Report on our website, using templates included in APL 24-016 in Q2 CY 2030 and every three years thereafter.

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 Health Equity 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 annual update 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, Community – Access – Respect – Engagement – Service (CARES) Training provided by Partnership, which includes core trainings that cover diversity, equity and inclusion (DEI) and transgender, gender diverse, intersex (TGI) competency.
  - Review submitted data of annual CARES training (sensitivity, diversity, communication skills, and cultural competency training) for staff via internal human resources department
  - Review submitted data of transgender, gender diverse, intersex (TGI) cultural competency training program completion for staff via internal human resources department
  - Review submitted data of CARES training (sensitivity, diversity, communication skills, and cultural competency training) for network providers from the provider relations department per APL 24-016. 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.
- Community Reinvestment Plan
  - Community Reinvestment Plan for each investment period
    - DHCS calculated minimum community reinvestment funding obligations required
    - Composite set of proposed community reinvestment activities by county served and expected dollar amount allocated for each community reinvestment activity
    - Description of approach taken to engage with CAC and QIHEC
    - Measurement, analysis and evaluation of community reinvestment programs initiatives (e.g. qualitative description of benefits to Members)
  - Community Reinvestment Analysis
    - The actual dollar amount spent on each Community Reinvestment activity by county.
    - Description of each Community Reinvestment activity by category and county.

        - Description of how each Community Reinvestment activity aligns with DHCS' Guiding Principles.
        - Description of how each Community Reinvestment activity aligns with designated Reinvestment categories
        - Outcomes from Community Reinvestment activities, including any preliminary data and qualitative description of benefits to Members and the communities in which they reside
        - Signed letters from the CAC with descriptions of the degree to which Partnership engaged with CAC members in planning efforts and clarification on how their feedback was integrated with reinvestment activities.
- 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 assessed and 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 access to staff for members and practitioners seeking information about the UM process and the authorization of care in the following ways:

- Calls from members are triaged through Member Services staff who are accessible to practitioners and members to discuss UM issues during normal working hours when the health plan is in operation (Monday - Friday 8 a.m. - 5 p.m.).
- After normal business hours, Members and Providers may contact the Partnership voice mail service to leave a message which is communicated to the appropriate person on the next business day. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
- After normal business hours, members may contact the advice nurse line at (866) 778-8873 for assistance with clinical concerns.
- Practitioners, both in-network and out-of-network, may contact UM staff directly either through secure email or voicemail. Each voice mailbox is confidential and will accept messages after normal business hours. Calls received after normal business hours are returned on the next business day and calls received after midnight on Monday - Friday are returned on the same business day.
    - Partnership has a dedicated after-hours phone number local (707) 430-4808 or toll free (855) 798-8759 to receive calls from physicians and hospital staff for addressing post-stabilization care and inter-facility transfer needs 24 hours per day, 7 days per week. Calls are returned within 30 minutes of the time the call was received. Partnership's Chief Medical Director or physician designee is on call 24 hours per day 7 days per week to authorize medically necessary post-stabilization care services and to respond to hospital inquiries within 30 minutes. Partnership clinical staff are available 24 hours per day 7 days per week to coordinate the transfer of a member whose emergency medical condition is stabilized.
- Partnership UM staff identify themselves by name, title and organization name when initiating or returning calls regarding UM issues.
- Partnership maintains a toll free number (800) 863-4155 that is available to both members and practitioners.
- Members can view information about Partnership's language assistance services and disability services in the Member Handbook which is made available to members upon enrollment and is always viewable online at http://www.partnershiphp.org/Members/Medi-Cal/Documents/MCMemberHandbook.pdf

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

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

No Cost Linguistic Services

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

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

REFERENCES

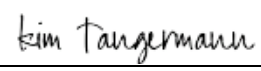
1. Department of Health Care Services (DHCS) standards

	**08/20/25**

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

	**09/10/25**

Angela Brennan, DO *Date Approved*
Physician Advisory Committee Chairperson

	**10/22/25**

Kim Tangermann *Date Approved*
Board of Commissioners Chairperson