

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
PHYSICIAN ADVISORY COMMITTEE ~ MEETING NOTICE**



Members: (21)

Angela Brennan, D.O. (Chair)	Christina Lasich, M.D.	Karina Gookin, M.D.	Teresa Shinder, D.O.
Betzabel Kunkel, M.D.	Danielle Oryn, D.O.	Leigh Vall-Spinosa, M.D.	Steve Gwiazdowski, M.D.
Brian Montenegro, M.D.	Darrick Nelson, M.D.	Malia Honda, M.D.	Zoe Cappe, M.D.
Candy Stockton, M.D.	Derice Seid, M.D.	Matthew Zavod, M.D.	
Chester Austin, M.D.	John McDermott, FNP-PAC	Michele Herman, M.D.	
Chris Myers, D.O.	Karen Sprague, MSN, CFNP	Mills Matheson, M.D.	

Partnership Executive Staff:

Sonja Bjork, Chief Executive Officer	Robert Moore, MD, MPH, Chief Medical Officer
Jennifer Lopez, Chief Financial Officer	Katherine Barresi, RN, Chief Health Services Officer
Wendi Davis, Chief Operating Officer	Mark Bontrager, Sr. Director of Behavioral Health
Amy Turnipseed, Chief Strategy & Government Affairs Officer	Tina Buop, Chief Information Officer

Regional Medical Directors

Jeffrey Ribordy, MD
Bradley Cox, DO
Colleen Townsend
Lisa Ward, MD
R. Doug Matthews, MD
Matthew Morris, MD

Region

Eureka - Del Norte, Humboldt, Mendocino & Lake
Redding - Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama
Fairfield - Napa, Yolo & Solano
Santa Rosa - Marin & Sonoma
Chico - Glenn, Butte, Sutter, Colusa & Yuba
Auburn - Plumas, Sierra, Nevada & Placer

Region Directors

Vicky Klakken
Vacant
Kathryn Power
Leigha Andrews
Rebecca Stark
Jill Blake

Kermit Jones, MD, Deputy Chief Medical Officer
Jeffrey DeVido, MD, Behavioral Health Clinical Director

Mark Netherda, MD, Medical Director for Quality Improvement
Vacant, MD, Medical Director for Medicare Services

Directors / Managers / Associate Directors

Isaac Brown, Snr. Director, Quality & Performance Improvement
Aaron Brinkco, Senior Director, Provider Relations
Brigid Gast, RN, Senior Director, Care Management
Stan Leung, Pharm.D., Director., Pharmacy Services
Mohamed Jalloh, Pharm.D., Director of Health Equity
Lisa O'Connell, Director, Enhanced Health Services
DeLorean Ruffin, DrPH, Director, Population Health Management
Vacant, RN, Director of Utilization Management
Vacant, Director, Health Analytics
Kristine Gual, Director, Quality Measurement
Priscila Ayala, Director, Network Services
Irem Conery, Director, Member Experience

Dorian Roberts, Senior Manager, Provider Relations Reps.
Vacant, Manager, Quality Incentive Programs
Sue Quichocho, Manager, Quality Measurement
Kevin Jarrett-Lee, RN, Assoc. Dir. of Utilization Management
Marshall Kubota, Associate Medical Director
Bettina Spiller, MD, Associate Medical Director
Teresa Frankovich, MD, Associate Medical Director
Michael George, MD, Associate Medical Director

cc: Partnership Commission Chair

Dean Germano, Partnership Board Chair

FROM: PAC@partnershipHP.org

DATE: August 7, 2026

SUBJECT: PHYSICIAN ADVISORY COMMITTEE MEETING

The Physician Advisory Committee will meet as follows and will continue to meet the second Wednesday of every month (July and December are tentative.) Please review the Meeting Agenda and packet, as discussion time is limited.

DATE: Wednesday, August 12, 2026

TIME: 7:30 a.m. – 9:00 a.m.

HOSTING LOCATIONS

Partnership HealthPlan of California
4605 Business Center Drive
Fairfield, CA

Partnership – Santa Rosa
495 Tesconi Circle
Santa Rosa, CA

Partnership – Redding
2525 Airpark Drive
Redding, CA

Partnership – Eureka
1036 5th Street
Eureka, CA

Partnership - Auburn
281 Nevada St.
Auburn, CA 95603

Partnership - Chico
1000 Fortress St.
Chico, CA 95973

Aliados Health
1310 Redwood Way
Petaluma, CA 94999

Tahoe Forest Health Systems
10976 Donner Pass Rd., Suite 9
Truckee, CA 96161

Office of Dr. Mills Matheson
1245 S. Main St.
Willits, CA 95490

Marin Community Clinic
3260 Kerner Blvd.
San Rafael, CA 949013

REGULAR MEETING OF PARTNERSHIP HEALTHPLAN OF CALIFORNIA'S PHYSICIAN ADVISORY COMMITTEE (PAC) - AGENDA

Date: August 12, 2026 **Time:** 7:30 – 9:00 a.m. **Location:** Partnership

Partnership HealthPlan of California 4605 Business Center Drive Fairfield, CA	Partnership – Santa Rosa Office 495 Tesconi Circle Santa Rosa, CA	Partnership – Redding Office 2525 Airpark Drive Redding, CA	Partnership – Eureka Office 1036 5 th Street Eureka, CA
Partnership - Auburn Office 281 Nevada St. Auburn, CA 95603	Partnership - Chico 1000 Fortress St. Chico, CA 95973		
Tahoe Forest Health Systems 10976 Donner Pass Rd., Suite 9 Truckee, CA 96161	Office of Dr. Mills Matheson 1245 S. Main St. Willits, CA 95490	Marin Community Clinic 3260 Kerner Blvd. San Rafael, CA 949013	Aliados Health 1310 Redwood Way Petaluma, CA 94999

PUBLIC COMMENTS			Speaker	2 minutes	
			Speaker	2 minutes	
This Brown Act meeting may be recorded. Any audio or video tape record 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					
I.		EXECUTIVE OFFICE UPDATES	LEAD		TIME
A.	I	Chief Executive Officer Administration Updates	Ms. Gordon		7:35
B.	I	Chief Medical Officer Health Services Report	Dr. Moore		7:45
II.	A	MOTIONS FOR APPROVAL	LEAD	PG	TIME
A.	A	Review of June 10, 2026, PAC Minutes	Dr. Brennan	5	7:55
B.	A	Consent Review: Agenda Items II. B.1, B.2, B.3, and B.5. <i>*Consent review allows multiple agenda items to be approved with one motion.</i>	Dr. Brennan	21 - 555	7:58
1	C	Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – June 2026 <u>Acceptance of Meeting Materials</u> - Internal Quality Improvement Meetings, June 9, 2026 - Agenda - Minutes - Quality / Utilization Advisory Committee, June 17, 2026 - Agenda - Minutes - Quality Improvement Update July 2026 <u>Acceptance of Meeting Materials</u> - Internal Quality Improvement Meetings, July 7, 2026 - Agenda - Minutes - Quality / Utilization Advisory Committee, July 15, 2026 - Agenda - Minutes - Quality Improvement Update	Dr. Brennan	21 23 31 33 45 58 60 69 71 81	7:58

II.B	C	Consent Review: Agenda Items II. B.1, B.2, Continued	LEAD	PG	TIME																																																														
1	C	<u>Q/UAC Special Presentations (not included in the packet, for reference only)</u> - Grievance & Appeals PULSE Report - Grievance & Appeals Department Annual Report - Annual Review of Utilization Management and InterQual® Criteria - Population Health Management 2025 Program Impact Analysis - Population Segmentation Presentation materials can be viewed in the June & July Q/UAC packets.	Dr. Brennan	N/A	7.58																																																														
2	C	Policy Summary p. 95 Synopsis of Changes p. 97 - 104 <table><tr><th colspan="2"><u>Policies/Procedures/Guidelines for Action</u></th></tr><tr><th colspan="2">Population Health Management</th></tr><tr><td>MPNP9002-D</td><td>Cultural & Linguistic Program Description <i>Attachment Only</i></td></tr><tr><td>MPND9007</td><td>Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)</td></tr><tr><td>MPNP9008</td><td>Women, Infants and Children (WIC) Supplemental Food Program</td></tr><tr><th colspan="2">Pharmacy Operations</th></tr><tr><td>MCRP4064</td><td>Continuation of Prescription Drugs</td></tr><tr><td>MPRP4062</td><td>Drug Wastage Payments</td></tr><tr><td>MPRP4065</td><td>Drug Utilization Review (DUR)</td></tr><tr><th colspan="2">Provider Relations</th></tr><tr><td>MPPR207</td><td>Annual Physician Satisfaction Survey</td></tr><tr><th colspan="2">Quality Improvement</th></tr><tr><td>MPXG5008</td><td>Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing</td></tr><tr><td>MPXG5009</td><td>Lactation Clinical Practice Guideline</td></tr><tr><td>MCQP1025</td><td>Substance Use Disorder (SUD) Facility Site Review and Medical Record Review</td></tr><tr><td>MCQP1052</td><td>Physical Accessibility Review Survey – SR Part C</td></tr><tr><th colspan="2">Utilization Management</th></tr><tr><td>MCUP3041</td><td>Treatment Authorization Request (TAR) Review Process</td></tr><tr><td>MCUP3140</td><td>Palliative Care: Pediatric Program for Members Under the Age of 21</td></tr><tr><td>MPUG3025</td><td>Insulin Infusion Pump and Continuous Glucose Monitor Guidelines</td></tr><tr><td>MPUP3039</td><td>Direct Members</td></tr><tr><td>MPUP3111</td><td>Pulmonary Rehabilitation</td></tr><tr><td>MPUP3139</td><td>Criteria and Guidelines for Utilization Management</td></tr><tr><td>MCUG3007</td><td>Authorization of Ambulatory Procedures and Services</td></tr><tr><td>MCUG3134</td><td>Hospital Bed/ Specialty Mattress Guidelines</td></tr><tr><td>MCUP3015</td><td>Family Planning Bypass Services</td></tr><tr><td>MCUP3114</td><td>Physical, Occupational and Speech Therapies</td></tr><tr><td>MCUP3141</td><td>Delegation of Inpatient Utilization Management</td></tr><tr><td>MPUG3010</td><td>Chiropractic Services</td></tr><tr><td>MPUP3042</td><td>Technology Assessment</td></tr><tr><td>MPUP3138</td><td>External Independent Medical Review</td></tr></table>	<u>Policies/Procedures/Guidelines for Action</u>		Population Health Management		MPNP9002-D	Cultural & Linguistic Program Description <i>Attachment Only</i>	MPND9007	Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)	MPNP9008	Women, Infants and Children (WIC) Supplemental Food Program	Pharmacy Operations		MCRP4064	Continuation of Prescription Drugs	MPRP4062	Drug Wastage Payments	MPRP4065	Drug Utilization Review (DUR)	Provider Relations		MPPR207	Annual Physician Satisfaction Survey	Quality Improvement		MPXG5008	Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing	MPXG5009	Lactation Clinical Practice Guideline	MCQP1025	Substance Use Disorder (SUD) Facility Site Review and Medical Record Review	MCQP1052	Physical Accessibility Review Survey – SR Part C	Utilization Management		MCUP3041	Treatment Authorization Request (TAR) Review Process	MCUP3140	Palliative Care: Pediatric Program for Members Under the Age of 21	MPUG3025	Insulin Infusion Pump and Continuous Glucose Monitor Guidelines	MPUP3039	Direct Members	MPUP3111	Pulmonary Rehabilitation	MPUP3139	Criteria and Guidelines for Utilization Management	MCUG3007	Authorization of Ambulatory Procedures and Services	MCUG3134	Hospital Bed/ Specialty Mattress Guidelines	MCUP3015	Family Planning Bypass Services	MCUP3114	Physical, Occupational and Speech Therapies	MCUP3141	Delegation of Inpatient Utilization Management	MPUG3010	Chiropractic Services	MPUP3042	Technology Assessment	MPUP3138	External Independent Medical Review	Dr. Brennan	105 117 126 130 136 153 157 159 193 199 258 359 348 391 408 421 427 432 436 441 446 452 458 461 467	7:58
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II.	A	MOTIONS FOR APPROVAL Consent Review: Agenda Items II. B. 3, B.5, and II.C	LEAD	PG	TIME
3	C	Pharmacy & Therapeutics Committee • Minutes, July 9, 2026 • Approved Criteria	Dr. Stan Leung	471 483	7:58
4	C	<i>Provider Education & Networking (PEN) Meeting</i>	Mr. Brincko		
5	C	Credentials Committee Meeting • Summary, May 13, 2026 • Credentialed List, May 13, 2026 • Summary, June 10, 2026 • Credentialed List, June 10, 2026	Dr. Netherda	528 533 536 544	7:58
6	C	<i>Pediatric Quality Committee</i>	Dr. Ribordy		
7	C	<i>Quality Improvement Health Equity Committee</i>	Dr. Jalloh		
III.	I	EXECUTIVE MEMBER UPDATE	LEAD	PG	TIME
A.	I	Deputy Chief Medical Officer, Dr. Kermit Jones	Dr. Jones		8:00
IV.	I	REGIONAL MEDICAL DIRECTOR REPORTS	LEAD		TIME
A.	I	Napa, Yolo & Solano	Dr. Townsend		8:05
B.	I	Marin & Sonoma	Dr. Ward		8:08
C.	I	Del Norte, Humboldt, Mendocino & Lake	Dr. Ribordy		8:11
D.	I	Glenn, Butte, Sutter, Colusa & Yuba,	Dr. Matthews		8:14
E.	I	Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	Dr. Matthews		8:17
F.	I	Plumas, Sierra, Nevada & Placer	Dr. Morris		8:20
V.	I	<i>Old Business</i>	LEAD	PG	TIME
VI.	I	SPECIAL PRESENTATIONS	LEAD	PG	TIME
A.	A	Primary Care Physician Quality Incentive Program Proposed Measurement Set, Measurement Year 2027	Ms. Beltran-Nampraseut	556	8:25
B.	A	Healthcare Effectiveness Data Information Set (HEDIS ®) Annual Summary of Performance • MY2025 Managed Care Accountability Set (MCAS)	Ms. Gual	564 581	8:40
VII.	I	ADJOURNMENT	LEAD		9:00
		Next PAC on September 8, 2026 at 7:30 a.m.	Dr. Brennan		

Except as provided by law, no action shall be taken on any topic not appearing on the agenda.

Government Code §54957.5 requires that public records related to items on the open session agenda for a regular committee meeting be made available for public inspection. Records distributed less than 72 hours prior to the meeting are available for public inspection at the same time they are distributed to all members, or a majority of the members of the committee. The committee has designated the Executive Assistant to the Chief Medical Officer as the contact for Partnership HealthPlan of California located at 4665 Business Center Drive, Fairfield, CA 94534, for the purpose of making those public records available for inspection. The Physician Advisory Committee Agenda and supporting documentation can also be found online at the [Physician Advisory Committee](https://www.partnershiphp.org/Providers/HealthServices/Pages/Physician-Advisory-Committee.aspx) webpage, linked here.
<https://www.partnershiphp.org/Providers/HealthServices/Pages/Physician-Advisory-Committee.aspx>

In compliance with the Americans with Disabilities Act (ADA), Partnership meeting rooms are accessible to people with disabilities. Individuals who need special assistance or a disability-related modification or accommodation (including auxiliary aids or services) to participate in this meeting, or who have a disability and wish to request an alternative format for any materials distributed at the meeting, should contact Partnership at least two (2) working days before the meeting at (800) 863-4155 or by email at pac@partnershiphp.org. Notification in advance of the meeting will enable Partnership to make reasonable arrangements to ensure accessibility to this meeting and to materials related to it.

Land Acknowledgment: Partnership HealthPlan honors the ancestral stewards of the land on which we meet today and acknowledges the displacement and lost lives due to colonization and ongoing disparities among California Native Americans.

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PARTNERSHIP)
MEETING MINUTES**

Committee: Physician Advisory Committee
Date / Time: June 10, 2026 - 7:30 to 9:00 a.m.

Voting members are required to attend in-person at one of Partnership HealthPlan's posted locations.

Members Present:	Angela Brennan, DO (FF) Betzabel Kunkel, MD (FF) Brian Montenegro, MD (FF) Matthew Zavod, MD (FF) Steven Gwiazdowski, MD (FF)	Teresa Shinder, MD (FF) Malia Honda, MD (E) Chester Austin, MD (C) John McDermott, FNP (C) Darrick Nelson, MD (R)	Karina Gookin, MD (AU) Christina Lasich, MD (SL) Mills Matheson, MD (OMM)	FF Fairfield SR Santa Rosa E Eureka R Redding C Chico AU Auburn	MCC Marin Community Clinics OMM Office of Dr. Matheson SL Sutter Health Lakeside

Members Excused:	Vanessa Walker, DO Karen Sprague, MSN, CFNP	Derice Seid, MD (MCC)

Members Absent:	Chris Myers, MD Danielle Oryn, DO	Candy Stockton, MD Michelle Herman, MD	Zoe Cappe, MD (FF)

Partnership Staff:	Sonja Bjork, Chief Executive Officer Jennifer Lopez, Chief Financial Officer Wendi Davis, Chief Operating Officer Leigha Andrews, Region Director Vicky Klakken, Region Director Brigid Gast, RN, Sr. Dir., Care Management Aaron Brincko, Sr. Dir., Provider Relations Lisa O'Connell, Dir. Enhanced Health Services Doreen Crume, RN, Mgr. Care Coord. Stephanie Nakatani, Supervisor Provider Relations Representatives	Katherine Barresi, RN, Chief Health Services Officer Robert Moore, MD, Chief Medical Officer Kermit Jones, MD, Deputy Chief Medical Officer Colleen Townsend, MD, Region Medical Director Jeffrey Ribordy, MD, Region Medical Director Bradley Cox, MD, Region Medical Director R. Doug Matthews, MD, Region Medical Director Matthew Morris, MD, Region Medical Director Lisa Ward, MD, Region Medical Director Mark Netherda, MD, Medical Director for Quality Jeffrey DeVido, MD, Behavioral Health Clinical Dir. Stan Leung, Pharm.D., Director, Pharmacy Services Marshall Kubota, MD, Associate Medical Director	DeLorean Ruffin, DrPH, Director, Population Health Mohamed Jalloh, Pharm.D., Director, Health Equity Isaac Brown, Sr. Dir., Quality & Performance Improvement Vacant, Director, Quality Management Kristine Gual, Director, Quality Measurement Vacant, Manager of QI Programs Sue Quichocho, Mgr., Quality Measurement Megan Shelton, Project Manager, Quality Improvement Vacant, RN, Director, Utilization Mgmt. (UM) Kevin Jarret-Lee, RN, Assoc. Dir. of UM Robby Potter, RN, Supervisor of Inpatient UM David Lavine, Assoc. Dir. of Workforce Development

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
Public Comments	PAC Chairperson asked for any public comments. None presented.	N/A	N/A
Quorum	13/21 – PAC	Committee quorum requirements met (13).	06/10/26

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.A. Chief Executive Officer (CEO) Report	Partnership’s Chief Executive Officer presented an administrative update. • State Budget / Medi-Cal Policy Outlook • Budget was due to the Governor by June 15 following intensive hearings in Sacramento among the Assembly, Senate, Administration, and stakeholders. • The May Revise proposed moving approximately 90,000 Partnership members with uncertain immigration status (UIS) out of Medi-Cal managed care and into state fee-for-service effective January 1, 2027. • California remains committed to providing Medi-Cal benefits to the UIS population beyond emergency and pregnancy-related care, but challenges may occur for affected members who are already assigned to doctors, may already be receiving specialty or ancillary care, and may experience major disruption if moved to a different network and lower state fee-for-service reimbursement structure. • Health plans proposed an alternative under which members would remain enrolled in their health plan while plans would use state-only dollars and separate funding from federal participation. support from California Medical Association (CMA), California Primary Care Association (CPCA), First 5, and many other groups. • The Assembly included the proposal in its version of the budget, but the Senate was less supportive because it was focused on achieving budget savings. • Constituents can still contact their Senator’s office or the Governor’s office to express support for keeping affected members in their health plans. • Operations • Operational concerns for Federally Qualified Health Centers (FQHC), tribal health centers, hospitals, and other providers, have been created by uncertainty of federal rules regarding immigration-status checks and pending litigation with an injunction. • Hospitals may bear a significant burden if members avoid primary care out of fear and later seek urgent or emergent care. • Hospitals are considering additional navigators, health care navigators, and community health workers to help members preserve eligibility and access appropriate care. • Member experience and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores have been topics of focus in efforts to improve members’ experience with the delivery system and mitigate the financial implications of low member-experience scores under state quality expectations. • County Eligibility and Work Requirement Implementation • Medicaid community engagement requirements, commonly referred to as work requirements, apply to Medi-Cal members ages 19–64 and require states to verify affected members meet 80 hours per week of work, volunteer activity, or school participation. • Native American members who identify that ethnicity on their Medi-Cal applications may be exempt from work requirements. The exemption does not discourage work, volunteering, or schooling, but may prevent additional bureaucracy for eligible members. • States are preparing eligibility systems and county processes to verify compliance after waiting for CMS instructions. • The proposed final rule does not include clear categorical exemptions for medically frail members, such as members with end-stage renal disease receiving dialysis several days per week. • The burden may shift to members and clinicians to complete paperwork documenting that a member’s medical condition prevents compliance and specifying the applicable duration. • The paperwork burden is similar to workers’ compensation and disability documentation but will affect medically vulnerable Medi-Cal members who may not know what steps are required to maintain eligibility. • Partnership and stakeholders who work with Medi-Cal members will need to help members understand and complete required documentation. • These new requirements will be added to the Keep Your Medi-Cal campaign and related member-facing and stakeholder-facing messaging. • Beginning January 2027, self-attestation may be permitted while states build eligibility systems and county workflows. Requirements for self-attestation are not yet available.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
I.B. Chief Medical Officer (CMO) Health Services Report	Partnership’s Chief Medical Officer presented the following Health Services report. Partnership Clinic Leadership Academy - Partnership Clinic Leadership Academy kicked off the first week of June with a cohort of 35 providers. - The program is being delivered in collaboration with Healthforce UCSF and is designed to strengthen clinic leadership capacity across Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Tribal Health Centers, which serve 92% of Partnership members. - The program will include four in-person sessions along with asynchronous training during the year. Public Health – Concerning Use of Kratom - Dr. Wu, Napa County Public Health Officer, in collaboration with the Napa Opioid Safety Coalition and the Napa-Solano Medical Society, provided a presentation on Kratom use and raised it as a public health concern. - Emergency physicians and clinicians involved in obstetric physician training have reported seeing kratom overdoses, including cases requiring higher doses of Narcan than typical opioid overdoses. - Dr. Moore noted concern about increasing teenage use, abuse, addiction risk, and overdose risk. - Kratom is an opioid-like substance, sometimes called “gas station heroin,” that can be purchased in some convenience store or gas station settings despite California restrictions. - It is illegal to sell and illegal to ingest in California, but not illegal to possess, creating a difficult enforcement environment. - Local law enforcement generally will not enforce the state restriction unless CDPH is involved, and enforcement may require a sting operation to catch an illegal sale. - Some states and counties have enacted additional ordinances that go beyond state law, including ordinances banning possession. - San Diego County was identified as having the strongest model ordinance. - Public Health Officers may face limitations in advocating for specific legislation because they work for counties, so medical societies and other organizations may need to advocate for additional local city and county regulations. - Partnership’s legislative team is following the topic closely. Partnership Leadership - Partnership’s Regional Medical Director for Napa, Yolo, and Solano Counties has been selected to serve on California’s Rural Health Policy Council, which will advise the state on how to invest rural health transformation do. - Jayne Botke has been appointed Redding Region Director. - Irem Connery has been appointed Director of Member Experience.

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.A.	May 13, 2026, PAC minutes were presented for approval.	<u>MOTION:</u> Dr. Zavod moved to approve Agenda II.A as presented, seconded by, seconded by Dr. Gwiazdowski. <u>ACTION SUMMARY:</u> [13] yes, [0] no, [0] abstentions.	06/10/26 Motion carried.
II.B.	Consent Calendar Review	<u>MOTION:</u> Dr. Gwiazdowski. moved to approve Agenda II.B.1, II.B.2, II.B.5, II.B.6, and II.B.7 as presented, seconded by Dr. Montenegro. <u>ACTION SUMMARY:</u> [13] yes, [0] no, [0] abstentions.	06/10/26 Motion carried.
II.B.1	• Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – May 20, 2026		
II.B.2	• Policies, Procedures, and Guidelines for Action Policy Summary May 13, 2026		
II.B.5	• Credentials Committee Meeting, April 8, 2026 Minutes Credentialed List		
II.B.6	• Pediatric Quality Committee Summary, May 5, 2026		
II.B.7	• Quality Improvement Health Equity Committee Summary, May 19, 2026		
II.C.1	Resignation from PAC, Dr. Vanessa Walker	<u>MOTION:</u> Dr. Montenegro moved to approve Agenda item II.C.1 as presented, seconded by Dr. Gwiazdowski. <u>ACTION SUMMARY:</u> [13] yes, [0] no, [0] abstentions.	06/10/26 Motion carried
II.C.2	Nomination to PAC, Dr. Leigh Vall-Spinosa	<u>MOTION:</u> Dr. Shinder moved to approve Agenda item II.C.2 as presented, seconded by Dr. Kunkel. <u>ACTION SUMMARY:</u> [13] yes, [0] no, [0] abstentions.	06/10/26 Motion carried
VI.A	Proposed 2027 Perinatal Quality Improvement Program (QIP) Measure Set	<u>MOTION:</u> Dr. Shinder moved to approve Agenda item VI.B as presented, seconded by Dr. Kunkel. <u>ACTION SUMMARY:</u> [13] yes, [0] no, [0] abstentions.	06/10/26 Motion carried

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III. A Committee Member Introduction	Dr. Leigh Vall-Spinosa is a family physician and Medical Director at the Dutton Clinic, part of Santa Rosa Community Health, located across the street from Partnership's Santa Rosa office. Dr. Vall-Spinosa began her medical career in Santa Rosa in 1996 through the Santa Rosa Family Medicine Residency, where Partnership Medical Director, Dr. Kubota served as her residency director. After completing residency, she and her husband, also a family physician, moved to Pueblo, Colorado where she worked as faculty in Southern Colorado Family Medicine and practiced in a busy faculty private practice for approximately five years. After having two sons, she and her family moved closer to family in New Mexico, where she is from. She worked at First Choice Community Health, an FQHC in Albuquerque, New Mexico. While at First Choice, she began prescribing Suboxone and became increasingly interested in addiction medicine. She and her family returned to Santa Rosa approximately ten years ago where her husband began working at Kaiser while she joined Santa Rosa Community Health. Partnership's Regional Medical Director for Sonoma and Marin County, Dr. Ward, was her then Medical Director when she started at Santa Rosa Community Health. Dr. Vall-Spinosa continued addiction medicine as part of her practice and became board certified in addiction medicine two years ago. She now also serves in a small faculty role for a new addiction medicine fellowship connected with the Santa Rosa residency program. Dr. Vall-Spinosa stated that she loves working in community health and FQHCs and is passionate about working with underserved populations. She looks forward to serving on PAC and working with other voting members to help patients receive the best possible care.
IV.A Status Update, Regional Medical	Partnership's Regional Medical Director for Napa, Solano, and Yolo Counties presented a brief update on activities. • Yolo County is recruiting for a Public Health Officer after Dr. Aimee Sisson's departure. • CommuniCare+OLE and Solano Family Health Services are recruiting to fill Chief Medical Officer roles. • Upcoming retirements will affect gastrointestinal (GI) and neurology specialty access in Yolo County. • General surgery, orthopedics, and oncology access remain open. • NorthBay Health acquisition of Providence Queen of the Valley continues to move forward. Meetings are being held in Napa to hear from the community.
IV.B. Status Update, Regional Medical	Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities. • Regional quality meeting was held on June 2 with approximately 35 people in attendance. Colorectal cancer screening was the primary topic. Alliance Medical Center and Petaluma Health Center presented best practices during the meeting. • Three leaders from Santa Rosa, Alexander Valley, and Marin City Health and Wellness are participating in the Partnership Clinical Leadership Program. • Partnership Santa Rosa hosted a Patient Information Session held at the Santa Rosa office, where Vanessa Hernandez, the new Member Engagement Specialist at the site, presented to 35 Spanish-speaking attendees and 35 English-speaking attendees. • Partnership helped connect RotaCare with Marin County, Marin Community Clinics, and a sister free clinic in Sonoma County for support in response to the possibility of more uninsured patients. • Met with Supervisor Rebecca Hermosillo in Sonoma County regarding Indigenous care and county capacity for eligibility and access. Partnership is working to stay closely connected with Supervisor Hermosillo because of shared purpose around these issues. • Quarterly meetings have been held with area providers to discuss recruitment challenges and innovations being developed by clinics, eligibility workers, and departments to respond to new workforce development demands. • The Hearts of Sonoma group is working again on local tobacco cessation strategies across Sonoma County. The group is attempting to encourage more local jurisdictions to adopt tobacco-related ordinances that make tobacco access more difficult. • Sonoma County Indian Health Project (SCIP) discussed new affiliations with UC Davis and Stanford for medical student rotations in addition to an affiliation with Kaiser for family medicine residency rotations as a long-term recruitment strategy and positive opportunity for clinicians to serve as mentors and preceptors. • Dr. Scott Holmes was named the new Chief Medical Officer at Alliance Medical Center. • Meetings are ongoing in work elevating billing issues from health centers and community-based organizations

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IV.C. Status Update, Regional Medical	Partnership’s Regional Medical Director for Lake, Mendocino, Humboldt, and Del Norte Counties presented a brief update on activities. • Del Norte County Department of Health and Human Services (DHHS) announced a ribbon cutting ceremony to be held on June 16, 2026, for a new emergency shelter and micro village offering 60 beds and 50 tiny homes to shelter unhoused individuals. Kitchen, bathroom, and laundry facilities will also be available. • Mendocino Community Health Centers (MCHC) recently opened a same-day clinic for existing members. MCHC optometry clinic will open in September. An urgent care facility is being planned, projected to open in 2028. • Mendocino Coast Clinics purchased a local pharmacy in order to preserve access for their members. • Dr. Jodi Parungao is working with both Long Valley Health and Round Valley Indian Health to support women’s health care needs.
IV.D. Status Update, Regional Medical	Partnership’s Regional Medical Director for Glenn, Butte, Sutter, and Colusa Counties presented a brief update on activities. • Oroville Hospital recently declared bankruptcy and was presented at bidding auction for sale. Any sale must be approved by a judge no later than August 13, 2026. Partnership is closely monitoring the outcome. • Meeting to be held with Touro University to discuss options for Physician Assistant (PA) rotations and fellowships in the region. • Peach Tree Clinic is interested in expanding service for chiropractic care and potentially primary care in the Chico region. • Healthy Rural California Family Practice and Psychiatry residency welcomed a new class starting June 17, 2026.
IV.E Status Update, Regional Medical	Partnership’s Regional Medical Director for Glenn, Butte, Sutter, and Colusa Counties presented a brief update on activities on behalf of Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties. • Jayme Botke has been appointed Partnership’s North Regional Director. • Obstetric (OB) and gynecology access has been constrained in the Red Bluff area due to the unexpected passing of a local OB/GYN. • CEO of Mercy Medical Center announced plans to retire in the fall. A replacement has not yet been selected. • Nourish and Flourish event in Redding was attended by an estimated 500 people. The event offered opportunities for wellness providing tests for diabetes screening, blood pressure, fluoride applications and offering education on CPR, asthma, and healthcare workforce.
IV.F Status Update, Regional Medical	Partnership’s Regional Medical Director for Plumas, Sierra, Nevada, Yuba, and Placer Counties presented a brief update on activities. • Operations meeting was held with Seneca Healthcare in Plumas County to discuss updates for the construction of a new hospital planned to open in 2027. Construction is on track and going well. Seneca’s CEO, Shawn McKenzie, announced plan to retire in November 2026. Chief Operations Officer (COO) Brady Haynes will succeed Mr. McKenzie as CEO. • Partnership’s Pharmacy Team met with Eastern Plumas Healthcare to focus on prescribing for improved management of diabetes and high blood pressure. • Nevada Memorial Hospital will be bringing in a surgical assist team to include a neurosurgeon trained in robotics. Future plans involve the addition of elastography (hydro scans), which is similar to an ultrasound and uses sound waves to determine how much scarring is in the liver. • Dr. Jarett Beaudoin has been appointed interim Public Health Officer for Yuba County. Yuba County is also recruiting for a Behavioral Health Director. • Placer County Health and Human Services in Auburn hosted Partnership’s ABCs of Quality event which was well attended by region healthcare providers. • Conducted a Perinatal Support Services webinar focused on childhood vaccinations attended by more than 100 participants.
IV. Introductions	No additional introductions were presented.
V. Old Business	No old business was presented.

AGENDA ITEM	DISCUSSION / CONCLUSIONS ACTION REQUIRED						
VI.A Proposed 2027 Perinatal Quality Improvement Program (PQIP) Measurement Set	Partnership staff presented the 2027 Perinatal Quality Improvement Program (PQIP) Measurement Set I. Summary of Current and Proposed Measures and/or Measure Changes (A) Gateway Measure – Measure 1 DataLink allows for data exchange from Provider Electronic Health Records to PARTNERSHIP to capture depression screening and follow-up care. DataLink implementation is a vital component of furthering PQIP technical advancement through the capture of claims and electronic data directly exported from participating providers Electronic Health Records (EHR) systems. (B) Clinical Measures – Measures 2-6 PHPS practices and select perinatal providers who provide quality and timely prenatal and postpartum care to PARTNERSHIP members have the option to earn additional financial incentives. The PQIP framework offers a simple and meaningful measurement set developed for PCPs and OB/GYNs and includes the following clinical measures: Timely Immunization Status - Tdap and Influenza Vaccine, Timely Prenatal Care, Late Entry to Care with Depression Screening >14 weeks gestation, Timely Postpartum Care and Timely Assessments. Key: New Proposed Measures Change to Measure Design <table border="1" data-bbox="667 699 1677 1070"> <thead> <tr> <th data-bbox="667 699 1171 792">Current 2026 6-month Bridge Measures</th><th data-bbox="1171 699 1677 792">Proposed 2027 Measures</th></tr> </thead> <tbody> <tr> <td colspan="2" data-bbox="667 792 1171 836">ECDS & Clinical Domains</td></tr> <tr> <td data-bbox="667 836 1171 1070"> Perinatal Medicine: 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive (Monitoring Only) </td><td data-bbox="1171 836 1677 1070"> Perinatal Medicine: 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive Assessments </td></tr> </tbody> </table> Proposed Changes for the PQIP 2027 Measure Set Programmatic Changes: Due to a new federal regulation that went into effect at the end of 2025, the Perinatal Quality Incentive Program must transition to a calendar year program by January 2027. Therefore, the proposed changes below pertain to the proposed 2027 Measurement Year covering the period of January 1, 2027, through December 31, 2027. In general, all the reporting timelines for any measures included in this set have been adjusted to correlate to a calendar year period. Those revisions are not presented here. What follows are the proposed measure changes with their rationales.	Current 2026 6-month Bridge Measures	Proposed 2027 Measures	ECDS & Clinical Domains		Perinatal Medicine: 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive (Monitoring Only)	Perinatal Medicine: 1. Electronic Clinical Data Systems (ECDS) 2. Prenatal Immunization 3. Timely Prenatal Care 4. Depression Screening 5. Timely Postpartum Care 6. Timely Comprehensive Assessments
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AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.A Proposed 2027 Perinatal Quality Improvement Program (PQIP) Measurement Set, Continued	A. Gateway Measure 1: Electronic Clinical Data Systems (ECDS) – Datalink Implementation This measure supports the allowance of data exchange from provider Electronic Health Records to Partnership to capture clinical screenings, follow-up care and outcomes. ECDS participation is a vital component of furthering the quality of care for covered Partnership members. Note that NCQA is converting most hybrid measures to ECDS measures in the coming years. DHCS continues to make Partnership accountable for several ECDS measures. Partnership partnered with DataLink (a qualified HEDIS data aggregator) who can pull a much larger scope of measures than what is currently required for the Perinatal QIP. The DataLink process will continue to increase in emphasis and is now a gateway measure to the Perinatal QIP. Proposal: It is proposed that contracting and connection with DataLink remain a gateway measure for 2027. It is recommended that a June 30th deadline be set to give any new providers adequate time to complete the extraction process. Measure Requirements All providers with existing DataLink connectivity must maintain those connections and extractions throughout the measurement year to be eligible to receive their 2027 PQIP incentive payment. All participants new to the PQIP in 2027 must complete all Implementation Phases and Participation Requirement Steps by June 30, 2027, to be eligible to receive their 2027 PQIP incentive payment. B. Clinical Measures Measure 3. Timely Prenatal Care (<14 Weeks of Gestation) Measure Summary: Timely prenatal care services rendered to pregnant Partnership members in the first trimester, as defined as less than 14 weeks of gestation, or within 42 days of enrollment in the organization. Proposal: Since DataLink connections and extractions have occurred for PQIP providers during the previous year, it is proposed to add monthly DataLink extractions be the only option for submitting visit and depression screening data. The manual submission option would be removed, but Partnership would retain the right to request manual submissions as a means of data validation if needed. Below is the suggested language change for the reporting section of the measure. Reporting (Applies to Measures 3 & 4) Monthly DataLink Extractions Counts of qualifying prenatal visits will be gathered through the DataLink extraction process. Partnership reserves the right to periodically request manual submissions to validate extracted data. A timely prenatal visit is a comprehensive first prenatal visit with a clinical provider of obstetrics services (MD/DO/CNM/LM/NP/PA-c) that occurs in the first trimester of the pregnancy or within 42 days of Partnership enrollment. Note: New providers entering the PQIP in 2027 that are not yet connected to DataLink may provide manual submissions on the provided Excel template by the tenth of each month for January through June but must complete the implementation process by June 30, 2027, to be eligible to receive incentive payment. To request a template and instructions, email perinatalqip@partnershiphp.org.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.A Proposed 2027 Perinatal Quality Improvement Program (PQIP) Measurement Set, Continued	II. Measure 4: Depression Screening at First Prenatal Visit with Late Entry to Care (>14 weeks Gestation) Measure Summary: Prenatal care visits to an OB/GYN or other perinatal care practitioner or PCP after the first trimester (equal to or greater than 14 weeks of gestation, as documented in the medical record) will be eligible for the incentive payment. A diagnosis of pregnancy must be present. Proposal: It is also proposed that Measure 4 have the same changes as noted in Measure 3. III. Measure 6: Timely Comprehensive Assessments Measure summary Providers will perform Comprehensive Health Assessments that included psychosocial, nutrition and health education assessments at the initiation of care, in each trimester and in the post-partum period. Proposal: It is proposed that this measure move from a monitoring measure to an incentivized measure as noted below. Measure Target Specifications Providers will earn a \$100 incentive for members who gave birth during the measurement year and received the following assessments: 1. Initial Assessment with code Z6500 or code Z6200 + Z6300 + Z6402 billed on claim(s) And 2. Three subsequent follow-up visits: one in the second trimester, one in third trimester and one postpartum. No incentive is earned if all visits are not completed. <i>A motion was taken for approval. Measure set passed without modification. No further questions were asked.</i>
VI.B Potentially Preventable Admissions	Partnership CMO Presented Potentially Preventable Admissions Partnership completed enough initial investigation to share findings with PAC to identify potential interventions that provider organizations could take within their own settings. The concept has been referred to by several names, including ambulatory care sensitive hospital admissions (ACSAs). The underlying principle is that certain hospital admissions are considered potentially preventable when strong primary care, outpatient care, and early treatment can prevent a member from becoming sick enough to require hospitalization. Measure definitions come from the Agency for Healthcare Research and Quality (AHRQ), which is part of the U.S. Department of Health and Human Services. • The AHRQ Quality Indicators (QIs) are standardized, evidence-based measures that assess health care quality, patient safety, and access using routinely collected hospital administrative data. • Most QIs are risk-adjusted to ensure fair comparisons across hospitals and regions. • Prevention Quality Indicators (PQIs) flag avoidable hospital admissions that may signal problems with access to outpatient or primary care. • Pediatric Quality Indicators (PDIs) focus on safety events and complications in hospitalized pediatric patients.

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VI.B Potentially Preventable Admissions, Continued	The adult heart failure measure is responsible for the largest number of preventable admissions in Partnership’s data. The importance of the principal diagnosis must be emphasized because the hospital’s coding decision determines whether an admission is counted as potentially preventable. If a different diagnosis is coded first and that diagnosis is not on the AHRQ list, the admission may no longer count as potentially preventable, even if heart failure is clinically relevant. The principal diagnosis assignment is usually determined by coders reviewing the medical record, based on coding rules and documentation. For the heart failure measure, certain exclusions apply, including cardiac procedures performed during the admission, such as cardiac catheterization, transplant, or valve procedures. • Transfers from another hospital are excluded. • Admissions from skilled nursing facilities are also excluded. • Hospice admissions are not specifically excluded, although some sicker skilled-nursing-facility patients may also be on hospice. • The heart failure diagnosis-code list includes a wide range of heart failure diagnoses, including right-sided failure, left-sided failure, reduced ejection fraction, and unspecified heart failure. Example Data Definition: Heart Failure • Included: • 18 years of age or older • Principal admission diagnosis: heart failure • Excluded: • Cardiac Procedures during admission • Transfers from hospital or SNF Heart failure diagnosis codes: (MRTCHFD) <table><tr><td>I0981</td><td>Rheumatic heart failure</td><td>I5041</td><td>Acute combined systolic (congestive) and diastolic (congestive) heart failure</td></tr><tr><td>I110</td><td>Hypertensive heart disease with heart failure</td><td>I5042</td><td>Chronic combined systolic (congestive) and diastolic (congestive) heart failure</td></tr><tr><td>I130</td><td>Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease</td><td>I5043</td><td>Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure</td></tr><tr><td>I132</td><td>Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease</td><td>I50810</td><td>Right heart failure, unspecified</td></tr><tr><td>I501</td><td>Left ventricular failure, unspecified</td><td>I50811</td><td>Acute right heart failure</td></tr><tr><td>I5020</td><td>Unspecified systolic (congestive) heart failure</td><td>I50812</td><td>Chronic right heart failure</td></tr><tr><td>I5021</td><td>Acute systolic (congestive) heart failure</td><td>I50813</td><td>Acute on chronic right heart failure</td></tr><tr><td>I5022</td><td>Chronic systolic (congestive) heart failure</td><td>I50814</td><td>Right heart failure due to left heart failure</td></tr><tr><td>I5023</td><td>Acute on chronic systolic (congestive) heart failure</td><td>I5082</td><td>Biventricular heart failure</td></tr><tr><td>I5030</td><td>Unspecified diastolic (congestive) heart failure</td><td>I5083</td><td>High output heart failure</td></tr><tr><td>I5031</td><td>Acute diastolic (congestive) heart failure</td><td>I5084</td><td>End stage heart failure</td></tr><tr><td>I5032</td><td>Chronic diastolic (congestive) heart failure</td><td>I5089</td><td>Other heart failure</td></tr><tr><td>I5033</td><td>Acute on chronic diastolic (congestive) heart failure</td><td>I509</td><td>Heart failure, unspecified</td></tr><tr><td>I5040</td><td>Unspecified combined systolic (congestive) and diastolic (congestive) heart failure</td><td></td><td></td></tr></table>	I0981	Rheumatic heart failure	I5041	Acute combined systolic (congestive) and diastolic (congestive) heart failure	I110	Hypertensive heart disease with heart failure	I5042	Chronic combined systolic (congestive) and diastolic (congestive) heart failure	I130	Hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease	I5043	Acute on chronic combined systolic (congestive) and diastolic (congestive) heart failure	I132	Hypertensive heart and chronic kidney disease with heart failure and with stage 5 chronic kidney disease, or end stage renal disease	I50810	Right heart failure, unspecified	I501	Left ventricular failure, unspecified	I50811	Acute right heart failure	I5020	Unspecified systolic (congestive) heart failure	I50812	Chronic right heart failure	I5021	Acute systolic (congestive) heart failure	I50813	Acute on chronic right heart failure	I5022	Chronic systolic (congestive) heart failure	I50814	Right heart failure due to left heart failure	I5023	Acute on chronic systolic (congestive) heart failure	I5082	Biventricular heart failure	I5030	Unspecified diastolic (congestive) heart failure	I5083	High output heart failure	I5031	Acute diastolic (congestive) heart failure	I5084	End stage heart failure	I5032	Chronic diastolic (congestive) heart failure	I5089	Other heart failure	I5033	Acute on chronic diastolic (congestive) heart failure	I509	Heart failure, unspecified	I5040	Unspecified combined systolic (congestive) and diastolic (congestive) heart failure		
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AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.B Potentially Preventable Admissions	Background of ACSAs and Resulting Financial Consequences • Avoidable cost analysis – DHCS uses logic from AHRQ referencing PQIs and PDIs • Efficiency comparison – DHCS compares the plan’s rate of potentially preventable admissions (PPAs) against established regional or statewide efficiency benchmarks. If a county plan demonstrates higher-than-expected rates of admission for conditions that could have been managed in outpatient or primary care settings, it is flagged inefficient. • Capitation Reduction Calculation – The avoidable costs associated with these excess PPAs are calculated and trimmed from the plan’s inpatient base data. Because this directly impacts the PMPM capitation rate, removing these expenses lowers the final actuarially sound capitation rate paid to the plan. Partnership can see the quality measure definitions but does not receive the full methodology or detailed calculation showing how the dollar adjustment is derived. At the end of the process, Partnership receives a dollar amount that is not included in its capitation rate. The adjustment is functionally similar to a penalty, even though it is framed as an actuarial or efficiency adjustment. The quality rationale remains important: avoiding preventable hospitalizations is good for members, helps avoid unnecessary hospital stays, and supports better preventive and chronic care. What is the financial impact? • “Efficiency Factor” for ACSA is rebranded by DHCS as “Potentially Preventable Admissions”. • In 2024, the efficiency adjustment was approximately \$25 million. The other efficiency factors were below \$2 million each. • DHCS does not show its work, they just send the final amount of efficiency factor with our rates. Preventable admissions are a major utilization issue with both clinical and financial implications. • In 2024, the potentially preventable admissions efficiency adjustment was approximately \$25 million, larger than any other single quality measure impact discussed, with member experience being the next major area. • Other efficiency factors were each below approximately \$2 million. • Although Partnership does not receive the full methodology, it is estimated that the adjustment may reflect roughly one-quarter of the amount Partnership pays for those admissions. Care Continuum and Where Preventable Admissions Can Potentially be Influenced. • The first opportunity is preventing healthy members from developing chronic conditions, such as diabetes or heart failure, through effective primary care and prevention. • The second opportunity is preventing acute conditions through vaccination or treating them early before they become severe. • For members with chronic conditions, primary care can help stabilize conditions and prevent worsening exacerbations. • When members develop acute symptoms, strong primary care access and on-call systems may help them avoid unnecessary emergency department visits. • Examples such as urinary tract infections or gastroenteritis that might be managed earlier or differently if after-hours advice or rapid access were available. • Once a member reaches the emergency department, hospital practice patterns influence whether the patient is admitted or treated and discharged. • Partnership can identify hospitals with higher propensities to admit, although those hospitals will not be named publicly. • Once admitted, length of stay becomes another factor affecting cost and avoidable utilization. • Hospitalists’ attention to throughput and discharge planning can affect length of stay. • Some hospitalist groups move patients through care more efficiently, while others take longer, potentially due to culture or misaligned incentives. • After discharge, members may either enter a readmission cycle or return to stable chronic-condition management. • Readmission prevention is a shared responsibility among primary care providers, hospitals, and the health plan.

AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.B Potentially Preventable Admissions, Continued	Key Findings from Partnership’s 2025 data using AHRQ adult PQIs and pediatric PDIs Adult PQI admissions represented approximately 97% of all potentially preventable admissions in the 2025 data. 75% of admitted members were admitted more than once annually, many members were readmitted within seven days of discharge. For heart failure, 647 members were admitted once, 150 members were admitted twice, and 59 members were admitted three times during the year. The repeated admission distribution continued across higher admission counts. - Heart failure was the highest-volume category for total admissions, with approximately 1,500 admissions and approximately 908 unique patients. - The difference between total admissions and unique patients demonstrated that some members were being admitted repeatedly for the same condition during the year. - A total of more than 20,000 hospital days across the included admissions. - While heart failure had the highest total admissions, the admission rate for adult short-term diabetes complications was slightly higher than the heart failure admission rate. - Diabetes-related PQIs are a major contributor, including adult short-term diabetes complications, adult long-term diabetes complications, pediatric short-term diabetes complications, and uncontrolled diabetes. - For cardiac admissions, the key categories included heart failure and hypertension, with heart failure making up the major share. - Cardiac conditions accounted for approximately 38% of total hospital days in the adult category. - Diabetes-related conditions accounted for approximately 39% of total hospital days, making diabetes as important as cardiac conditions for intervention planning. One particularly concerning example was a member with adult long-term diabetes complications who was admitted 29 times in the calendar year. - Respiratory conditions included COPD, asthma in older adults, asthma in younger adults, and bacterial pneumonia. - Respiratory conditions accounted for approximately 16% of total hospital days. - Urinary tract infection accounted for approximately 4% of total hospital days. Pediatric PDI admissions represented approximately 3%, meaning adult admissions are the primary opportunity for impact. - PDI measures included short-term diabetes complications, asthma, gastroenteritis, and urinary tract infection. - Asthma was the largest pediatric PDI contributor, but pediatric preventable admissions remained small compared with adult admissions. - The top ten Primary Care Provider groups represented approximately the top 24% of admissions. - Total preventable admissions for 2025 were referenced at approximately 4,673. - One PCP group had approximately 1,605 admissions in the data view, and heart failure represented a significant share within high-volume groups. - Heart failure, adult short-term diabetes complications, and adult long-term diabetes complications were among the highest-volume categories across PCP groups. - Reviewing high-admission PCP groups and understanding case-by-case admission patterns may identify practical intervention opportunities. Preventable-admissions Data and PCP QIP Performance. - For controlling high blood pressure, hypertension and heart failure admissions may overlap with the PCPQIP measure population. - Although admissions represent a small portion of the overall denominator, a high percentage of admitted members appear to be in care gaps. - For hypertension admissions, approximately 88% of those admissions were associated with members in the care gap for controlling blood pressure measure. - For diabetes-related admissions, adult short-term complications, adult long-term complications, and uncontrolled diabetes were grouped, totaling approximately 829 patients. Among those members, approximately 91% were in the care gap for A1C control; 81% were in the care gap for retinal eye exams.

AGENDA ITEM	DISCUSSION / CONCLUSIONS																																																																																					
VI.B Potentially Preventable Admissions, Continued	Hospital Level Analysis One way to examine hospital influence is to look at preventable admissions by hospital, though raw numbers are affected by hospital size. Potentially preventable admissions may also be reviewed as a percentage of total hospital admissions but cautioned that those comparisons are affected by payer and patient mix, particularly whether a hospital provides obstetric and pediatric services. For example, if one regional medical center does not provide OB services, its denominator and comparisons are affected. Partnership plans to conduct additional analysis to break out those factors before drawing firm conclusions from hospital comparisons What can PCPs do now? • Ensure excellent follow-up on patients being discharged with CHF, DM, COPD/Asthma. • Strive for high rates of control of BP and DM: don't give up on anyone! • Ensure patients with COPD or asthma have an asthma control plan with rescue medications to handle exacerbations early. • Ensure good after-hours coverage for your patients' questions. • Strive for high rates of influenza, RSV, COVID vaccines in adults, especially those with other risk factors for admission. The following slides were presented at the meeting illustrating key findings. Factors impacting admission and length of stay <pre>graph LR HP([Healthy Patient]) -- "Some preventable with primary care" --> PC([Patient with Chronic Condition*]) HP -- "Some acute conditions preventable (vaccines) or severity less (early UTI) with primary care" --> PAC([Patient with acute condition]) PC -- "Some well controlled/stable with primary care" --> PAC PAC -- "Good co-ordination system could lead to outpatient treatment" --> PED([Patient in ED]) PAC -- "ER propensity to admit" --> PED PED --> PA([Patient Admitted]) PA -- "Hospitalist attention to care impacts LOS" --> PD([Patient discharged]) PD -- "Readmission Cycle" --> PC PD -- "Post-discharge case management and PCP care" --> PC</pre> *CHF, HTN, DM, COPD, Asthma Admissions Data <table><thead><tr><th>Admission Category</th><th>Total Admissions</th><th>Unique Patients</th><th>Sum of length of stay</th><th>Rate</th></tr></thead><tbody><tr><td>ASTHMA PED</td><td>145</td><td>135</td><td>263</td><td>1.07</td></tr><tr><td>ASTHMA IN YOUNG ADULTS</td><td>45</td><td>37</td><td>141</td><td>1.22</td></tr><tr><td>BACTERIAL PNEUMONIA</td><td>366</td><td>326</td><td>1441</td><td>1.12</td></tr><tr><td>COPD ASTHMA OLDER ADULT</td><td>416</td><td>298</td><td>1664</td><td>1.40</td></tr><tr><td>DIABETES LONG-T ADULT</td><td>505</td><td>351</td><td>3166</td><td>1.44</td></tr><tr><td>DIABETES SHORT-T ADULT</td><td>731</td><td>412</td><td>2033</td><td>1.77</td></tr><tr><td>DIABETES SHORT-T PED</td><td>51</td><td>42</td><td>119</td><td>1.21</td></tr><tr><td>GASTROENTERITIS PED</td><td>92</td><td>90</td><td>268</td><td>1.02</td></tr><tr><td>HEART FAILURE</td><td>1537</td><td>908</td><td>6947</td><td>1.69</td></tr><tr><td>HYPERTENSION</td><td>193</td><td>179</td><td>541</td><td>1.08</td></tr><tr><td>LOWER-EXTREMITY AMPUT AMONG PTS W/DIABETES</td><td>111</td><td>79</td><td>1226</td><td>1.41</td></tr><tr><td>LOWER-EXTREMITY AMPUT AMONG PTS W/DIABETES/ DIABETES LONG-T ADULT</td><td>111</td><td>71</td><td>935</td><td>1.56</td></tr><tr><td>UNCONTROLLED DIABETES</td><td>123</td><td>86</td><td>365</td><td>1.43</td></tr><tr><td>URINARY TRACT INFECTION PED</td><td>30</td><td>30</td><td>84</td><td>1.00</td></tr><tr><td>URINARY TRACT INFECTION ADULT</td><td>217</td><td>197</td><td>814</td><td>1.10</td></tr><tr><td>TOTALS</td><td>4673</td><td>3241</td><td>20013</td><td></td></tr></tbody></table>	Admission Category	Total Admissions	Unique Patients	Sum of length of stay	Rate	ASTHMA PED	145	135	263	1.07	ASTHMA IN YOUNG ADULTS	45	37	141	1.22	BACTERIAL PNEUMONIA	366	326	1441	1.12	COPD ASTHMA OLDER ADULT	416	298	1664	1.40	DIABETES LONG-T ADULT	505	351	3166	1.44	DIABETES SHORT-T ADULT	731	412	2033	1.77	DIABETES SHORT-T PED	51	42	119	1.21	GASTROENTERITIS PED	92	90	268	1.02	HEART FAILURE	1537	908	6947	1.69	HYPERTENSION	193	179	541	1.08	LOWER-EXTREMITY AMPUT AMONG PTS W/DIABETES	111	79	1226	1.41	LOWER-EXTREMITY AMPUT AMONG PTS W/DIABETES/ DIABETES LONG-T ADULT	111	71	935	1.56	UNCONTROLLED DIABETES	123	86	365	1.43	URINARY TRACT INFECTION PED	30	30	84	1.00	URINARY TRACT INFECTION ADULT	217	197	814	1.10	TOTALS	4673	3241	20013	
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AGENDA ITEM

VI.B

Potentially
Preventable
Admissions,
Continued

DISCUSSION / CONCLUSIONS

2025 ACSAs: Adult Diagnosis Groups

Category	Diagnosis Groups	Number Partnership Members	Percent of all hospital days	Total hospital days in category
Cardiac	Heart Failure	1537 (33%)	35%	38%
	Hypertension	193 (4%)	3%	
	Long term complications	505 (11%)	16%	
Diabetes	Short term complications	731 (16%)	10%	39%
	Lower Extremity Amputation	222 (5%)	11%	
	Adult Uncontrolled DM	123 (3%)	2%	
	COPD/Asthma (older adult)	416 (9%)	8%	
Respiratory	Asthma younger adults	45 (1%)	1%	16%
	Bacterial Pneumonia	366 (8%)	7%	
Urinary	UTI	217 (5%)	4%	4%
	Total Adult	4232 (93%)	97%	
Total Adult + Peds		4550 (100%)	100%	100%

2025 ACSAs: Child Diagnosis Groups

Category	Diagnosis Groups	Number Partnership Members	Percent of all hospital days
Diabetes	Short term complications	51 (1%)	1%
Respiratory	Asthma	145 (3%)	1%
GI	Gastroenteritis	92 (2%)	1%
Urinary	UTI	30 (1%)	0.4%
Total		318 (7%)	3%

Top 24% of admissions by PCP and PQI/PDI

	WA	ASTHMA IN YOUNGER ADULTS	BACTERIAL PNEUMONIA	COPD ASHTMA OLD ADLT	DIABETES LONG-T ADULT	DIABETES SHORT-T ADULT	DIABETES SHORT-T PED	GASTROENTERITIS PED	HEART FAILURE	HYPERTENSION	LOWER-EXTREMITY AMPUT AMONG PAT W DIABETES	LOWER-EXTREMITY AMPUT AMONG PAT W DIABETES / LONG-T ADULT	UNCONTROLLED DIABETES	URINARY TRACT INFECTION ADULT	URINARY TRACT INFECTION PED	Grand Total
1	3		13	9	9	23			48	3	2		3	2	4	122
2	1	2	8	11	12	18			45	6	5		6	3	5	122
3		1	3	11	13	18			25	13			9		2	95
4		1	11	7	9	10			34	3	1	2	2		8	88
5			5	14	15	29			82	8	1		9		2	185
6	3		6	10	8	7	1	2	34	4	3	2			4	82
7	8	2	7	8	11	30	4	2	37	12	4	5	3	1	8	142
8		1	6	4	15	15			22	5	2	2	5		3	80
9	1		12	19	11	7	5	1	50	7	1	2	3		4	121
10	4		4	6	16	13	1		35	2	4	3	3		4	95
Grand Total	18	7	75	99	119	170	9	5	410	63	23	25	40	3	44	1110

4673 total admissions

AGENDA ITEM

DISCUSSION / CONCLUSIONS

VI.B

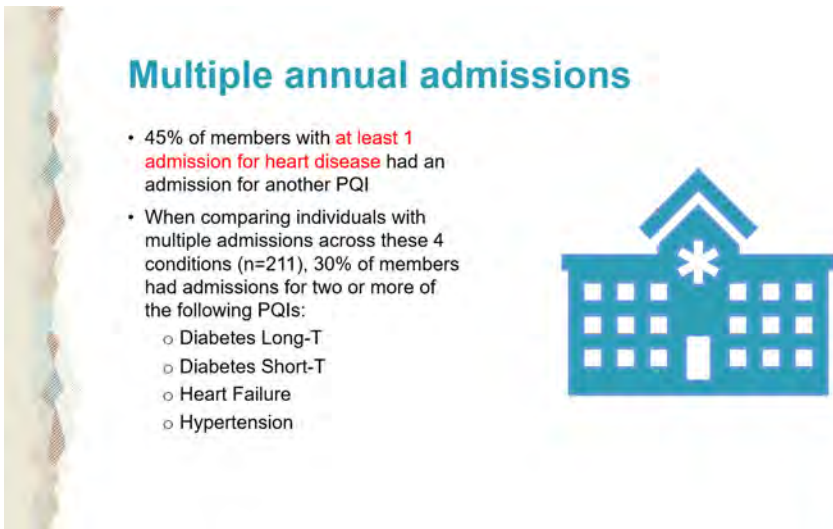
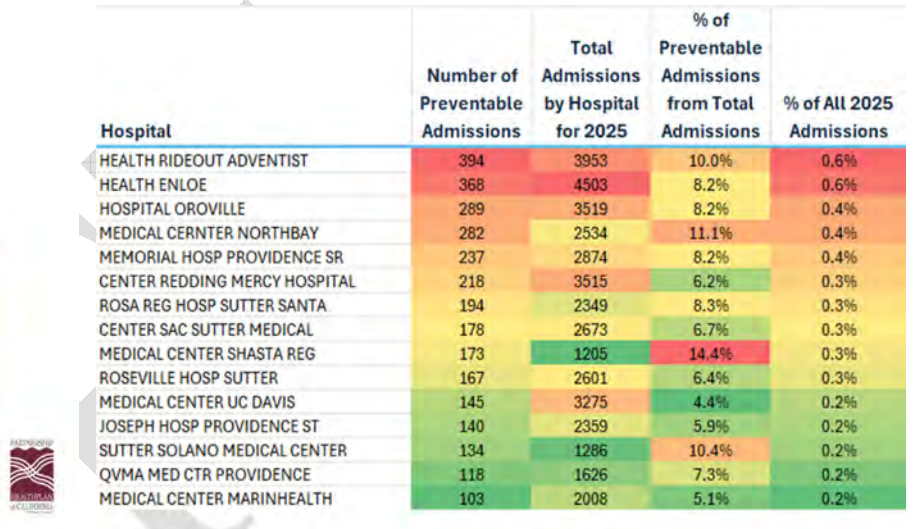
Potentially
Preventable
Admissions,
Continued

Sum of Admissions Annually by Condition

Admission Category	1	2	3	4	5	6	7	8	9	10	11	12	13	14-28	29+ admissions	Total
ASTHMA PED	125	10														135
ASTHMA IN YOUNG ADULTS	31	5	1													37
BACTERIAL PNEUMONIA	282	30	6	5		1	1		1							326
COPD ASTHMA ODER ADULT	233	87	35	24	18	8	3	8								416
DIABETES LONG-T ADULT	253	59	21	8	3	4		1					1		1	351
DIABETES SHORT-T ADULT	273	72	28	16	11	4	3	1		2	2					412
DIABETES SHORT-T PED	35	5	2													42
GASTROENTERITIS PED	88	2														90
HEART FAILURE	647	150	59	19	15	5	4	3	2	1	1		1			907
HYPERTENSION	153	14	5	3	1	1	1				1					179
LOWER-EXTREMITY AMPUT AMONG PTS W/DIABETES	55	17	6	1												79
LOWER-EXTREMITY AMPUT AMONG PTS W/DIABETES/ DIABETES LONG-T ADULT	53	12	4	1			1									71
UNCONTROLLED DIABETES	65	14	2	2	1		1					1				86
URINARY TRACT INFECTION PED	30															30
URINARY TRACT INFECTION ADULT	182	10	3		1	1										197
																3358

QIP data compared with ASCA (2025)

Measure	Numerator	Denominator	# of distinct members with ASA admit of related PQI in the denominator	% of ASA members in the care gap for QIP
Controlling High Blood Pressure	23744	35819	91 (PQI=hypertension)	88% (84% of this group were missing a BP reading)
			335 (PQI=heart failure)	88%
			829 (PQI=diabetes S-Term, L-Term and uncontrolled)	91%
HbA1C Good Control	22105	22920	407 (PQI=heart failure)	90%
Diabetes Retinal Eye Exam	18299	29920	829 (PQI=diabetes S-Term, L-Term and uncontrolled)	89%

AGENDA ITEM	DISCUSSION / CONCLUSIONS
VI.B Potentially Preventable Admissions, Continued	  This includes 10% of the hospitals (n=15) with the highest count of admissions which constitutes 3140 total admissions (67% of all admissions in 2025)
AGENDA ITEM	ADJOURNMENT
PAC adjourned at 9:03 a.m.	Next Physician Advisory Committee announced for August 12, 2026.

For Signature Only

The foregoing minutes were APPROVED AS PRESENTED on _____

Date

Angela Brennan, D.O., Committee Chairperson

The foregoing minutes were APPROVED WITH MODIFICATION on _____

Date

Angela Brennan, D.O., Committee Chairperson

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE
MEETING AGENDA**

Date: Tuesday, June 9, 2026

Time: 1:30 - 3:30 p.m.

Locations:

Napa/Solano (Fairfield West)
Trinity Alps (Redding – Airpark)

To Join by Webex:

<https://partnershiphp.webex.com/meet/iqi>
Meeting # 2631 319 6924

To Join by Telephone:

Toll Free: 844-621-3956
Access Code: 2631 319 6924

	Item	Lead	Time	Page #
I.	Call to Order//New Staff Introduction(s)/Announcements/Approval of Minutes			
I	Approval of Internal Quality Improvement (IQI) Committee Meeting Minutes of May 12, 2026	Robert Moore, MD, MPH, MBA	1:30	5 – 13
II.	Old Business – None			
III.	New Business – Consent Calendar			
Health Services Departments’ Policies	Consent Calendar	All	1:40	14
	Grievance & Appeal PULSE Report, Issue 17, June 2026			15 – 25
	Pharmacy			
	MCRP4064 – Continuation of Prescription Drugs			27 – 29
	MPRP4062 Drug Wastage Payments			30 – 46
	Quality Improvement			
	MCQP1052 – Physical Accessibility Review Survey			47 – 147
	Utilization Management			
	MPUG3010 – Chiropractic Services Guidelines			149 – 151
	MPUP3111 – Pulmonary Rehabilitation			153 – 158
	MPUP3139 – Criteria and Guidelines for Utilization Management			159 – 163
	Non-HS Policies			
Network Services - Credentialing				
MPCR13C – Osteopathic Manipulation Treatment Credentialing	165 – 166			
MPCR702 – Initial and Ongoing Vetting Requirements and Sanction Monitoring for Transportation Service Providers ¹	167 – 171			
MPPR203 – Provider Enrollment Status Guidelines	173 – 174			
IV.	New Business – Discussion Policies			
	Synopsis of Changes		--	175 – 179
	Population Health			
	MPND9001 – Population Health Management Strategy & Program Description	DeLorean Ruffin, DrPH	1:45	181 – 239
	MPND9007 – Lactation Policy and Guidelines	Christine Smith	1:55	241 – 248
	MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program		2:00	249 – 252

¹ new Attachment A (Attestation) not included here but will be provided to the Credentials Committee before July 8

	Item	Lead	Time	Page #
	Utilization Management			
	MCUP3041 – Treatment Authorization Request (TAR) Review Process	Tony Hightower, CPhT	2:05	253 – 271
V.	Presentations			
1	Quality Improvement Update	Isaac Brown, MHA/MBA	2:10	273 – 285
2	Hospital Quality Incentive Program (HQIP) Calendar Year (CY) 2027 Proposed Measurement Set	Troy Foster	2:15	287 – 296
3	Annual Review of UM and InterQual® Criteria ²	Tony Hightower / Lorna Grote, RN	2:25	297 – 338
4	Grievance & Appeals Department Annual Report CY 2025	Kory Watkins, MBA-HM	2:40	339 – 356
5	Population Health Management Grand Analysis – <i>PowerPoint presentation begins on p. 357</i> - Population Health Management 2025 Program Impact Analysis – <i>p. 395</i> - Population Segmentation – <i>p. 437</i>	DeLorean Ruffin, DrPH	2:55	357 – 444
FYI	PHM Work Plan			445 – 484
	Adjournment by 3:30 p.m. to 1:30 p.m. Tuesday, July 7, 2026			

² InterQual® is proprietary and so no paper is included in this packet outlining any demonstration by UM staff.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, June 9, 2026 / 1:34 – 3:30 PM

Members Present:

Andrews, Leigha, Regional Director (SW)
 Ayala, Priscila, Director of Network Services
 Beard, Alyssa, RN, Manager of CC Regulatory Performance
 Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations
 Bjork, Sonja, JD, Chief Executive Officer
 Bontrager, Mark, Senior Director of Behavioral Health, Health Services
 Brincko, Aaron, Director of Provider Relations
 Brown, Isaac, MHA/MBA, Senior Director, Q & PI
 Brunkal, Monika, RPh, Associate Director of Population Health
 Campbell, Anna, MPH, Policy Analyst, Utilization Management
 Devan, James, Director of Quality Improvement, QI
 DeVido, Jeffrey, MD, Behavioral Health Clinical Director
 Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
 Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI
 Hightower, Tony, CPhT, Associate Director, UM Regulations

Innes, Latrice, Compliance Manager, Grievance & Appeals
 Jalloh, Mohamed, Pharm.D, Dir. of Health Equity (Health Equity Officer)
 Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Services
 Klakken, Vicky, Regional Director (NW-Eureka)
 Leung, Stan, Pharm.D, Director of Pharmacy Services
 Matthews, R. Douglas, “Doug,” 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, Mgr, Clinical Comp. – Quality Inspections
 O’Connell, Lisa Brundage, MHA, Director, Enhanced Health Services
 Randhawa, Manleen, Senior Health Educator, Population Health
 Ruffin, DeLorean, DrPH, Director of Population Health
 Townsend, Colleen, MD, Regional Medical Director (SE-Fairfield)
 Villasenor, Edna, Senior Director, Member Services and Grievance
 Vaisenberg, Liat, Director of Health Analytics
 Ward, Lisa, MD, Regional Medical Director (SW-Santa Rosa)

Members Absent:

Barresi, Katherine, RN, BSN, PHN, Chief Health Services Officer

Davis, Wendi, Chief Operating Officer
 Jensen, Annika, RN, Assoc. Dir. of Clinical Integration, Care Coordination

Guests:

Ahedo, Danika, Supervisor of Credentialing, Network Services
 Akintan, Folo, MBBS/MD, MPH, MBA, Epidemiologist, Pop Health
 Allen, Angier, Sr. Data Scientist I, Finance
 Arguello, Amanda, Lead Trainer, Network Services
 Cook, Dawn R., Program Manager II (QUAC), Quality Improvement
 Durst, Jennifer, Senior Manager of Performance Improvement, QI
 Foster, Troy, Program Manager II (HQIP & PQIP), QI
 Grote, Lorna, RN, Supervisor of Long Term Support Services, UM
 Harris, Vander, Sr. Health Data Analyst I, Finance
 Isola, Brandy, Manager of Performance Improvement, QI (Chico)
 Kim, Amanda, Improvement Advisor, QI (Redding)
 Krznarich, Jackie, RN, Supervisor of Clinical Compliance, QI
 Kubota, Marshall, Associate Medical Director
 Kulkarni, Shreya, JD, Policy Analyst, Regulatory Affairs & Compliance
 Leung, Paul, Sr. Health Data Analyst I, Finance
 Ling, Samuel, Sr. Health Data Analyst I, Finance
 Mednick, Christy, Sr. Health Data Analyst I, Finance
 Moraghebi, Roudabeh, Manager of Health Analysts, Finance

Morris, Matthew, MD, Regional Medical Director (Auburn)
 Muncy, Kellie, Manager of Change Management & Configuration
 Nguyen, Tom, Manager of Health Analytics., Finance
 O’Leary, Hannah, Manager of Population Health
 Quichocho, Sue, Manager of Quality Measurement, QI
 Rathnayake, Rasitha, Sr. Health Data Analyst I, Finance
 Rednic, Hanny, Program Manager I, UM
 Roach, Erika, Program Manager I, Network Services
 Salehi, Tiphannie, Senior Health Data Analyst II, Finance
 Seale, J’aime, PR Lead, Network Services
 Sivasankar, Shivani, Sr. Data Scientist, Finance
 Smith, Christine, Community Health Needs Liaison, Population Health
 Stark, Rebecca, Regional Manager (Chico)
 Stites, Jaylyn, Program Manager II, Provider Relations (Redding)
 Thomas, Penny, Senior Health Data Analyst I, Finance
 Trosky, Renee, Mgr., Provider Relations Compliance, Network Svcs
 Vance, Brooke, Program Manager I, Network Services
 Watkins, Kory, MBA-HM, Director, Grievance & Appeals
 Yu, Fei, Sr. Data Scientist I, Finance
 Zhao, Li Sr. Health Data Analyst I, Finance

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order - Approval of Minutes - Announcements	CMO Robert Moore, MD, MPH, MBA called the meeting to order at 1:34 p.m. from the Fairfield-West office. - The May 12 IQI Minutes were approved after Mark Bontrager corrected a typo. - Following June 9 IQI approval of the May 12 minutes, staff was informed via several emails that a RAC review date need not be added to policies. (This bullet was added to the <i>approved</i> May 12 minutes before that document was sent to Regulatory Affairs and Delegation Oversight.)	Motion to approve IQI Minutes as corrected for a typo: Mark Netherda, MD Second: Isaac Brown, MHA/ MBA
II. Old Business – None		
III. New Business Consent Calendar (Committee Members as applicable)		
Grievance & Appeals PULSE Report, Issue 17, June 2026 – <i>refer questions to Latrice Innes</i> Health Services Policies <u>Pharmacy</u> MCRP4064 – Continuation of Prescription Drugs MPRP4062 – Drug Wastage Payments <u>Quality Improvement</u> MCQP1052 – Physical Accessibility Review Survey <u>Utilization Management</u> MPUG3010 – Chiropractic Services Guidelines MPUP3111 – Pulmonary Rehabilitation MPUP3139 – Criteria and Guidelines for Utilization Management Non-Health Services Policies <u>Network Services – Credentialing</u> MPCR13C – Osteopathic Manipulation Treatment Credentialing MPCR702 – Initial and Ongoing Vetting Requirements and Sanction Monitoring for Transportation Service Providers <i>Attachment A, (Attestation), was not provided for today's packet but should be included in the July 8 Credentials Committee meeting materials.</i> MPPR203 – Provider Enrollment Status Guidelines		Motion to approve the slate as presented: Isaac Brown Second: Mark Netherda, MD <u>Next Steps Pharmacy Policies:</u> - July 9 Pharmacy & Therapeutics Committee - Aug. 12 Physician Advisory Committee (PAC) <u>Next Steps QI & UM Policies:</u> - June 17 Quality/Utilization Advisory Committee (Q/UAC) - Aug. 12 (PAC) <u>Next Step Approved Credentialing Policies:</u> - July 8 Credentials Committee
IV. New Business – Discussion Policies		
Policy Owner: Population Health – Presenter: Christine Smith, Community Health Needs Liaison, Pop Health		
MPNP9007 – Lactation Policy and Guidelines	I. Related Policies: Updated policy code (“MC to MP”) for relevant policies, updated reference to MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program. III.D Definitions: Updated Partnership Advantage effective date to Jan. 1, 2028; Updated Partnership Advantage “members” to “enrollees.” V.A Purpose: Added language clarifying lactation services and supplies covered preventive services provided without cost sharing VI.E Policy/Procedure: Added requirement for culturally and linguistically appropriate delivery of lactation services, aligned with California Advancing and Innovating Medi-Cal (CalAIM) and DHCS health equity standards; included reference to MPND9002	Motion to approve as amended: Colleen Townsend, MD Second: Anna Campbell, MPH <u>Next Steps:</u> June 17 Q/UAC Aug. 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	VII.1B Policy/Procedure: Clarified Electronic Visit Verification (EVV) applies only to home-based lactation services; excluded facility/office settings VI.I. Policy/Procedure: Added language recognizing doulas as Medi-Cal providers for lactation support; referenced MPNP9006 and MPCR15 VI.C.1 Timing of Lactation Support Services: Clarified eligibility for lactation support services during pregnancy and up to one year post-partum. VI.C.2 Providers of Lactation Support Services: Clarified provision of lactation education and support across prenatal, delivery, and postpartum periods; added reference to APL 26-005. VI.C.2D Providers of Lactation Support Services: Added telehealth guidance for lactation services; ensured access to in-person care is maintained VI.C.5A-B Lactation Support Services: Clarified lactation services as a covered preventive benefit without cost sharing per APL 26-005; defined preventive services versus medically necessary services requiring authorization VI.C.5D Lactation Support Services: Clarified prior authorization not required for routine preventive lactation services; required for extended or medically necessary services consistent with DHCS guidance VI.C.6C Breast Pumps: Clarified breast pump coverage without a Treatment Authorization Request; added three-year limit, and defined TAR requirement for early replacement VII.M References: Added APL 26-005. Anna Campbell suggested that since the policy refers to telehealth, MCUP3113 Telehealth Services should be added to the Related Policies section. IQI agreed. A long discussion ensued between physicians Robert Moore and Colleen Townsend about whether or not and under what circumstances TARs might be required. Dr. Moore thought some wording was too vague. Dr. Townsend said she is “no fan” of TARs or Referral Authorizations (RAFs) for lactation services. The discussion devolved to coding issues: Dr. Moore noted that when a code is used too many times, that may trigger a review. Dr. Townend added that billable and non-billable providers alike offer lactation services, using the same codes. Manager of Change Management & Configuration Kellie Muncy commented. IQI agreed to a rewrite of portions of VI.C.5 – Lactation Support Services. Subsection c. reads: c. No Referral Authorization nor Treatment Authorization is required for medically necessary services. The last sentence of subsection d is deleted (In addition, lactation services provided by a Comprehensive Perinatal Service Program (CPSP) provider after the post-partum member’s eligibility for CPSP has expired, may also use the S9445 HCPCS Code.) and the paragraph is rewritten to read: Services provided in a contracted hospital outpatient services, physician office, IBCLC private office, via telehealth or member’s home may be billed to Partnership using the S9445 HCPCS code, billed in 15 minute increments, up to a maximum of 4 units per day. Dr. Moore concluded that lactation benefit is under-utilized by Partnership members.	
MPNP9008 – Women, Infants and Children	I. Related Policies: Updated policy code (“MC to MP”) for MPNP9006 – Doula Services Benefit.	Motion to approve as amended: Anna Campbell

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
(WIC) Supplemental Food Program	III. Definitions: Updated terminology to reflect “nutritious food packages” and removed reference to prescriptive checks; Updated Partnership Advantage (D-SNP) effective date to Jan. 1, 2028 and updated Partnership Advantage “members” to “enrollees.” VI.A.1 Coverage Guidelines: Clarified Partnership responsibility to identify, refer, and follow up with eligible members to support access to WIC services VI.B.1 Identification and Referral: Added provider requirement to assess nutritional risk and food insecurity for WIC eligibility VI.B.5 Identification and Referral: Added requirement to follow up on WIC referrals and document member access to services in the medical record VI.B.6 Identification and Referral: Clarified documentation of WIC referrals and outcomes; added reference to MPNP9007 VI.C.1 Follow-up : Clarified provider training requirements for WIC referrals, follow-up, and documentation VI.C.3 Follow-up: Added QI monitoring of WIC referral and follow-up practices VI.D.1 MOU Requirements: Clarified requirement for good faith execution of WIC MOUs with county providers per APL 23-029. VII.F References: Added APL 26-005. Anna Campbell noted that Definition III.B (Partnership Advantage) should be updated to include a new concluding sentence: “Coverage criteria apply on implementation of D-SNP, subject to CMS and DHCS approval.” IQI agreed. (The definition as revised should be carried going forward through all policies that carry the PA definition.) After discussion, IQI agreed with Mark Bontrager and physicians Robert Moore and Kermit Jones to strike “good faith effort” from VI.D.1, amending it to “Per APL 23-029 Attachment G WIC MOU, Partnership and the respective WIC Providers in the counties Partnership serves shall maintain executed MOUs with WIC providers, or document when an MOU cannot be established, outlining respective responsibilities and obligations. MOUs shall be reviewed periodically and define roles, responsibilities, and referral processes.” Dr. Moore noted that, although DHCS is moving to “more aspirational language,” Partnership generally should not do so. Dr. Folo Akintan asked how this change may affect First 5’s and other programs’ MOUs. Dr. Moore responded that this is just about how we manage WIC.	Second: Mark Netherda, MD <u>Next Steps:</u> June 17 Q/UAC Aug. 12 PAC
Policy Owner: Utilization Management – Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations		
MCUP3041 – Treatment Authorization Review Request (TAR) Review Process	Section I. B. and L.: Policy MPUP3014 Emergency Services was added as a Related Policy and policy MCUP3064 Communication Services was removed, because that policy has been archived and the information is included in policy MPU3001 UM Program Description, which is already listed. VI. A.2.b.: Clarification was added to say that Partnership’s Online Services (OLS) portal is available “24 hours per day, 7 days per week.” VI.B.1.a. – c.: Clarification was added to specify that Partnership requires TARs for certain procedures in three categories: Non-behavioral (medical) healthcare, Behavioral healthcare, and Pharmacy. VI.B.3.: Additional language was added in paragraph regarding exhaustion of Medicare coverage to say “This requirement applies only when Medicare coverage is primary and applicable to the requested service.”	Motion to approve as amended: Mark Netherda, MD Second: Colleen Townsend, MD <u>Next Steps:</u> June 17 Q/UAC Aug. 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	VI.C.2.b.: Redundant sentence regarding the assignment of a specified number of days for an inpatient TAR was deleted because the same information was stated below at VI.C.2.b.1). VI.C.3.a.: Language regarding long term care facility was removed because Partnership does not typically see emergency or obstetrical admissions to an LTC facility. VI.C.4.b.: CCR Title 22 section 50777 was added as a regulation requiring that Medi-Cal beneficiaries apply for any available health care coverage when no cost is involved. VI.C.4.d.: Language was updated to clarify that Partnership assigns Members with ESRD to a Direct Member status (rather than issuing a lifetime TAR) to ensure that dialysis services are approved in an efficient manner. VI.C.5.: Hospice Services section was updated to include language from recent APL 25-008. VI.C.6.: Terminology was updated from Long Term Care to Extended Care nursing services. VI.D.6.a.3): Language was changed to say “as soon as possible” rather than “within 24 hours” for Partnerships attempts to obtain any missing necessary information for urgent concurrent care. VI.D.6.a.4): Language was clarified to describe how Partnership will inform the hospital Utilization Review department staff of denial decisions for urgent concurrent reviews. VI.D.6.c.1): Time frame for rendering a decision for a non-urgent pre-service review was changed from 5 business days to 7 calendar day as per CMS-0057-F. VI.D.6.c.4): Language describing a second pend time frame up to 28 days was removed as this is no longer applicable according to CMS-0057-F. VI.D.6.c.5)a): Time frame for rendering a decision for a non-urgent pre-service review was changed from 5 business days to 7 calendar days as per CMS-0057-F and option to extend a pend up to 28 days was removed. VI.E.4.: Policy language was updated to include description of IRR audits for pharmacist reviewers and lead pharmacy technicians, in addition to the IRR audits already described for physician and nurse reviewers. VII.A.: Reference to DHCS Contract was updated. VII.B.: Date of APL 21-011 was updated for revision. VII.C.: Reference for APL 22-012 was updated to reflect current APL 25-013. VII.E.: Reference to Title 42 CFR 438.114 was updated to include description VII.F.: Reference was added for Title 22 CCR 50763 and 50777 VII.G.: Reference to Title 28 CCR 1300.71.4 was updated to include description VII.H.: Reference to CMS Final Rule CMS-0057-F was updated Attachment A: Various policy numbers and names were updated throughout. Reference to APL 22-012 was updated to reflect APL 25-013 for Medi-Cal Rx Tony verbalized a change to Attachment A, Section H: the acronyms of three imaging studies are now spelled out: Magnetic Resonance Angiography (MRA), Mass Spectrometry Imaging (MSI), and Magnetoencephalography (MEG). This note was also added: “No TAR is required for CT scans or MRIs.” Associate Medical Director Marshall Kubota noted that some alphanumeric reformatting of the policy is necessary as no section VI.B.2 currently exists. Dr. Moore and Anna Campell had “bundling” questions. These will be discussed at a future meeting of the Benefit Review and Evaluation Workgroup (BREW).	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
V. Presentations		
QI Update – Isaac Brown, MPH/MBA, Senior Director, Quality Improvement and Performance		
- We are on track to get all of our Quality Incentive Programs (QIPs) on an annual calendar year (January-December) as necessitated by contracting changes. - QI Program Manager Tasha Krongard continues to work with network providers on our Preventive Care Bridge Project. The project developed a set of Locum Tenen Implementation Tools and other resources designed to help provider more effectively integrate locum staffing into preventive care models and close care gaps, particularly in well-child visits and cervical cancer screenings. - The annual HEDIS® (Healthcare Effectiveness Data Information Set) summary of performance will be presented to IQI and Q/UAC in July. Measurement Year (MY) 2025 HealthPlan Accreditation (HPA) final rates have been approved by our HPA auditor. MY2025 Managed Care Accountability Set (MCAS) final rates have been submitted; we are awaiting auditor approval.		
Hospital Quality Incentive Program (HQIP) Calendar Year 2027 Proposed Measurement Set – Troy Foster, Program Manager II, Quality Improvement		
In summary, this proposal takes out two measures and brings back three based on new qualifications. <u>In the Clinical Domain:</u> Existing Measure 8 – Expanding Delivery Privileges – Requirements will be delineated by hospital size: X-Large (>100 Licensed General Acute beds), and Small and Large (between 25 and 100 LGA beds. Hospitals with existing family physicians and midwives privileged to perform deliveries will get full QIP credit so long as these clinicians remain active delivering babies in the hospital. Old Measure 10 – Increasing Mammography Capacity – is deleted because this cannot be done every year. Old Measure 11 – Vaccines for Children (VFC) Enrollment – is deleted and replaced with New Measure 10 – Hepatitis B Vaccination. New Measure 11 – ALSO and BLSO (Advanced Life Support in Obstetrics and Basic Life Support I Obstetrics) Certification Training – is added and is particularly important for our Critical Access Hospitals in our rural communities. <u>In the Patient Safety Domain:</u> Measure 13 – Substance Use Disorder 7-day Follow-up After ED Visit (FUA) – will come to align with the HEDIS® measure of the same name. <u>In the Operations / Efficiency Domain:</u> Measure 14 – Quality Improvement Capacity – was removed from the 6-month 2026 bridge set and is returning for CY 2027. The measure is designed to provide a free full-day Hospital Quality Symposium each measurement year for our participating hospitals. <u>In the Patient Experience Domain:</u> Measure 16 – Cal Hospital Compare patient Experience – was removed from the 6-month 2026 bridge set and is returning for CY 2027. Partnership’s scoring relies upon California Hospital Compare’s scores. Measure 17 – Health Equity – was removed from the 6-month 2026 bridge set and is returning for CY 2027. <u>Next Steps:</u> This HQIP will be on Q/UAC’s June 17 consent calendar. Director of Quality Management James Devan will present it to the PAC on Aug. 12.		
Annual Review of UM and InterQual® Criteria – Tony Hightower, CPhT, and Lorna Grote, RN, Supervisor of Long Term Support Services, UM		
Tony explained what InterQual® is and how Partnership uses it in the UM decision making process before Lorna presented a fictional case study to demonstrate step by step how we use it to help us optimize caring for our members. Partnership utilizes 14 InterQual® criteria modules: adult and pediatric acute care, inpatient rehabilitation, long-term acute care, subacute/skilled nursing facility (SNF), durable medical equipment (DME), imaging procedures, molecular diagnostics, adult and child psychiatry, substance use disorders, behavioral health services, and Medicare post-acute and DME. InterQual® content is produced using a rigorous development process based on the principles of evidence-based medicine (EBM). InterQual® clinical content is created by the Optum research and content development staff of more than 55 research and clinical decision support specialists, including physicians, registered nurses, physician		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	assistants, nurse practitioners, social workers, physical and occupational therapists, and other healthcare professionals. Content is peer reviewed by a 1,200+ multidisciplinary panel of board-certified, practicing clinicians. Tony commented that Partnership leverages InterQual®, but that it is not our “single source of truth” in our criteria of decision making. See also Partnership policy MPUP3139 – Criteria and Guidelines for Utilization Management – which is on today’s consent calendar for annual review and approval. Lorna shared a fictional account of a 76-year old female that collapsed in public in the presence of her daughter, who reports to ambulance and emergency room staff that her mother has had a recent diagnosis of arterial fibrillation, which ED staff then verifies in the patient’s health record. Lorna recounted this fictional patient’s vitals and list of medications at the point they are hospitalized. Lorna continued demonstrating how InterQual® might be used to best determine next steps. Entering this data into the program, she gets > 60 returns, which she narrows down to one option by choosing “stroke.” (Clicking on “notes” will suggest interventions.) Even though the patient is getting a neuro assessment every few hours, InterQual® points the reviewing clinician in a different direction. The clinician completes the review and decides on a level of care. On day two, the afib-controlled, intermittently confused, speech slurring patient exhibiting right side weakness is moved to a med/surg bed. Day three, the patient is febrile with diminished lung sounds. X-ray reveals pneumonia. The clinical reviewer can close the review or start another but elects to stay in the module and go to episode day three for adult acute care. The reviewer clicks on pneumonia and enters the patient’s current vitals and choses all criteria the patient meets. The patient may or may not continue to meet InterQual® criteria for acute care. If at any time the still-hospitalized patient no longer meets acute criteria, the reviewer would escalate the case to a Partnership medical director for a secondary review. IQI members had no questions. Anna Campbell noted that the Optum platform carrying InterQual® is now integrated into Essette. No approval is needed at IQI: Dr. Moore encouraged anyone who had presentation suggestions for June 17 Q/UAC to contact Tony.	
	Grievance & Appeals Department Annual Report CY 2025 – Kory Watkins, MBA-HM, Director, Grievance & Appeals	
	CY 2025 case volume increased 18% above CY 2024 and is likely to continue to grow as our member numbers increase. Trinity, Shasta, and Placer counties were the top three counties for grievances per 1,000 members. Transportation at 50% remained the highest grievance category, although some aspects have improved since the benefit was brought n-house. Fourteen percent of civil rights allegations were substantiated in 2025, up from 10% in 2024. <i>A more detailed account of this report will be available in the July 15 Q/UAC minutes. (This report is pulled from the June 17 Q/UAC agenda to allow time for presentation of the Population Health Grand Analysis.)</i> Staff asked several questions of Kory at IQI. • Southwest Regional Medical Director Lisa Ward asked how our various rates compare to other plans. Kory did not have a definitive answer. • Dr. Akintan asked what Partnership is doing about disability discrimination. Kory replied we are now looking at what ADA (Americans with Disabilities Act) accommodations different providers may or may not have in place. Dr. Moore asked Health Equity Officer Mohamed Jalloh, Pharm.D, if we have just become more aware and are better classifying this discrimination category? Dr. Jalloh replied the there is no “gold standard” against which to assess data. His team is keeping NCQA (National Committee for Quality Assurance) in mind as his team works with Health Analytics during the next year to better understand allegations of mental and physical disability discrimination.	
	Population Health Grand Analysis – DeLorean Ruffin, DrPH, Director of Public Health	
	DeLorean first went through the MPND9001 – Population Health Management Strategy & Program Description – synopsis of changes. Time ran out before she could present the Grand Analysis; therefore, Kory agreed to delay her G&A Grand Analysis from June 17 to July 15 Q/UAC to allow DeLorean to present to June Q/UAC her Pop Health package, including this policy, a PowerPoint presentation, and two supplemental documents, the Pop Health Management 2025 Program Impact Analysis and the Program Segmentation report.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Annual update includes revisions and updated All Plan Letter (APL) references to further align the document with National Committee on Quality Assurance (NCQA) and state requirements. Many small changes for grammar, clarity, and/or readability. Highlights below: P. 4 Introduction: Updated D-SNP (Dual-eligible Special Needs Plan) <i>aka</i> “Partnership Advantage” Medicare services go-live date to Jan. 1, 2028. P. 9-10 Population Needs and Local Planning Requirements Community Health Assessment / Community Health Improvement Plan (CHA/CHIP): Noted that the Population Needs Assessment (PNA) Committee was disbanded in March 2026. Described 2025 requirement for county behavioral health departments (BHPs) to integrate into their local county CHA/CHIP processes, and that Partnership works with them to advance statewide behavioral health goals. Gave more details about the DHCS PHM Strategy Deliverable. P. 14 Population Risk Stratification & Segmentation: Clarified Partnership’s proprietary risk scoring vs. the Department of Health Care Services’ RSST, and the use of both in tandem in the future. P. 19-20 Future Risk Stratification, Segmentation, and Risk Tiering: Updated language to reference Medi-Cal Connect. Added that in 2026, Partnership is piloting DHCS’s RSST into operational workflows to inform member identification, outreach, and intervention planning. Described plans following the implementation of Medi-Cal Connect, and actions Partnership takes when members are identified as high risk. P. 22-23 Wellness, Prevention, and Chronic Disease Management Programs: Added language about offering of chronic disease management programs, and direct the reader to refer to the Growing Together Program charter and Basic Population Health Management chronic disease management program charter for more information. P. 26 Organizational Support for PHM: Added that providers have on-demand access to care gap data via eReports, and that the Partnership Quality Dashboard (PQD) is updated monthly. P. 29: Updated an intervention for moderate/rising risk pregnant members, saying “Offer a pay-for-performance program that incentivizes chronic disease management, which can enable purchasing POC devices.” P. 37 Practitioner Education and Training: Explained that DEI training for providers, partnership staff, and subcontractors and downstream subcontractors is called “CARES training.” Added reference to forthcoming Health Equity policy MCEP6004 DEI/Cultural Connection Training. P. 40 Informing Members About Available PHM Programs: Added “Partnership also has the ability to inform providers of various programs through Partnership’s website, various provider newsletters, in-person meetings, fax blasts, email, and flyer distribution.” Clarified that providers are informed as appropriate to support referrals and coordination of member care. P. 43 Community Engagement and Coordination of PHM Programs: Updated list of Partnership MOUs and refer to MCCP2036 Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities P. 45 Delivery-System Supports for Population Health Management: Updated this section with more detail. P. 48 Partnership Quality Dashboard (PQD): Added detail for data available through PQD, and information about QI trainings. P. 50-55 Team Roles and Responsibilities: Rewrote various department position descriptions to better mirror official job descriptions. IQI members posed no questions before the Committee approved MPND9001 as presented. <i>Motion: Lisa Ward, MD / Mark Netherda, MD</i>	
	VI. Adjournment	
	Dr. Moore adjourned the meeting at 3:30 p.m. IQI will meet next Tuesday, July 7, 2026.	
	<i>Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement</i> <i>Approval Signature:</i> _____ <i>Date:</i> _____ <i>Robert Moore, MD, MHA, MBA</i> <i>Chief Medical Officer and Committee Chair</i>	

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

Date: June 17, 2026

Time: 7:30 – 9:00 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
1000 Fortress St., Chico, CA 95973 | Stony Creek Conference Room

Other Locations:

Open Door Community Health Center, 770 10th St., Arcata
Chapa-de Indian Health: 11670 Atwood Road, Auburn
Kaiser Permanente, 5820 Owens Drive, Pleasanton

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 Partnership locations

	Item	Lead	Time	Page #
I.	Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes			
1	Approval of May 20, 2026 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	5 – 12
2	Acknowledgment and acceptance of draft minutes of the - May 12 Internal Quality Improvement (IQI) Committee – with one post June 9 IQI approval postscript p. 2 - May 19 Quality Improvement Health Equity Committee (QIHEC) Minutes			--
				13 – 21
				23 – 38
3	Announcements			--
II.	Standing Updates			
1	Quality and Performance Improvement Program Update	Isaac Brown, MHA/MBA	7:36	39 – 51
2	HealthPlan Update	Robert Moore, MD	7:41	--
III.	Old Business – None			
IV.	New Business – Consent Calendar			
Health Services	Consent Calendar	All	7:46	52
	Grievance & Appeals PULSE Report – Issue 17, June 2026 – direct questions to Latrice Innes			53 – 63
	Hospital Quality Incentive Program (HQIP) Proposed Calendar Year (CY) 2027 Measurement Set – direct questions to Troy Foster			65 – 74
	Quality Improvement			
	MCQP1052 – Physical Accessibility Review Survey			75 – 175
	Utilization Management			
	MPUG3010 – Chiropractic Services Guidelines			177 – 179
	MPUP3111 – Pulmonary Rehabilitation			181 – 186
	MPUP3139 – Criteria and Guidelines for Utilization Management			187 – 191
V.	New Business – Discussion Policies – Health Services			

	Item	Lead	Time	Page #
	Synopsis of Changes		--	193 – 196
	Population Health			
	MPNP9007 – Lactation Policy and Guidelines	Christine Smith	8:00	197 – 205
	MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program		8:06	207 – 210
	Utilization Management			
	MCUP3041 – Treatment Authorization Request (TAR) Review Process	Tony Hightower, CPhT	8:12	211 – 229
VI.	Presentations			
1	Annual Review of UM and InterQual® Criteria ¹	Tony Hightower / Lorna Grote, RN	8:18	231 – 272
2	Population Health Management Grand Analysis – <i>see pages 335-372 for PowerPoint presentation</i> • MPND9001 Synopsis of Changes – <i>pp. 273-274</i> • MPND9001 Population Health Management Strategy & Program Description – <i>pp. 275-333</i> • Population Health Management 2025 Program Impact Analysis – <i>pp. 373-413</i> • Population Segmentation – <i>pp. 415-422</i>	DeLorean Ruffin, DrPH	8:33	273 – 422
FYI	PHM Work Plan			423 – 462
	Adjournment scheduled for 9:00 a.m. Q/UAC next meets 7:30 a.m. Wednesday, July 15, 2026			

¹ InterQual® is proprietary and so no paper is included in this packet outlining any demonstration by UM staff.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Quality and Utilization Advisory Committee (Q/UAC) Meeting Minutes

Wednesday, June 17, 2026 / 7:33 a.m. – 9:04 a.m.

Fairfield: Napa/Solano Room, Redding: Airpark, Chico: Story Creek, Santa Rosa Huddle

<u>Voting Members Present:</u>		
Choudhry, Sara, MD	Montenegro, Brian, MD	Strain, Michael, Consumer Member
Gwiazdowski, Steven, MD, FAAP	Mulligan, Meagen, FNP-BC	Swales, Chris, MD
Emma Hackett, MD, FACOG	Quon, Robert, MD, FACP	Thomas, Randy, MD
<u>Voting Members Absent:</u> Lane, Brandy, Consumer Member; Murphy, John, MD; Wilson, Jennifer, MD, MPH		
<u>Partnership Ex-Officio Members Present:</u> Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI Bontrager, Mark, Senior Director of Behavioral Health Brown, Isaac, MBA/MHA, Interim Senior Director of Q & P Improvement DeVido, Jeff, MD, Behavioral Health Clinical Director Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management Glickstein, Mark, MD, Associate Medical Director Hightower, Tony, CPhT, Associate Director, UM Regulations Jalloh, Mohamed “Moe”, Pharm.D, Dir. of Health Equity (Health Equity Officer) Jones, Kermit, MD, JD, Medical Director for Medicare Services Katz, Dave, MD, Associate Medical Director Leung, Stan, Pharm.D, Director of Pharmacy Services Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair Netherda, Mark, MD, Medical Director for Quality – Vice Chair Newman, Rachel, RN, BSN, Assoc. Dir., Credentialing O’Connell, Lisa, Director, Enhanced Health Services Spiller, Bettina, MD, Associate Medical Director Townsend, Colleen, MD, Regional Medical Director (Southeast) Ward, Lisa, MD, Regional Medical Director (Southwest) Watkins, Kory, MBA-HM, Director, Grievance & Appeals		
<u>Partnership Ex-Officio Members Absent:</u> Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer Cox, Bradley, DO, Regional Medical Director (Northeast) Guillory, Ledra, Senior Manager of Provider Relations Representatives Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination Randhawa, Manleen, Senior Health Educator, Population Health Ribordy, Jeff, MD, Regional Medical Director (Northwest) Ruffin, DeLorean, DrPH, MPH, Director of Population Health		
<u>Guests:</u> Beard, Alyssa, RN, Manager of CC Regulatory Performance Campbell, Anna, Health Policy Analyst, UM Regulations Cook, Dawn R., Program Manager II (NCQA), QI Cunningham, Aryana, Policy Analyst, Care Coordination Devan, James, Director of Quality Management Durst, Jennifer, Manage of Performance Improvement (Fairfield) Grote, Lorna, RN, Supervisor, Long-Term Support Services, UM Gual, Kristine, Director of Quality Measurement Kubota, Marshall, MD, Reg. Medical Director Matthews, Richard, MD, Regional Medical Director (Chico) Morris, Matthew, MD, Regional Medical Director (Auburn) O’Leary, Hannah, Manager of Population Health, Pop Health Quichocho, Sue, Manager of Quality Measurement, QI Smith, Christine, Community Health Needs Liaison, Pop Health Thornton, Aaron, MD, Associate Medical Director		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – <i>none made</i> Approval/ Acceptance of Minutes Announcements	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:33 a.m. - May 20, 2026 Q/UAC Minutes were approved without any corrections. <i>Acknowledgment and acceptance of draft meeting minutes of the</i> - May 12 Internal Quality Improvement (IQI) Committee - May 19 Quality Improvement Health Equity Committee (QIHEC) <u>Announcements:</u> - Jayne Bottke, who was formerly on our Board from Tehama County, has now joined Partnership in Redding as our new regional director. - Irem Conery, formerly with Sharp's Healthcare in the San Diego area, is our new Director of Member Experience. She reports to CEO Sonja Bjork, JD.	Motion to approve the Q/UAC minutes: Brian Montenegro, MD Second: Robert Quon, MD <i>Approved unanimously</i> Motion to accept other minutes: Steven Gwiazdowski, MD Second: Chris Swales, MD <i>Accepted unanimously</i>
II. Standing Updates		
Quality and Performance Improvement Program – Isaac Brown, MBA/MHA, Senior Director, Q&PI		
- The Performance Improvement team facilitates Joint Leadership Initiative (JLI) meetings with seven partner organizations across Partnership's provider network. This consultation and collaboration is a large undertaking to improve the scores of our lower performing participants in the Primary Care Providers Quality Incentive Program (i.e., those who did not earn at least 75 percent of their PCP QIP scores in the previous year). The number of organizations participating in this JLI could change once 2025 PCP QIP scores are finalized. - The Preventive Care Bridge Project (formerly known as the Locum Pilot Initiative) has developed a set of Locum Tenen Implementation Tools available for us by any of our provider organizations. We are now sharing best practice at regional meetings. There will be more reporting on this at our August meetings. - We have had good success partnering with Exact Sciences in promoting colorectal cancer screening kits. We are working to eliminate minimums so those with smaller member loads can order. The next facilitated order is scheduled to launch July 20 and is aligned with the timeline to address 2026 and 2027 PCP QIP measures. Any provider interested in more information can fill out the Partnership's Cologuard Facilitated Order Interest Form on our Cologuard Care-Gap Orders page. - We are now getting back our Healthcare Effectiveness Data Information Set (HEDIS®) scores and will be sharing results at July IQI and Q/UAC.		
Health Plan – Robert Moore, MD, MPH, MBA, Chief Medical Officer		
- Partnership had its kickoff session of the Partnership Clinic Leadership Academy. This is a group of 35 emerging leaders from health centers, FQHCs, rural health centers and Tribal health centers from throughout our region. It is being put together by the Health Force UCSF, but uniquely we have integrated quite a bit of quality improvement content and coaching into that program. The program includes a project for each of them focused on one of our priority areas. The initial group was very talented and very excited and engaged. We only have the funding for one year and will reevaluate at the end of the year. - We are seeing increasing rates of kratom addiction in California, and policy issues are emerging. Interestingly, both the consumption and sale of kratom is illegal in California, but enforcement is very complicated, and possession is not illegal. We are seeing increased overdosed in emergency rooms. Narcan doesn't work as well in kratom. The active drug is an opioid-like substance, but it is not exactly an opioid: it is more potent than morphine. It is sometimes called "gas station heroin." The way to enforce it is for the Department of Public Health and local Sheriffs together to walk into a gas station and try to solicit sales, and when they sell it to them, then they've broken the law and they get a misdemeanor. Some policy was introduced last year at the state level, but it died. Some local counties throughout California are taking action: San Diego has a ban on possession of kratom and some other Bay Area counties have followed suit. None of Partnership's		

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	counties have done so at this time. - The Cal Rural Health Transformation grant program will kick off in the next couple of weeks. Dr. Colleen Townsend has been appointed to the California Rural Health Policy Council, and we are excited about that. More to come. - Local health plans in California, the California Association of Health Plans, and other stakeholders are trying to preserve some coverage for the UIS (unsatisfactory immigration status) population. The Governor’s budget wanted to carve that population out of Medi-Cal starting in January and have it be paid fee-for-service straight from the State. When the rates haven’t gone up in 40 years, that is pretty uncovered. This would also exclude the PPS rate for FHQCs, RHCS, and Tribal Health, which was the safety valve for those low, low rates. It would be hard to put together a healthcare delivery system with that, so the proposal was to divide up the benefit, keeping hospital and emergency benefit, including pregnancy, and let the State cover that directly and then have the health plans cover primary care, specialty care and other things as a sort of package. The State is financially and logistically skeptical. Partnership has 90,000 members who would fall into this group, so absent this, we would lose 90,000 members in January. - The Finance Committee is meeting this morning to review next year’s budget. We will have some idea of that next month. - The CMS (Centers for Medicare and Medicaid) came out with some official language around work requirements, which was different from what DHCS was putting together. One thing that is apparent is that for the first year, a person who is medically fragile can attest that they are medically fragile, but then they have to prove it after that first year.	
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
	Proposed CY 2027 Hospital Quality Incentive Program (QIP) Measure Summary – <i>direct questions to Troy Foster</i> Grievance & Appeals PULSE Report – Issue 17, June 2026 – <i>direct questions to Latrice Innes</i> Health Services Policies <u>Quality Improvement</u> MCQP1052 – Physical Accessibility Review Survey <u>Utilization Management</u> MPUG3010 – Chiropractic Services Guidelines MPUP3111 – Pulmonary Rehabilitation MPUP3139 – Criteria and Guidelines for Utilization Management Q/UAC voter Randy Thomas, MD, pulled MPUP3111 to point out what he read as some discrepancies between policy sections as to what conditions made a patient eligible or ineligible for pulmonary rehabilitation. After discussion between voters Thomas and Chris Swales, MD, together with Dr. Moore and Mark Netherda, MD. Q/UAC voter Swales said he worried that his workload could “double or triple” if persons are coming in saying ‘I’m medically frail.’ Dr. Moore directed UM staff to take back the policy. <i>Meeting postscript: IQI approved the policy as revised July 7.</i>	Motion to approve the slate without MPUP3111: Randy Thomas, MD Second: Steven Gwiazdowski, MD <i>Approved unanimously</i> <u>Next Steps:</u> All approved policies go to the Aug. 12 Physician Advisory Committee (PAC) MPUP3111 will come back on Old Business at July 7 IQI and July 15 Q/UAC.
V. New Business – Discussion Policies		
Policy Owner: Population Health – Presenter: Christine Smith, Community Health Needs Liaison, Pop Health		
MPNP9007 – Lactation Policy and Guidelines	I. Related Policies: Updated policy code (“MC to MP”) for relevant policies, updated reference to MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program.	<i>QUAC voters posed no questions.</i>

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	III.D Definitions: Updated Partnership Advantage (D-SNP) effective date to 1/1/2028; Updated Partnership Advantage “members” to “enrollees.” Also added that coverage criteria apply upon implementation, subject to CMS and DHCS approval. V.A Purpose: Added language clarifying lactation services and supplies covered preventive services provided without cost sharing VI.E Policy/Procedure: Added requirement for culturally and linguistically appropriate delivery of lactation services, aligned with California Advancing and Innovating Medi-Cal (CalAIM) and DHCS health equity standards; included reference to MPND9002 VI.I.1B Policy/Procedure: Clarified Electronic Visit Verification (EVV) applies only to home-based lactation services; excluded facility/office settings VI.I. Policy/Procedure: Added language recognizing doulas as Medi-Cal providers for lactation support; referenced MPNP9006 and MPCR15 VI.C.1 Timing of Lactation Support Services: Clarified eligibility for lactation support services during pregnancy and up to one year post-partum. VI.C.2 Providers of Lactation Support Services: Clarified provision of lactation education and support across prenatal, delivery, and postpartum periods; added reference to APL 26-005. VI.C.2D Providers of Lactation Support Services: Added telehealth guidance for lactation services; ensured access to in-person care is maintained VI.C.5A-B Lactation Support Services: Clarified lactation services as a covered preventive benefit without cost sharing per APL 26-005; defined preventive services versus medically necessary services requiring authorization VI.C.6B3 Breast Pumps: Replace CPSP with PHPS health education codes for reimbursement of breast pump education. VI.C.6C Breast Pumps: Clarified breast pump coverage without a Treatment Authorization Request; added three-year limit, and defined TAR requirement for early replacement VII. References: Added APL 25-013 - Medi-Cal Rx Pharmacy Benefits, And Cell and Gene Therapy Coverage (09/18/2025) – supersedes (APL) 22-012 Added APL 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members (03/25/2026) IX. Position Responsible for Implementing Procedure: Updated to Chief Medical Officer.	Motion to approve as presented: Steven Gwiazdowski, MD Second: Robert Quon, MD <i>Approved unanimously</i> <u>Next Steps:</u> Aug. 12 PAC
MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program	I. Related Policies: Updated policy code (“MC to MP”) for MPNP9006 – Doula Services Benefit. III. Definitions: Updated terminology to reflect “nutritious food packages” and removed reference to prescriptive checks; Updated Partnership Advantage (D-SNP) effective date to Jan. 1, 2028 and updated Partnership Advantage “members” to “enrollees.” Also added that coverage criteria apply upon implementation, subject to CMS and DHCS approval. VI.A.1 Coverage Guidelines: Clarified Partnership responsibility to identify, refer, and follow up with eligible members to support access to WIC services VI.B.1 Identification and Referral: Added provider requirement to assess nutritional risk and food insecurity for WIC eligibility	<i>QUAC voters posed no questions.</i> Motion to approve as presented: Steven Gwiazdowski, MD Second: Randy Thomas, MD <i>Approved unanimously</i> <u>Next Steps:</u>

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	VI.B.5 Identification and Referral: Added requirement to follow up on WIC referrals and document member access to services in the medical record VI.B.6 Identification and Referral: Clarified documentation of WIC referrals and outcomes; added reference to MPNP9007 VI.C.1 Follow-up: Clarified provider training requirements for WIC referrals, follow-up, and documentation VI.C.3 Follow-up: Added QI monitoring of WIC referral and follow-up practices VI.D.1 MOU Requirements: Reverted to original WIC MOU execution language, removing the “good faith effort” standard. VII.F References: Added APL 26-005 - Maternity Services for Pregnant and Postpartum Medi-Cal Members (03/25/2026) IX. Position Responsible for Implementing Procedure: Updated to Chief Medical Officer.	Aug. 12 PAC
Policy Owner: Utilization Management – Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations		
MCUP3041 – Treatment Authorization Request (TAR) Review Process	Section I. B. and L.: Policy MPUP3014 Emergency Services was added as a Related Policy and policy MCUP3064 Communication Services was removed, because that policy has been archived and the information is included in policy MPU3001 UM Program Description, which is already listed. VI. A.2.b.: Clarification was added to say that Partnership’s Online Services (OLS) portal is available “24 hours per day, 7 days per week.” VI.B.1.a. – c.: Clarification was added to specify that Partnership requires TARs for certain procedures in three categories: Non-behavioral (medical) healthcare, Behavioral healthcare, and Pharmacy. VI.B.2.: Additional language was added in paragraph regarding exhaustion of Medicare coverage to say “This requirement applies only when Medicare coverage is primary and applicable to the requested service.” VI.C.2.b.: Redundant sentence regarding the assignment of a specified number of days for an inpatient TAR was deleted because the same information was stated below at VI.C.2.b.1). VI.C.3.a.: Language regarding long term care facility was removed because Partnership does not typically see emergency or obstetrical admissions to an LTC facility. VI.C.4.b.: CCR Title 22 section 50777 was added as a regulation requiring that Medi-Cal beneficiaries apply for any available health care coverage when no cost is involved. VI.C.4.d.: Language was updated to clarify that Partnership assigns Members with ESRD to a Direct Member status (rather than issuing a lifetime TAR) to ensure that dialysis services are approved in an efficient manner. VI.C.5.: Hospice Services section was updated to include language from recent APL 25-008. VI.C.6.: Terminology was updated from Long Term Care to Extended Care nursing services. VI.D.6.a.3): Language was changed to say “as soon as possible” rather than “within 24 hours” for Partnerships attempts to obtain any missing necessary information for urgent concurrent care. VI.D.6.a.4): Language was clarified to describe how Partnership will inform the hospital Utilization Review department staff of denial decisions for urgent concurrent reviews.	Motion to approve as amended: Brian Montenegro, MD Second: Chris Swales, MD <i>Approved unanimously</i> <u>Next Steps:</u> Aug. 12 PAC

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	VI.D.6.c.1): Time frame for rendering a decision for a non-urgent pre-service review was changed from 5 business days to 7 calendar day as per CMS-0057-F. VI.D.6.c.4): Language describing a second pend time frame up to 28 days was removed as this is no longer applicable according to CMS-0057-F. VI.D.6.c.5)a): Time frame for rendering a decision for a non-urgent pre-service review was changed from 5 business days to 7 calendar days as per CMS-0057-F and option to extend a pend up to 28 days was removed. VI.E.4.: Policy language was updated to include description of IRR audits for pharmacist reviewers and lead pharmacy technicians, in addition to the IRR audits already described for physician and nurse reviewers. VII.A.: Reference to DHCS Contract was updated. VII.B.: Date of APL 21-011 was updated for revision. VII.C.: Reference for APL 22-012 was updated to reflect current APL 25-013. VII.E.: Reference to Title 42 CFR 438.114 was updated to include description VII.F.: Reference was added for Title 22 CCR 50763 and 50777 VII.G.: Reference to Title 28 CCR 1300.71.4 was updated to include description VII.H.: Reference to CMS Final Rule CMS-0057-F was updated Attachment A: • Various policy numbers and names were updated throughout. • Updated the Diagnostic Studies section H. on page 1 of policy Attachment to define and clarify three acronyms we were using at A.B. and C. as follows; A. Magnetic Resonance Angiography (MRA) B. Mass Spectrometry Imaging (MSI) C. Magnetoencephalography (MEG) and also added a Note to specify that “No TAR is required for CT scans for MRIs.” • References to APL 22-012 were updated to reflect APL 25-013 for Medi-Cal Rx Tony went through the synopsis, adding that Hospice does not typically require a TAR, but there is a process for hospice election, and language was updated to reflect this. The “major” update was the timeline for non-urgent preservice requests in alignment with the CMS Interoperability and Prior Authorization Final Rule, CMS-0057-F. This also aligns with NCQA (National Committee for Quality Assurance). The second pend timeframe up to 28 days was also removed from this policy to align with CMS-0057-F. Q/UAC voter Swales asked about VI.B.4, which states “Authorizations granted for single-encounter, outpatient medical services (dental anesthesia, sleep studies, surgical procedures, interventional pain management procedures, genetic testing, and laboratory studies) may be limited to a six-month authorization period.” Dr. Swales asked if a six-month timeframe was adequate given that patients can face scheduling delays when provider calendars are impacted. Tony said he isn’t	

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	aware of a regulatory requirement about that limit. Senior Director of Care Management Brigid Gast, RN, said she too is not aware of such a requirement. No one objected to Dr. Moore's suggestion that six months be changed to 12 months, and the policy was approved with this one amendment.	
V. Presentations		
Annual Review of UM and InterQual® Criteria – Tony Hightower, and Lorna Grote, RN, Supervisor, Long-Term Support Services, UM		
Tony explained what InterQual® is and how Partnership uses it in the UM decision making process before Lorna presented a fictional case study to demonstrate step by step how we use it to help us optimize caring for our members. Partnership utilizes 14 InterQual® criteria modules: adult and pediatric acute care, inpatient rehabilitation, long-term acute care, subacute/skilled nursing facility (SNF), durable medical equipment (DME), imaging procedures, molecular diagnostics, adult and child psychiatry, substance use disorders, behavioral health services, and Medicare post-acute and DME. InterQual® content is produced using a rigorous development process based on the principles of evidence-based medicine (EBM). InterQual® clinical content is created by the Optum research and content development staff of more than 55 research and clinical decision support specialists, including physicians, registered nurses, physician assistants, nurse practitioners, social workers, physical and occupational therapists, and other healthcare professionals. Content is peer reviewed by a 1,200+ multidisciplinary panel of board-certified, practicing clinicians. Tony commented that Partnership leverages InterQual®, but that it is not our “single source of truth” in our criteria of decision making. See also Partnership policy MPUP3139 – Criteria and Guidelines for Utilization Management – which is on today’s consent calendar for annual review and approval. Lorna shared a fictional account of a 76-year old female that collapsed in public in the presence of her daughter, who reports to ambulance and emergency room staff that her mother has had a recent diagnosis of arterial fibrillation, which ED staff then verifies in the patient’s health record. Lorna recounted this fictional patient’s vitals and list of medications at the point they are hospitalized. Lorna continued demonstrating how InterQual® might be used to best determine next steps. Entering this data into the program, she gets > 60 returns, which she narrows down to one option by choosing “stroke.” (Clicking on “notes” will suggest interventions.) Even though the patient is getting a neuro assessment every few hours, InterQual® points the reviewing clinician in a different direction. The clinician completes the review and decides on a level of care. On day two, the afib-controlled, intermittently confused, speech slurring patient exhibiting right side weakness is moved to a med/surg bed. Day three, the patient is febrile with diminished lung sounds. X-ray reveals pneumonia. The clinical reviewer can close the review or start another but elects to stay in the module and go to episode day three for adult acute care. The reviewer clicks on pneumonia and enters the patient’s current vitals and chooses all criteria the patient meets. The patient may or may not continue to meet InterQual® criteria for acute care. If at any time the still-hospitalized patient no longer meets acute criteria, the reviewer would escalate the case to a Partnership medical director for a secondary review. Neonatologist and Q/UAC voter Steven Gwiazdowski, MD, said he sees no instances in the InterQual® modules to which Partnership subscribes any reference to the neonate: the protocols under “nursery” do not seem to apply to NICU (neonatal intensive care unit). Lorna did a real-time word search in the Acute Care - Pediatrics module and got two returns. Anna Campbell said she can speak to our Optum rep for more information. Southwest Regional Medical Director Lisa Ward, MD, noted that sometimes the acute modules do reference critical care. Lorna word searched “respiratory distress in a newborn.” Neonatologist ad Q/UAC voter Brian Montenegro, MD, suggested searching “meconium aspiration.” Medical Director for Quality Mark Netherda, MD, pointed out we do have “neonatal third level.” We can send Dr. Gwiazdowski that information/training offline.		

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	Motion to continue using InterQual®: Steven Gwiazdoski, MD / Randy Thomas, MD. Unanimously approved.	
	Population Health Grand Analysis: MPNP9001 PHM Strategy and Program Description, PHM 2025 Program Impact Analysis, and Population Segmentation reports – Hannah O’Leary, Manager, Population Health	
	<u>Synopsis of Changes to MPND9001 – Population Health Management Strategy & Program Description</u> Annual update includes revisions and updated All Plan Letter (APL) references to further align the document with National Committee on Quality Assurance (NCQA) and state requirements. Many small changes for grammar, clarity, and/or readability. Highlights below: P. 9-10 Population Needs and Local Planning Requirements (CHA/CHIP) Community Needs Assessments: Noted that the Population Needs Assessment Committee was disbanded in early 2026 (March). Described 2025 requirement for county behavioral health departments to integrate into their local county CHA/CHIP processes, and that Partnership works with them to advance statewide behavioral health goals. Gave more details about the DHCS PHM Strategy Deliverable. P. 14 Population Risk Stratification & Segmentation: Clarified Partnership’s proprietary risk scoring vs. DHCS’s RSST, and the use of both in tandem in the future. P. 19-20 Future Risk Stratification, Segmentation, and Risk Tiering: Updated language to reference Medi-Cal Connect. Added that in 2026, Partnership is piloting DHCS’s RSST into operational workflows to inform member identification, outreach, and intervention planning. Described plans following the implementation of Medi-Cal Connect, and actions Partnership takes when members are identified as high risk. P. 22-23 Wellness, Prevention, and Chronic Disease Management Programs: Added language about offering of chronic disease management programs, and direct the reader to refer to the Growing Together Program charter and Basic Population Health Management chronic disease management program charter for more information. P. 26 Organizational Support for PHM: Added that providers have on-demand access to care gap data via eReports, and that the Partnership Quality Dashboard (PQD) is updated monthly. P. 29: Updated an intervention for moderate/rising risk pregnant members, saying “Offer a pay-for-performance program that incentivizes chronic disease management, which can enable purchasing POC devices.” P. 37 Practitioner Education and Training: Explained that DEI training for providers, partnership staff, and subcontractors and downstream subcontractors is called “CARES training.” Added reference forthcoming policy MCEP6004 DEI/Cultural Connection Training Policy P. 40 Informing Members About Available PHM Programs: Added “Partnership also has the ability to inform providers of various programs through Partnership’s website, various provider newsletters, in-person meetings, fax blasts, email, and flyer distribution.” Clarified that providers are informed as appropriate to support referrals and coordination of member care. P. 43 Community Engagement and Coordination of PHM Programs: Updated list of Partnership MOUs and refer to M CCP2036 Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities P. 45 Delivery-System Supports for Population Health Management: Updated this section with more detail. P. 48 Partnership Quality Dashboard (PQD): Added detail for data available through PQD, and information about QI trainings. P. 50-55 Team Roles and Responsibilities: Rewrote various department position descriptions to better mirror official job descriptions. <u>Grand Analysis</u> Hannah began her presentation by saying the results of Grand Analysis include our Population Health Impact Analysis and Segmentation report. This report mainly meets NCQA standards but there is an opportunity to include other measures to better streamline in the future. This presentation mainly goes over the results that showed statistically significant differences so not all measures will be represented. While not all of our NCQA goals were met, we are continuously striving for improvement.	

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	Population Health’s 2025 Impact Analysis looks at our Growing Together Programs (GTP) and some member experience feedback from other Partnership programs. Most of these programs had two or three outcome goals but due to time restraints, we will only be looking at one or two statistically significant goals per program. Data sources included Member demographics, encounters, immunization, DHCS medical and pharmacy claims, Member Experience survey results, and information available in PointClickCare and Essette systems. The percentages for the goals we will look at were based on adjustments as the programs have evolved since their beginning with Health Analytics. The analysis • Integrates data across clinical, claims, and member experience systems • Provides a comprehensive population health view • Risk adjusts results to reflect program evolution • Focuses on statistically significant outcomes across programs <u>GTP comprises three pillars:</u> Healthy Babies (0-30 months); Healthy Kids (ages 3-6), and the Perinatal program (covers the prenatal and postpartum period). Some definitions are required: • Engaged – members who qualified for the program, reached by phone, and opted in to program participation • Declined – members who qualified for the program, reached by phone, and opted against program participation • Left Message – members who qualified for the program, did not answer the phone, and were left a voice message encouraging a behavior • Unable to Reach – members who qualified for the program but were not able to be reached via phone • Not Referred – members who qualified for the program retrospectively, but were not identified prospectively for campaign inclusion <u>GTP: Perinatal</u> The Prenatal Program’s first goal (Increase T-DAP Rates intervention) was that 80% of members engaged in the program during the previous measurement year would have a higher percentage of Tdap vaccinations within 120 days (four months) prior to delivery. The rate of engaged members was = 79%, (725 Members of the 922 engaged). This did not meet the goal; however, • Engaged members had a statistically significantly higher rate of outcome completion (Rate = 79%) compared to members who: • Declined (Rate = 67%, Chi-Square = 16.56,, p <.0001) • Were left a message (Rate = 70%, Chi-Square = 16.17, p = 0.0001) • Were unable to be reached (Rate = 70%, Chi-Square = 12.41, p = 0.0004) • Were not referred (Rate = 69%, Chi-Square = 35.71, p <.0001) The White Engaged members had a statistically significantly lower rate of outcome completion (Rate = 70%) compared to Hispanic members (Rate = 86%, Chi-Square = 27.81, p <.0001). This data shows our current campaign seems to be making a measurable difference in the lives of our Hispanic populations. The Postpartum Program goal #1 was for 75% of engaged members to attend a postpartum visit within 60 days of delivery. Postpartum visit attendance exceeded our goal at 79% (1,696 Members of the 2,153 engaged). Engagement clearly drives better outcomes, as all other groups performed significantly lower. We also observed disparities across racial groups, highlighting an opportunity to further tailor our approach. One important finding is that White engaged members had lower postpartum visit rates compared to Asian and Hispanic members, and these differences were statistically significant. This suggests that while the program is effective overall, there are opportunities to better understand and address variation across populations. Overall, the program is effective, with increasing engagement being the key opportunity moving forward. (For context, attendance rates were consistently lower among members who declined, received only a message, or couldn’t be reached—reinforcing that direct engagement is a key driver of outcomes. Only about a third of qualifying members were actually engaged, so the takeaway is that the program works when members engage. Our next step is scaling that engagement to reach more of the population.)	

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	Postpartum Goal #2 was that 70% of newborns linked to engaged members would attend a well-child visit within 60 days of birth. The goal was met at 76%: (1,517 newborns of 2,153 engaged Members). There was no statistically significant difference in the rate between white engaged members and all other engaged races/ethnicities. <u>GTP: Healthy Babies</u> Goal #1 was for 80% of members engaged in the program to be compliant with 50% or more of their vaccinations during the program period. The goal was met (Rate = 83% or 2,589 of 3,106 engaged Members). Engaged members significantly outperformed all other groups. Large gaps observed vs declined (67%) and unable to reach (62%). The white engaged population had a statistically significant lower rate of completing vaccination compared to the Asian, Hispanic, and other / unknown populations. Goal 2: 65% of engaged members would be compliant with <i>some</i> of their well-child visits (WCV: infants <24 months). The goal was met (Rate = 89%). Equity Insight: the White engaged population had a statistically significantly lower completion rate compared to Hispanic and unknown/other populations. This highlights an opportunity to better understand barriers, tailor outreach for this subgroup, and ensure equity-focused interventions are incorporated into future efforts. Goal 3: 25% of engaged members would attend <i>all</i> the WCVs (infants <24 months). The goal was exceeded (Rate = 60% or 1,849 of 3,106 engaged Members). The 26-point gap between engaged and unreachable families reinforces that engagement is the key lever. While overall performance is strong, recurring equity differences point to opportunities for more tailored outreach. <u>GTP: Healthy Kids</u> The Healthy Kids program aims to reach all children between the ages 3 through 6 that have not had a well-child visit in the last 11 months or longer. Once identified, these members are offered an incentive to encourage the completion of their annual well-child visits prior to their next birthday. Goal: 50% of engaged members will have a WCV within 120 days of the phone call indicated “agreed to participation.” The goal <i>not</i> met (Rate = 41% or 262 of 641 engaged Members). Goal: 70% of engaged members will have a WCV between July 2024 – June 2025. The goal was met (Rate = 80% or 511 of 641 engaged Members). <u>Transitional Care Services – Member Experience Results</u> These are <u>Adult Members</u> (age > 20) discharging home from an inpatient admission with any length of stay, and who meet the criteria for high-risk transitioning members AND <u>Pediatric Members</u> (under age 21) discharging home from an inpatient stay with an admission date > 60 days from their date of birth and having any length of stay. Goal 1: 75% of members surveyed agree with each statement of the <u>Adult</u> TOC or TCS satisfaction survey. The goal was met: average score ranged from 2.77 to 2.99, exceeding the goal average of 2.5. Goal 2: 75% of members surveyed agree with each statement of the <u>Pediatric</u> TCS satisfaction survey. The goal was met: average score ranged from 2.80 to 3.00, exceeding the goal average of 2.5. <u>Complex Case Management – Member Experience Results</u> The program provides support for Members who have multiple chronic conditions, social determinants of health barriers and/or difficulty navigating the healthcare system. Goal 1: 75% of members surveyed agree with each statement of the <u>Adult</u> CCM satisfaction survey. The goal was met: average score ranged from 2.60 to 3.00, which is above the goal average of 2.5.	

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	Goal 2: 75% of members surveyed agree with each statement of the <u>Pediatric</u> CCM satisfaction survey. The goal was met: average score ranged from 2.60 to 3.00, which is above the goal average of 2.5. Summary <u>Lessons learned</u> have shown that the most effective programs utilize multiple modalities of reaching members, such as combining mailings with phone calls and with incentives to maximize engagement. Among the clinical measures, program goals were met for vaccination rates among infants enrolled in the Healthy Babies program. For utilization measures, we met our goal of newborns attending well child visits who are linked to members engaged in the prenatal and postpartum program. We also met the goal for Members to attend postpartum visits among members enrolled in the postpartum program. Furthermore, we met the goal for members to attend well child visits who were enrolled in the Healthy Babies program and one of the goals for kids to attend well child visits who were enrolled in the Healthy Kid’s program. An interesting finding was the white population had statistically significant lower rates for certain well-child attendance visit goals, and postpartum visits when compared to other racial groups. Under the Prenatal Program, there was no statistical significance between the white population and other non-white populations for the linked newborns to well child visits measure. As for Member Experience measures, we met all goals under both the Transitions of Care/Transitional Care Services and Complex Case Management programs. A significant finding that has carried on through 2025 is feedback from members about the ongoing challenges around scheduling well child visits due to the lack of provider availability to serve the member population in a timely manner. Q/UAC Voters’ Comments and Concerns / Partnership Responses Dr. Steven Gwiazdowski wondered if it would be helpful to do a regression analysis to better understand the social/economic drivers and help Partnership resolve racial/ethnic inequalities. Dr. Moore said Health Services Officer Mohamed Jalloh, Pharm.D., does a deeper analysis of the HEDIS® data in the fall. Dr. Jalloh said we have seen these same trends the past four years in our disparity analyses. He offered to share some hypotheses offline. Dr. Brian Montenegro said that as a pediatrician and neonatologist he is “uncomfortable” with some of the postpartum numbers. “I have a saying for our NICU moms: ‘If mom is not okay, then nobody in the house is okay.’ I find it concerning and maybe even horrifying that one in five moms are not being seen within 60 days. There are quality studies by ACOG (American College of Obstetricians and Gynecologists) that set a 90% goal. I would advocate for that. I don’t know if it’s an access or transportation issue, but in a First World country, 90% is what we should target.” Director of Quality Measurement Kristine Gual responded that the HEDIS® figures Q/UAC will see July 15 will be “significantly higher” in the HEDIS® measure, albeit that is computed via a different methodology. “We are more in line with that 90% you are looking for and even higher in some areas. It is a Plan focus to bring those Members up to the rates of the Plan-wide population.” Dr. Moore made additional comments. Dr. Townsend we are working across the provider network to get postpartum moms in for a first visit within three weeks and a second visit before 12 weeks. Senior Director of QI Isaac Brown said we are working on transportation solutions for rural Modoc County moms to get them to postpartum visits. Dr. Moore added he and Dr. Townsend are working on ways to empower rural area PCPs to provide some postpartum services. <i>Motion to approve the Grand Analysis reports and the Program Description: Brian Montenegro, MD / Second: Robert Quon, MD. Unanimously approved.</i>	
	The PHM Work Plan was included in the packet as FYI. No vote required.	
	VI. Adjournment to additional meeting scheduled for 7:30 – 9:00 a.m. June 17, 2026	

Dr. Moore adjourned the meeting at 9:04 a.m.

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

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Signature of Approval: _____ Date: _____ Chief Medical Officer Robert Moore, MD, MPH, MBA		

<u>QUALITY INCENTIVE PROGRAMS (QIPs)</u>	
PROGRAM	UPDATE
PRIMARY CARE PROVIDER QUALITY INCENTIVE PROGRAM (PCP QIP)	Program Overview Pay for performance program incentivizing improved performance on Clinical, Non-Clinical, and Unit of Service (UOS) measures in the Primary Care setting. Program Update • Payments for the 2025 PCP QIP were sent the week of May 25th before the end of May deadline. The PCP QIP team is currently working on measure development for MY2027 which is earlier than prior years due to the new contract amendment requirements. Provider comment period will be earlier this year so it is important that providers be prepared to review measures and offer feedback before Q3 advisory group.
PALLIATIVE CARE QUALITY INCENTIVE PROGRAM (PALLIATIVE CARE QIP)	Program Overview Pay for performance program which offers significant financial incentives to support and improve the access to and quality of palliative care provided by our contracted palliative care providers. Program Update • The Palliative Care QIP has wrapped up payment for 2025 Measure Period II (July – December) with a total payout of \$1,450,200.
PERINATAL QUALITY INCENTIVE PROGRAM (PQIP)	Program Overview The Perinatal QIP offers financial incentives to participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers providing quality and timely prenatal and postpartum care to Partnership members Program Update Program Update Program Update • The Fostering Connections with Perinatal Providers WebEx series kicked off in April. Dr. Townsend facilitates these meetings with perinatal providers to touch base on current progress in the PQIP and describe the services available to pregnant and postpartum members through Partnership. The meetings between April and September will occur with providers that need extra support to improve perinatal services. • The 6-month measure set was approved by PAC in April. Utilizing data from DataLink is option one for Measures 3 and 4, therefore a team is looking into the best way to use data from DataLink to determine timely prenatal visit counts for the Perinatal QIP 6-month bridge period that will start July 1-December 31, 2026.
ENHANCED CARE MANAGEMENT QUALITY	Program Overview

INCENTIVE PROGRAM (ECM QIP)	The ECM QIP offers financial incentives to motivate, modify, and improve the health outcomes of seven identified groups of individuals by standardizing a set of care management services and interventions Program Update ECM QIP is currently under measurement development and is working with the ECM team to track any programmatic updates.
HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)	Program Overview The Hospital QIP offers financial incentives to improve performance related to Readmissions, Advance Care Planning, Clinical Quality, Patient Safety, Operations and Efficiency, and Patient Experience Program Update The HQIP 6-Month Bridge Set covering the period of July 1 – December 31st was approved by PAC in May. The Bridge Set is an abbreviated set to help us transition to a calendar year program starting January 2027. No measures were added to the set, but three were removed as they were not compatible with the 6-month timeframe. The 2027 measure set will go to IQI in June and PAC in August. Many Hospitals have worked to improve their 7-day follow up rates. The current average rate is 39.6%, which is above the full points target for the measure. Substance Use Disorder Referrals are also up with the average being 40.6% of qualifying members receiving follow-up MAT or prescription for Buprenorphine within 60 days of discharge.
EXTENDED CARE FACILITY INCENTIVE PROGRAM (EXT QIP)	Program Overview The EXT QIP offers financial incentives to support and improve the quality of long-term care provided to our members, with measures in the following domains: Clinical, Functional Status, Resource Use, and Operations / Satisfaction. Program Update - The EXT team has been sending friendly reminders to providers to submit their QAPI plans and attestation forms. This month, our team will host a Technical Work Group session to gather insights on potential updates for the upcoming measurement period. - Additionally, we are collaborating with the Provider Relations team to organize EXT luncheons for our providers. These luncheons will serve as an opportunity to strengthen engagement, provide program updates, share best practices, and address questions in a more interactive setting. The sessions will also create space for open dialogue, allowing providers to share feedback, highlight challenges, and discuss strategies to improve performance.
<u>QUALITY DATA TOOLS</u>	
TOOL	UPDATE

PARTNERSHIP QUALITY DASHBOARD (PQD)	Program Overview The Partnership Quality Dashboard (PQD) is a Tableau designed to inform, prioritize, and evaluate quality improvement efforts. Dashboards and performance metrics built into the PQD provide the ability to track and trend QIP data. Program Update No new updates for PQD or eReports in June following the PQD launch in May.
EREPORTS	Program Overview eReports is a web application that allows providers to see their quality metrics in Partnership's PCP QIP program. eReports updates twice a week for near real-time visibility to quality metrics while PQD refreshes monthly for historical trending. Program Update No new updates for PQD or eReports in June following the PQD launch in May.
<u>PERFORMANCE IMPROVEMENT (PI)</u>	
ACTIVITY	UPDATE
STATE MANDATED WORK: PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE	Program Overview All plans in California are required to conduct PIPs as part of their agreements. DHCS has assigned Partnership two PIPs: a non-clinical PIP for BH and a disparity PIP. DHCS can also require plans to do mandated improvement PDSA projects Program Update The final submission for the non-clinical PIP is scheduled for August 6, 2026
QUALITY MEASURE SCORE IMPROVEMENT	Program Overview Internal measure-focused workgroups, which bring together perspectives across Partnership's services delivery continuum with the goal of strategically improving measures that align with the strategic priorities of Partnership HealthPlan. Current Priority Measures: - Child and Adolescent Well Care Visits (WCV) - Adolescent Immunizations (IMA-2) - Controlling High Blood Pressure (CBP) - Glycemic Status Assessment for People with Diabetes (GSD) - Timely Prenatal Care (PPC-Pre) Workgroup Updates Pediatrics: Continuing interviews with high performing practices in WCV and IMA. Started outreach to practices with low performance in DEV to provide one-on-one education based on their specific challenges. TFL data received from DHCS and under review by the HEDIS team. Completed W30+6 pilot in Siskiyou County and looking for another rural hospital to partner with. Women's Health & Perinatal: Providers have been identified for outreach and engagement due to low PPC Pre Timeliness of Prenatal care performance and high

	third next available appointments. Fostering Connections provider meetings are in progress. Shasta County perinatal care coalition planning is underway with representatives from 3 health centers. • Chronic Disease: Using county-level data and a partnership with UC Davis, we support Tehama County clinics with targeted education, technical assistance, and workflow improvement for colorectal cancer screening. The team meets monthly to review progress and community outreach opportunities. Next meeting for Tehama County will be held June 8th, with an introduction into Butte County meeting happening 5/29/26. • Behavioral Health: BH workgroup meetings have been on a temporary hold since April as we focus on improving data and aligning with the regional model. Department updates are being shared via email.
IMPROVEMENT ACADEMY	Program Overview The Partnership Improvement Academy launched in 2014 to offer various programs which provide training and technical assistance designed to help practices optimize population health, enhance the patient experience, promote provider and care team satisfaction, and foster a culture of continuous quality improvement. These programs are designed for a variety of audiences, including clinicians, administrators, and staff to gain quality improvement expertise from industry leaders and peers. Current Offerings QI Project Management Training Program The Quality Improvement (QI) Project Training Program is designed to help provider organizations and community partners strengthen their skills to lead and manage QI initiatives by offering training and use of standardized tools, templates, and best practices. The program features a 6-session webinar series delivered over 12 weeks, covering all phases of the project life cycle and focuses on applying those methods to real-world QI efforts. Program Update • Following the successful conclusion of the Spring, a comprehensive evaluation is currently underway. The final analysis is slated for completion by 06/30/2026, and those findings will be leveraged to drive modifications for the upcoming Fall cohort beginning 09/01/2026. • Fall 2026 cohort kicks off on 9/1. Registration is open through 08/25/2026. Improving Measure Outcomes Webinar Series

	This series is designed to help Quality Improvement teams turn knowledge into action. These sessions focus on Partnership’s Primary Care and Perinatal Provider Quality Incentive Program (QIP) measures, offering practical strategies to close care gaps, advance health equity, and improve clinical outcomes. Each session highlights proven strategies and best practices from peer clinics that are actively achieving measurable improvements in patient care. Program Update - Attendance at the 2026 Improving Measure Outcomes (IMO) webinars, occurring February through April, ranged from 52-72 attendees, with each session representing 31-45 unique organizations. Of attendees who completed the post session evaluations for all six webinars, 100% selected <i>Strongly Agree</i> or <i>Agree</i> when asked if the webinar was relevant and useful. ABCs of Quality Improvement Program Overview The ABCs of Quality Improvement (QI) is a full day in-person training designed to introduce participants to key QI methodologies with a specific focus on the Model for Improvement – a widely used framework for driving measurable change in health care settings. Program Update - The ABCs of Quality Improvement was offered via three in-person sessions this fiscal year. Attendance ranged from 24-63 attendees, representing 16-22 unique organizations. Of attendees who completed post session evaluations, 95%-100% of respondents were <i>Extremely Satisfied</i> or <i>Satisfied</i> with this course. Microlearning Program Overview These short, focused modules deliver key concepts in easily digestible formats. Program Update - The Pre-visit Planning microlearning module is in final production and nearing completion. This microlearning will focus on how proactive chart review and early outreach can reduce day-of disruptions, support quality care, reduce care gaps, and enhance the patient and staff experience.
JOINT LEADERSHIP INITIATIVE (JLI)	Program Overview The Performance Improvement team facilitates Joint Leadership Initiative meetings with seven parent organizations across the Partnership network. Four of the seven organizations are in our expansion counties (Chico and Auburn Regions). This is a quality improvement strategy to collaborate with the largest parent organizations

	providing primary care who did not earn at least 75% of their PCP QIP scores in the previous year. This number could change once final 2025 PCP QIP scores are finalized. Update No meetings scheduled for June
REGIONAL IMPROVEMENT MEETINGS	Program Overview Regional Quality Improvement meetings are held quarterly at each of our 6 regional offices (Eureka, Redding, Chico, Auburn, Fairfield, and Santa Rosa) or online with the goal of bringing together regional health center quality leaders to share and discuss strategies to improve measures that are regionally important and learn from Partnership regarding any program changes and/or priorities. Update Santa Rosa and Fairfield Regions – - Napa/Solano/Yolo/ meeting scheduled for 6/2/2026 - Santa Rosa meeting scheduled for 6/2/2026 - Santa Rosa Small Health Center Quality Meeting scheduled 6/25/2026 Chico and Auburn Regions – - No meetings scheduled for June Redding and Eureka Regions – - Eureka Region meeting scheduled for 06/09/2026 - Redding Region meeting scheduled for 06/02/2026

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

QI PROGRAM & PROJECT MANAGEMENT

ACTIVITY	UPDATE
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS® (CAHPS) PROGRAM -MEDI-CAL PRODUCT LINE & ORG GOALS – FY 24/25 MEMBER EXPERIENCE AND ACCESS ORG GOALS – FY 25/26 MEMBER EXPERIENCE	Program Overview Oversees NCQA Accreditation requirements for Member Experience (ME) 7 (Elements C and D). Conducts annual regulated CAHPS® surveys for Medi-Cal members and non-regulated surveys to assess patient experiences. Results drive improvements in care quality and member experience. Program Updates CAHPS® Regulated Measurement Year (MY) 2025 / Report Year (RY) 2026 Survey - Our certified survey vendor, Press Ganey, has routed the regulated survey data to NCQA for official validation. Once data integrity is confirmed, the finalized raw survey results will be available. - Preliminary Year-Over-Year Survey Respondent Rate Comparisons:

	• Adult Population ○ 2024-2025 - 15.4% (3,375/511) ○ 2025-2026 - 14.2% (2,700*/380) *Sample size reduced to from 3,375 to 2,700. • Child Population ○ 2024-2025 - 15.8% (5,000/783) ○ 2025-2026 - 14.1% (5,000/703) • As a proactive step, the Partnership CAHPS team engaged ACAP CAHPS Collaborative participants, including sister plans, to assess broader market trends. Feedback indicated a shared decline in response rates across plans, suggesting this was not an isolated trend. At a high level, this downward trend appears to be influenced by factors such as increasing survey fatigue and recent Medi-Cal eligibility changes, which may be impacting overall member engagement. <i>Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)</i> • Fiscal Quarter 4: (On-Track Estimated Complete 80%): Goal activities continue through the end of this month, led by champions from four departments: Transportation, Member Services, Population Health, and Quality Improvement. • For more insights on goal progress and milestone accomplishments, please visit the OpEx PMO internal goal dashboard (Partnership4Me, under Smart Links).
EQUITY & PRACTICE TRANSFORMATION PROJECT	Program Overview The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative aimed at advancing health equity while reducing COVID-19 driven care disparities. During the three (3) year program, practices receive payments for achieving population health milestones that enable the implementation of improvements across their infrastructure, data capabilities and care management processes to promote patient well-being, health equity and whole-person care. Currently, 22 providers are participating in the EPT Program, with total estimated funding of \$13.3 million over the three-year project period. These providers are expected to receive payments tied to milestone achievements that support sustainable practice transformation. The last and final opportunity to submit eligible deliverables for milestone achievement is in November 2026 when the program concludes. Payments for the November 2026 successfully completed milestones will be paid out early 2027. Program Updates • PHLC established minimum requirements for providers to remain in the program. Deliverables, due 05/01/2026, included: ○ 2026 PhmCAT ○ Milestone 3: Empanelment Policy & Procedure ○ Milestone 4: Data Governance & HEDIS Policy & Procedure

	- o Milestone 6: Data Implementation Plan - o Milestone 8: Disparity Reduction Plan - o One Model of Care Document (Milestones 9-12) • Provider Portal was open for deliverable submissions beginning 04/01/2026 and closed on 05/01/2026 at 5:00 PM PST. • Currently 3 providers are at risk for being removed from the program, for not submitting the required deliverables by 05/01/26: Chapa-De Indian Health Program, Baechtel Creek Medical Clinic and K'ima:w Medical Center • Notices went out to these providers, and they were given a deadline extension until 06/19/2026 to complete outstanding deliverables. • PHLC is working on a deliverable submission report for the May 2026 deliverables, which should be available by June 2026. • The quarterly CaTS report for MY 07/31/24-06/30/25 was completed and submitted, by Partnership, to Pop Health Learning Center (PHLC) by the due date, 04/30/2026. • The next CaTS Report for MY 10/1/24-09/30/2025 will be due on 07/31/2026.
EXPANDED COUNTIES REINVESTMENT IN QUALITY (E-RIQ)	Program Overview <i>The Expansion Counties Reinvestment in Quality (E-RIQ) program is a strategic \$2 million investment to improve health outcomes and member experience across the ten expansion counties: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Tehama, Yuba, and Sutter.</i> <i>Funding is allocated through two pathways:</i> • Phase I: \$500,000 (\$50K allocated to each county) to strengthen community-based engagement and access across priority focus areas • Phase II: \$1.5 million for Provider opportunities to drive measurable improvements in quality priority measures through targeted initiatives and activities.
PREVENTIVE CARE BRIDGE PROJECT (FORMERLY: LOCUM PILOT INITIATIVE)	Overview of the Preventive Care Bridge Project The Preventive Care Bridge Project was developed as a short-term solution to address access challenges by providing targeted locum support with the goal of improving performance on preventive care measures, specifically well-child visits and cervical cancer screenings. By proactively guiding providers to maximize the locum resources through clear onboarding, scope alignment, and data tracking, the pilot explores a potential model for supporting improved measure performance, reducing withholds and sanctions associated with unmet benchmarks, and enhancing the overall member experience. Project Update • The project resulted in the development of a set of <i>Locum Tenen Implementation Tools</i> and other resources designed to help providers more effectively integrate locum staffing into preventive care models. These resources are published on the Partnership website for ongoing access and use. The implementation model and

	supporting tools are also being shared through presentations at regional quality meetings to promote awareness and adoption across provider organizations.																																													
MOBILE MAMMOGRAPHY PROGRAM	Program Overview Aims to boost breast cancer screening (BCS) rates for providers performing below the 50th percentile benchmark. Partnership collaborates with Alinea Medical Imaging and providers to host Mobile Mammography events, helping members complete preventive screenings. Program Updates - Event Days for FY 25/26 Q4 (April – June) <table><tr><th colspan="5">Current Event Days 04/01/2026 – 06/30/2026</th></tr><tr><th>Region</th><th># of Provider Organizations</th><th># of Provider Sites</th><th># of Provider Event Days</th><th># of Community Event Days</th></tr><tr><td>Auburn</td><td>2</td><td>3</td><td>3</td><td>0</td></tr><tr><td>Chico</td><td>2</td><td>7</td><td>7</td><td>0</td></tr><tr><td>Eureka</td><td>9</td><td>16</td><td>19</td><td>0</td></tr><tr><td>Fairfield</td><td>3</td><td>4</td><td>4</td><td>0</td></tr><tr><td>Redding</td><td>10</td><td>11</td><td>11</td><td>1</td></tr><tr><td>Santa Rosa</td><td>1</td><td>1</td><td>1</td><td>0</td></tr><tr><td>Plan Wide</td><td>27</td><td>42</td><td>45</td><td>1</td></tr></table> * Totals may not match across columns due to provider orgs hosting event days at multiple sites and regions within the quarter. ** Community event days are reported separately and not included in provider totals. - Scheduling for FY 26/27 Q1 (July - September) is currently in process.	Current Event Days 04/01/2026 – 06/30/2026					Region	# of Provider Organizations	# of Provider Sites	# of Provider Event Days	# of Community Event Days	Auburn	2	3	3	0	Chico	2	7	7	0	Eureka	9	16	19	0	Fairfield	3	4	4	0	Redding	10	11	11	1	Santa Rosa	1	1	1	0	Plan Wide	27	42	45	1
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Redding	10	11	11	1																																										
Santa Rosa	1	1	1	0																																										
Plan Wide	27	42	45	1																																										
PARTNERING FOR PEDIATRIC LEAD PREVENTION PROGRAM (PPLP)	Program Overview Provides LeadCare II POC devices to qualified providers and enrolls them in a year-long program with coaching and education. Offers lead poisoning prevention education to all and collaborates with local agencies. Program Updates - Three new provider organizations were distributed a total of 5 LeadCare II POC devices. 1 device for Achieve Community Health Center 2 devices for Elica Health Centers																																													

	- o 2 devices for Pediatric Medical Associates • One provider organization has an MOU in development to receive one LeadCare II POC device. - o 1 device for Midha, Sanjiv MD
EXACT SCIENCES: PROMOTING COLORECTAL CANCER SCREENINGS	Offering Overview Providers can place care-gap orders for Cologuard kits directly through Exact Sciences or via facilitated orders through Partnership to eliminate the minimum requirement of 200 members. Any provider interested in more information can fill out the Partnership's Cologuard Facilitated Order Interest Form on our Cologuard Care-Gap Orders page. Program Updates Partnership Facilitated Orders • The next Facilitated Order is scheduled to launch on 07/20/2026 and is aligned with QIP's timeline for addressing 2026 and 2027 PCP QIP Measures .
QI TRILOGY PROGRAM	Program Overview Annually, the Quality Improvement (QI) department updates three core documents – often referred to as the QI Trilogy Documents, that collectively describe the program structure, priorities and performance. The Program Description outlines the overall QI framework, the Work Plan details active and planned initiatives aligned with strategic priorities, and the Program Evaluation assesses progress, outcomes and opportunities for improvement. Program Updates • Updates and internal review of the 2026–2027 QI Program Description have been completed. The Program Description has been submitted to the NCQA Consultant (MHR), and feedback has been provided. Final edits are complete and the document is now ready for Committee and Board review. • Submissions for the 2025-2026 QI Program Evaluation were due 05/29/2026 and internal reviews are underway. • Initial notices for the 2026-2027 QI Work Plan were sent 06/04/2026 with submissions due 06/18/2026. • Live QI Trilogy trainings have been scheduled with invites sent to Sponsors, Business Owners, and Contributors: ▪ 2025-2026 QI Program Evaluation 05/13/2026

	2026-2027 QI Work Plan (Goal Submissions) is scheduled for 06/04/2026 at noon
SAGE GRANT	Program Overview The <i>Systems Advancement for General EHR</i> (SAGE) Grant is designed to assist healthcare providers in implementing or upgrading their EHR systems, to help modernize and enhance their ability to deliver high-quality, efficient, and member-centered care. This grant will help providers overcome common barriers to EHR adoption by offering financial support and implementation guidance. The recipient of the SAGE grant, Kimaw Medical Center, signed the agreement on 12/05/2025. The first payment installment of \$125,000 was initiated. The SAGE Grant team will continue to conduct regular check-ins and monitor implementation milestones. The SAGE Grant Timeline can be found here. Program Updates The January-June Progress Check-In with Kimaw and Partnership is scheduled on 06/15/2026.
D-SNP MEDICARE	<u>D-SNP</u> Program Overview The D-SNP Quality team is responsible for 1) Development and finalization of the Model of Care document, 2) Management of Partnership's CMS Medicare Star quality program, and 3) Developing D-SNP readiness for all Quality Improvement teams. The team has revised QI Department D-SNP Project plans to reflect the launch postponement with vendor-related projects TBD. All QI D-SNP related project plans can be found on the Partnership Advantage Share Point Project plan site. The D-SNP team has developed introductory level educational content for QI team members about Medicare, dual special needs programs and Medicare Stars. The content is being reviewed by T&D as we prepare to develop it into a series of micro learnings.
ACTIVITY	UPDATE
<u>QUALITY ASSURANCE AND PATIENT SAFETY</u>	
ACTIVITY	UPDATE

POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 4/27/2026 TO 5/29/2026	Program Overview To identify, report, and manage Potential Quality Issues (PQI), to determine opportunities for improvement in the provision of care and services to our members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity. Program Update • 32 referrals were received with 27 coming from Grievance and Appeals, 2 from Utilization Management, 1 from Care Coordination, 1 from Pharmacy and 1 from an Associate Medical Director • 25 cases were processed and closed • 123 cases are currently open • 2 cases were discussed at Peer Review Committee (PRC) on 5/20/2026 and there are 3 cases awaiting PRC review. • 1 case was sent to an external Subject Matter Expert (MRIOA) for review • Two nurses from the Member Safety team attended the Cal HQ Kickoff: Partnering for Progress meeting in Sacramento on April 30, 2026. The meeting focused on strengthening collaboration between health plans and hospitals to improve quality outcomes by reducing healthcare acquired infections statewide.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR)	Program Overview Site Review and Medical Record Review performed for monitoring of providers. Program Update • No new updates

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	Program Overview HEDIS is used to evaluate clinical quality in a standardized way. This program shares performance measurement rates with the intent of improving the quality of care delivered to members. Program Update • MY2025 HealthPlan Accreditation (HPA) final rates were approved by our HPA Auditor, the HPA audit is locked. • MY2025 Managed Care Accountability Set (MCAS) final rates have been submitted and awaiting auditor approval. • Medical Record Review and Validation audit passed at 100% for both HPA and MCAS with first submission. • The Annual Summary of Performance reports will be posted on our Partnership website in August 2026.

HEDIS® Program Overall	Program Updates No new updates
<u>NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION</u>	
ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	Program Overview The State of California requires all Managed Care Plans (MCPS) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years, and reporting HEDIS and CAHPS results every year for a Health Plan Rating (HRP) score. Partnership's next HPA Renewal Survey is scheduled for 09/15/2026. Program Update - MY2025 final rates have been approved and locked for NCQA HealthPlan Accreditation audit. - MY2025 final rates for the DHCS Managed Care Accountability Set (MCAS) audit have been submitted and are pending auditor approval. Final rate approval is anticipated by 06/15/2026. - The Medical Record Review and Validation (MRRV) audits for both HPA and MCAS passed at 100% with first submission.
NCQA Health Outcome Accreditation (HOA)	Program Overview The State of California requires all Managed Care Plans (MCPs) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years. Partnership's next HOA Renewal Survey is tentatively scheduled for 05/16/2028. Program Update No new updates
NCQA Health Plan Accreditation (HPA) and Health Outcomes Accreditation (HOA)	No new updates

**PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE
MEETING AGENDA**

Date: Tuesday, July 7, 2026

Time: 1:30 - 3:30 p.m.

Locations:

Napa/Solano (Fairfield West)
Trinity Alps (Redding – Airpark)

To Join by Webex:

<https://partnershiphp.webex.com/meet/iqi>
Meeting # 2631 319 6924

To Join by Telephone:

Toll Free: 844-621-3956
Access Code: 2631 319 6924

	Item	Lead	Time	Page #		
I.	Call to Order//New Staff Introduction(s)/Announcements/Approval of Minutes					
I	Approval of Internal Quality Improvement (IQI) Committee Meeting Minutes of June 9, 2026	Mark Netherda, MD	1:30	5 – 12		
2	Acknowledgment and Acceptance of draft minutes of the - May 28 Member Grievance Review Committee (MGRC) - April 29 Over/Under Utilization Workgroup			13 – 28		
II.	Old Business					
1	MPUP3111 – Pulmonary Rehabilitation – pulled at June 15 Q/UAC – synopsis of change begins on p. 29		1:37	31 – 36		
III.	New Business – Consent Calendar					
Health Services Policies	Consent Calendar	All	1:42	37		
	Pharmacy					
	MCRP4064 – Continuation of Prescription Drugs			39 – 44		
	MPRP4065 – Drug Utilization Review (DUR) Program			45 – 48		
	Population Health Management					
	MPND9002 – Cultural & Linguistic Program Description – Attachment D – updated by translation vendor after April PAC approval; updated PD cover page begins on p. 49			49 – 62		
	Quality Improvement					
	MCQP1025 – Substance Use Disorder (SUD) Facility Site Review and Medical Record Review			63 – 121		
	MPXG5009 – Lactation Clinical Practice Guideline			123 – 128		
	Utilization Management					
	MCUG3007 – Authorization of Ambulatory Procedures and Services			129 – 132		
	MCUG3134 – Hospital Bed/Specialty Mattress Guidelines			133 – 138		
	MCUP3015 – Family By-Pass Services			139 – 143		
	MCUP3114 – Physical, Occupational and Speech Therapies			145 – 150		
	MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21			151 – 163		
	MCUP3141 – Delegation of Inpatient Management			165 – 170		
	MPUP3042 – Technology Assessment			171 – 176		
	MPUP3138 – External Independent Medical Review			177 – 180		
	Non-HS			Member Services		
				MC344 – American Indian/Alaska Native Right and Protections – NEW TITLE		181 – 182

	Item	Lead	Time	Page #
	Provider Relations			
	MPPR207 – Annual Physician Satisfaction Survey –			183 – 184
	MPPRGR210 – Provider Grievance – <i>clean copy begins on p. 189</i>			185 – 191
	Network Services			
	MPNS208 – Provider Notification of Provider Termination, Site Closure or Change in Location Information – <i>note new alpha designation as policy moves from Provider Relations to Network Services</i>			193 – 198
IV.	New Business – Discussion Policies			
	Synopsis of Changes		--	199 – 201
1th Services Policies	Quality Improvement			
	MPXG5008 – Clinical Practice Guideline: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing	Jeffrey DeVido, MD	1:50	203 – 235
	Utilization Management			
	MPUG3025 – Insulin Infusion Pump and Continuous Glucose Monitor Guidelines	Tony Hightower, CPhT	2:00	237 – 253
	MPUP3039 – Direct Members		2:10	255 – 267
V.	Presentations			
1	Quality Improvement Update	Issac Brown, MHA/MBA	2:20	269 – 282
2	Enhanced Care Management Quality Incentive Program (ECM QIP) 2025 Evaluation	Deanna Watson	2:30	283 – 294
3	Healthcare Effectiveness Data Information Set (HEDIS ®) Annual Summary of Performance - MY2025 Managed Care Accountability Set (MCAS) – <i>begins on p. 313</i> - MY2025 HealthPlan Accreditation (HPA) – <i>begins on p. 367</i>	Kristine Gual / Sue Quichocho	2:45	295 – 435
	Adjournment by 3:30 p.m. to 1:30 p.m. Tuesday, Aug. 11, 2026			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE *Extra-Curricular* MEETING MINUTES
Tuesday, July 7, 2026 / 1:31 – 3:33 PM

<u>Members Present:</u> Beard, Alyssa, RN, Manager of CC Regulatory Performance Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations Brincko, Aaron, Director of Provider Relations Brown, Isaac, MHA/MBA, Senior Director, Q & PI Brunkal, Monika, RPh, Associate Director of Population Health Campbell, Anna, MPH, Policy Analyst, Utilization Management Devan, James, Director of Quality Improvement, QI DeVido, Jeffrey, MD, Behavioral Health Clinical Director Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI Hightower, Tony, CPhT, Associate Director, UM Regulations Innes, Latrice, Compliance Manager, Grievance & Appeals	Jalloh, Mohamed, Pharm.D, Dir. of Health Equity (Health Equity Officer) Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Services Klakken, Vicky, Regional Director (NW-Eureka) Krznarich, Jackie, RN, <i>Interim</i> Mgr, Member Safety – Quality Inspections Matthews, R. Douglas, “Doug,” MD, Regional Medical Director (Chico) Netherda, Mark, MD, Medical Director for Quality (Vice Chair) Newman, Rachel, RN, BSN, Associate Director, Credentialing O’Connell, Lisa Brundage, MHA, Director, Enhanced Health Services Townsend, Colleen, MD, Regional Medical Director (SE-Fairfield) Villasenor, Edna, Senior Director, Member Services and Grievance Vaisenberg, Liat, Director of Health Analytics Ward, Lisa, MD, Regional Medical Director (SW-Santa Rosa)
<u>Members Absent:</u> Andrews, Leigha, Regional Director (SW) Ayala, Priscila, Director of Network Services Barresi, Katherine, RN, BSN, PHN, Chief Health Services Officer Bjork, Sonja, JD, Chief Executive Officer Bontrager, Mark, Senior Director of Behavioral Health, Health Services	Davis, Wendi, Chief Operating Officer Jensen, Annika, RN, Assoc. Dir. of Clinical Integration, Care Coordination Leung, Stan, Pharm.D, Director of Pharmacy Services Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair) Randhawa, Manleen, Senior Health Educator, Population Health Ruffin, DeLorean, DrPH, Director of Population Health
<u>Guests:</u> Akintan, Folo, MBBS/MD, MPH, MBA, Epidemiologist, Pop Health Allen, Angier, Sr. Data Scientist I, Finance Allegro, Baylie, Compliance Analyst, Grievance & Appeals Arguello, Amanda, Lead Trainer, Network Services Beltran-Nampraseut, Athena, Program Manager II, QI (PCP QIP) Bikila, Dejene, Manager of Data Science, Finance Chebolu, Radha, Sr. Health Data Analyst II, Finance Cunningham, Aryana, Policy Analyst, Care Coordination Durst, Jennifer, Senior Manager of Performance Improvement, QI Elder, Alaina, Mgr of Provider Network Teams, Provider Relations Flournoy, Candis, Project Manager II, QI Godinez, Juan, Improvement Advisor, QI Isola, Brandy, Manager of Performance Improvement, QI (Chico) Lee, Donna, Manager of Claims, Claims Ling, Samuel, Sr. Health Data Analyst I, Finance Mednick, Christy, Sr. Health Data Analyst I, Finance Moraghebi, Roudabeh, Manager of Health Analysts, Finance Morris, Matthew, MD, Regional Medical Director (Auburn) Newell, Amber, CPhT, Program Manager I, QI Nguyen, Tom, Manager of Health Analytics, Finance	Quichocho, Sue, Manager of Quality Measurement, QI Power, Kathryn, Regional Director (SE) Rathnayake, Rasitha, Sr. Health Data Analyst I, Finance Rednic, Hanny, Program Manager I, UM Robertello, Kimberly, Senior Medicare QI Program Manager, QI Romero, Liz, Improvement Advisor, QI Sackett, Anthony, Program Manager II, Member Experience, Administration Salehi, Tiphannie, Senior Health Data Analyst II, Finance Seale, J’aime, PR Lead, Network Services Sivasankar, Shivani, Sr. Data Scientist, Finance Smith, Christine, Community Health Needs Liaison, Population Health Stark, Rebecca, Regional Manager (Chico) Stites, Jaylyn, Program Manager II, Provider Relations Thomas, Andrea, Project Manager I, QI Thomas, Penny, Senior Health Data Analyst I, Finance Vance, Brooke, Program Manager I, Network Services Watkins, Kory, MBA-HM, Director, Grievance & Appeals Watson, Deanna, Program Manager I, QI (ECM QIP) Wellander, Emily, Improvement Advisor, QI (Santa Rosa) Yu, Fei, Sr. Data Scientist I, Finance Zhao, Li Sr. Health Data Analyst I, Finance

O’Leary, Hannah, MPH, CHES, Manager of Population Health		Zhao, Monika, Data Analyst, Finance																										
AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION																										
I. Call to Order - Announcements - Approval of Minutes	Medical Director for Quality Mark Netherda, MD, called the meeting to order at 1:31 p.m. from the Fairfield-West office. Dr. Netherda welcomed Rachel Newman, RN, and Jackie Krznarich, RN, in their new roles. Rachel now serves as the Associate Director of Credentialing in Network Services; Jackie assumes Rachel’s former duties as Manager, Member Safety – Quality Inspections. New employee Irem Conery introduced herself as the Director of Member Experience, the head of a new team now operating under Administration. - The June 9 IQI Minutes were approved as presented. <i>Acknowledgment and Acceptance of draft minutes of the</i> - May 28 Member Grievance Review Committee (MGRC) - April 29 Over/Under Utilization Workgroup	Motion to approve IQI minutes: Isaac Brown Second: Lisa O’Connell Motion to accept the other draft minutes: Isaac Brown Second: Kristine Gual																										
II. Old Business – MPUP3111 – Pulmonary Rehabilitation <i>Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations</i>																												
Quality/Utilization Advisory Committee voter Randolph Thomas, MD, concerned that three sets of Medi-Cal coverage criteria seemed out of sync with one another, pulled this policy from the June 15 Q/UAC consent calendar. The first two sets of criteria are now combined into VI.E.1. and the second set is now defined for Members with moderate functional pulmonary disability at VI.E.2. Attachment A is further modified to clarify that the physician filling out the form should state the diagnosis. VI.E.1 - Chronic pulmonary conditions eligible for pulmonary rehabilitation include, but are not limited to, the following: <table><tr><td>a. Chronic Obstructive Pulmonary Disease (COPD) – chronic bronchitis or emphysema</td><td>n. Radiation pneumonitis</td></tr><tr><td>b. Interstitial lung disease or idiopathic pulmonary fibrosis</td><td>o. Ankylosing spondylitis</td></tr><tr><td>c. Alpha-1-antitrypsin deficiency</td><td>p. Bronchopulmonary dysplasia</td></tr><tr><td>d. Asbestosis</td><td>q. Guillain-Barre syndrome or other infective polyneuritis</td></tr><tr><td>e. Asthma</td><td>r. Lung cancer</td></tr><tr><td>f. Bronchiectasis</td><td>s. Muscular dystrophy</td></tr><tr><td>g. Chronic airflow obstruction</td><td>t. Myasthenia gravis</td></tr><tr><td>h. Cystic fibrosis</td><td>u. Pulmonary Arterial Hypertension (PAH)</td></tr><tr><td>i. Fibrosing alveolitis</td><td>v. Paralysis of the diaphragm</td></tr><tr><td>j. Lung Reduction Surgery</td><td>w. Sarcoidosis</td></tr><tr><td>k. Pneumoconiosis</td><td>x. Scoliosis</td></tr><tr><td>l. Pulmonary alveolar proteinosis</td><td></td></tr><tr><td>m. Pulmonary hemosiderosis</td><td></td></tr></table> VI.E.2 - A Member will also qualify for pulmonary rehabilitation if they meet the criteria detailed in Attachment A and have at least moderate functional pulmonary disability, with appropriate medical management, as demonstrated by one of the following within 12 months prior to the TAR (unless there are special considerations as noted in Section VI.F): - Obstructive disorders: Moderate to very severe COPD (defined as GOLD classification II, III, IV) - Restrictive/fibrotic disorders FEV1, FVC, TLC, or DLCO less than 60% of predicted - Either: A maximal pulmonary exercise stress test under optimal bronchodilatory treatment, as indicated, that demonstrates limitation to exercise with a maximal oxygen uptake (VO2max) equal to or less than 20ml/kg/min, or about 5 metabolic equivalents (METS) Tony went through the synopsis, adding that Medi-Cal generally limits pulmonary rehab to no more than 72 sessions over a lifetime.		a. Chronic Obstructive Pulmonary Disease (COPD) – chronic bronchitis or emphysema	n. Radiation pneumonitis	b. Interstitial lung disease or idiopathic pulmonary fibrosis	o. Ankylosing spondylitis	c. Alpha-1-antitrypsin deficiency	p. Bronchopulmonary dysplasia	d. Asbestosis	q. Guillain-Barre syndrome or other infective polyneuritis	e. Asthma	r. Lung cancer	f. Bronchiectasis	s. Muscular dystrophy	g. Chronic airflow obstruction	t. Myasthenia gravis	h. Cystic fibrosis	u. Pulmonary Arterial Hypertension (PAH)	i. Fibrosing alveolitis	v. Paralysis of the diaphragm	j. Lung Reduction Surgery	w. Sarcoidosis	k. Pneumoconiosis	x. Scoliosis	l. Pulmonary alveolar proteinosis		m. Pulmonary hemosiderosis		<i>IQI voters posed no questions.</i> Motion to approve as presented: Brigid Gast, RN Second: Isaac Brown <u>Next Steps:</u> July 15 Q/UAC Aug. 12 Physician Advisory Committee (PAC)
a. Chronic Obstructive Pulmonary Disease (COPD) – chronic bronchitis or emphysema	n. Radiation pneumonitis																											
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AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
III. New Business Consent Calendar (Committee Members as applicable)		
	Health Services Policies <u>Pharmacy</u> MCRP4064 – Continuation of Prescription Drugs MPRP4065 – Drug Utilization Review (DUR) Program <u>Population Health</u> MPND9002 – Cultural & Linguistic Program Description revised cover page & Attachment D updated by vendor <u>Quality Improvement</u> MCQP1025 – Substance Use Disorder (SUD) Facility Site Review and Medical Record Review MPXG5009 – Lactation Clinical Practice Guideline – Anna Campbell pulled to ask questions of Colleen Townsend, MD <u>Utilization Management</u> MCUG2007 – Authorization of Ambulatory Procedures and Services MCUG3134 – Hospital Bed/Specialty Mattress Guidelines MCUP3015 – Family By-Pass Services MCUP3114 – Physical, Occupational and Speech Therapies MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21 MCUP3141 – Delegation of Inpatient Management MPUP3042 – Technology Assessment MPUP3138 – External Independent Medical Review Non-Health Services Policies <u>Member Services</u> MC344 – American Indian/Alaska Native Right and Protections – NEW TITLE <u>Network Services</u> MPNS208 – Provider Notification of Provider Termination, Site Closure or Change in Location Information – <i>note new alpha designation as policy moves from Provider Relations to Network Services</i> <u>Provider Relations</u> MPPR207 – Annual Physician Satisfaction Survey MPPGR210 – Provider Grievance – Director of Provider Relations Aaron Brincko pulled for more work; will come back to IQI in fall MPXG5009 was edited before coming to July IQI for concurrence with Pop Health’s MPNP9007 approved at June IQI and Q/UAC and going to Aug. 12 PAC. Regulatory Compliance had added some statutory citations to MPXG5009 text. Anna had questions, which Dr. Townsend answered with “medically necessary manual and electric pumps are covered when prescribed.” Aaron Brincko confirmed that Members can get both options if the first prescribed does not work. UM’s MCUP3013 Durable Medical Equipment (DME) Authorization is added as a Related Policy. MPXG5009 as amended will advance to July 15 Q/UAC: <i>Motion: Brigid Gast, RN / Lisa Ward, MD</i>	Motion to approve the slate without MPXG5009 and MPPRGR210: Lisa O’Connell Second: Anna Campbell <u>Next Steps Health Services Policies</u>: • July 15 Q/UAC (Pharmacy instead to P&T Committee) • Aug. 12 PAC <u>Next Steps Non HS Policies</u>: • MC344: Dept. Director • MPNS208: CEO Signature • MPPR207: Aug. 12 PAC
IV. New Business – Discussion Policies		
Policy Owner: Quality Improvement – <i>Presenter: Jeffrey DeVido, MD, Behavioral Health Clinical Director</i>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPXG5008 – Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing	This policy, like MCQP1025 on today’s consent calendar, does not change the Drug Medi-Cal Organized Delivery System (DMC-ODS) language. Both policies may come back to committees when Partnership sunsets this program. Section III. The Partnership Advantage definition is updated to note the additional line: Coverage criteria apply on implementation of D-SNP (Dual-eligible Special Needs Plan), effective January 1, 2028 and subject to CMS and DHCS (Centers for Medicare and Medicaid Services and Department of Health Care Services) approval. Section IV. Primary Care and Emergency Department attachments (i.e., A & C) updated to reflect policy changes. Section VI.B.8 (Primary Care Clinician (PCP)) is edited: The CDC (Centers for Disease Control) recommends that clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, with a suggested interval of every three months for most patients. For those at higher risk for (Opioid Use Disease) OUD or overdose (depression or other mental health conditions, a history of (Substance Use Disorder) SUD or overdose, taking ≥ 50 MME/day, or taking other CNS depressants), a greater frequency of reevaluation is recommended. Section VI.C.4 (Specialist Referral) is edited: Partnership Behavioral Health Access Line replaces Carelon reference. For residents of all other Partnership HealthPlan counties, contact the relevant county behavioral health access department: <i>a list of phone numbers may be found under “Benefits: Alcohol and Drug Treatment” at https://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx</i>. Deleted mention of the no-longer-required Drug Enforcement Agency (DEA) waiver (aka “X-Waiver) for buprenorphine prescribing. Section VI.D.2e. added: Recommend, furnish, or prescribe naloxone to patients at risk of overdose, family and friends who may witness an overdose or are themselves at risk of overdose. As of 2026, naloxone is available over the counter (OTC) at pharmacies, online retailers and community organizations without a prescription. Medi-Cal Rx covers both prescription and OTC naloxone with no copayments. Medicare Part D may cover the cost of prescribed forms of naloxone. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose, including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set to, in regulations, require employers to include naloxone in workplace first-aid kits by December 2028. Section VI.D.4.d: deleted incomplete list of validated screening tools, instead suggesting that “Validated screening tools for substance misuse or substance use disorder can be helpful. Please refer to <u>Attachment A of policy MPBP8007 Screening and Treatment for Substance Use Disorders for a table of Recommended Tools and Training Resources for Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)</u>, including validated tools for pregnant people. Section VI.G.1. adds two hyperlinked articles recommended for ED personnel’s consideration in screening for SUD and initiating Medication-Assisted Treatment (MAT). References: two are deleted and another is added. Hyperlink accessibility verified on each. Dr. DeVido reiterated that this policy will come back to committees when Partnership sunsets its Wellness & Recovery contracts with counties during the coming months. In VI.B.8, we intentionally refrain from a specific timeline, leaving increasing frequency to clinical	Motion to approve as amended: Colleen Townsend, MD Second: Lisa Ward, MD <u>Next Steps:</u> July 15 Q/UAC Aug. 12 PAC Any Partnership policy utilizing the MAT acronym should first spell it out as “Medication for Addiction Treatment” on next renewal. <i>Meeting Postscript:</i> After email discussions with Dr. Kubota, Dr. DeVido suggests that VI.D.4.a remain as edited at IQI, given that we cannot identify any list of specifically covered point-of-care tox screens.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	judgement. The naloxone language has been carried across the four policy attachments. Dr. Netherda asked how “higher risk” in VI.B.8 is determined. Dr. DeVido responded that different clinicians have different thresholds, with some using ≥ 50 MME/day and others using ≥ 90 MME/day. Dr. DeVido suggested we could add “as based on an informed clinical assessment.” Anna Campbell asked whether MAT is “Medication-Assisted Treatment” or “Medication Addiction Treatment.” Dr. DeVido said the industry-preferred term is “Medication for Addiction Treatment.” This policy will be updated accordingly before July 15 Q/UAC. Anna questioned the age and current veracity of the toxicology Important Provider Notices (IPN) noted on our website. After a short discussion on in-office toxicology screens, Dr. DeVido said he would pursue the matter further offline with Associate Medical Director Marshall Kubota, MD. IQI agreed to modify Section VI.D.4.a as follows: Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs. ~~Certain in-office toxicology screens are covered by Partnership (See Important Provider Notice on Partnership’s website for details.)~~	
Policy Owner: Utilization Management – Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations		
MPUG3025 – Insulin Infusion Pump and Continuous Glucose Monitor Guidelines	III.D: Definition of Direct Member was updated to include Partnership Advantage and to say that Partnership supports coordination of care among providers for Direct Members. III.F: Definition of Partnership Advantage program was updated to add “Coverage criteria apply on implementation of D-SNP, effective January 1, 2028 and subject to CMS and DHCS approval. “ III.G. Definition of Whole Child Model was updated IV.B.: Attachment B, which was the CCS Numbered Letter (N.L.) 15-1222 regarding Continuous Glucose Monitors (CGMs), was removed because DHCS has discontinued sharing that particular N.L. on their website. Partnership submitted an inquiry to DHCS for the missing N.L. and received a response saying N.L.15-1222 is still active policy, but several N.L.’s were removed from the DHCS website because they were no longer compliant with the American Diabetes Association 2025 release of Standards of Care in Diabetes. DHCS did say they are in the process of updating NLs to be ADA compliant, but they have not completed this item yet. Therefore, Partnership is removing Attachment B at this time. VI. B.2.c.4): TAR information required for an insulin infusion pump was updated. Requirement for a 30 consecutive day self-test blood glucose log was removed and replaced with a requirement for “Documentation that Member is insulin dependent or on agents that are associated with hypoglycemia.” VI.C.1.a.4): Because CGMs are now covered by Medi-Cal Rx, statement was added to TAR requirements for a CGM supplied under DME as follows: “Documentation that the device is not available from a Medi-Cal Rx pharmacy.” VI.C.2.a.: Language was updated to describe how CGMs are dispensed through a Pharmacy Provider. VI.C.3.c.: Criteria description was simplified in this section describing long-term continuous glucose monitoring for patients with type 2 or gestational diabetes.	Motion to approve as amended: Brigid Gast, RN Second: Aaron Brincko <u>Next Steps:</u> July 15 Q/UAC Aug. 12 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	VII.A., B., and H: Additional References were added for DHCS guidelines and the Medi-Cal Rx Manual. The Reference for the CCS N.L. 15-1222 was removed, and the Reference for APL 22-012 was updated to reflect 25-013. Attachment B: As described above for IV.B., this attachment was archived for now because this DHCS guidance is not currently available. Brigid Gast, RN, said she was confused by the phrasing of VI.C.2. “CGMs Dispensed through a Pharmacy Provider.” Aaron Brincko wondered if the current phraseology did not suggest a double overage. Director of Pharmacy Services Stan Leung, Pharm.D, noted that most CGM requests come through Claims through the pharmacy carve-out known as Medi-Cal Rx. At Dr. Netherda’s suggestion, Anna will reverse and further edit VI.C.1 and 2 for clarity before July 15 Q/UAC.	
MPUP3039 – Direct Members	Section I. C.,E. and F.: In the Related Policies section, • Policy MPCP2002 California Children’s Services was removed because the Whole Child Model now applies to all Partnership counties as per policy M CCP2024. • Our policy regarding Foster Children was updated in name and number to MCBP8015 Coordination of Care for Child Welfare-Involved Members. • Policy MCUP3051 Long Term Care SSI Regulation was removed as that policy been archived, with information added to policy MCUG3038 Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities. Section III. C. and D.: Definitions for Partnership Advantage and Whole Child Model were updated Section VI.A.: Definition of Direct Members was updated to say that “When a PCP is not assigned, Partnership supports coordination of care among providers. Section VI.E.1.c.: Clarification was added to say that if a request for Direct Member status is denied, the Member will receive written notice that includes the reason for the decision and appeal rights. Section VII.D: Reference was added for Code of Federal Regulation, Title 42 § 438.206 Attachment A: Partnership’s Direct Member / Health Conditions Category Designation Grid was updated throughout for upcoming HRP category descriptions. • H13 terminology was updated to say “birthing Member.” • H18 requirements were clarified for Native Americans Redding Rancheria Liberty site. • H20 requirements were clarified for Medi-Medi Members • H28 Aid codes for Long Term Care were clarified • H32 Holderman Patients was deleted Before Tony went through the synopsis, Dr. Netherda expressed surprise that this policy rests under the UM umbrella and not with Care Coordination or Member Services. Tony agreed. Dr. Netherda expressed appreciation for the Attachment A grid, which Member Services updates throughout the year.	Motion to approve as presented: Brigid Gast, RN Second: Edna Villasenor <u>Next Steps:</u> July 15 Q/UAC Aug. 12 PAC

V. Presentations

QI Update – Isaac Brown, MPH/MBA, Senior Director, Quality Improvement and Performance

- The Perinatal and Hospital Quality Incentive Programs (QIPs) are moving from fiscal year to an annual calendar year (January-December) effective Jan. 1, 2027 as necessitated by contracting changes. Thus, six-month “Bridge” measure sets have been created and approved in committees. Perinatal’s six-month program kicked off in a webinar earlier today. The HQIP kick-off webinar will occur the week of July 13. The seminars will cover provider questions on Datalink and whether providers can continue to participate in the QIPs. With the help of our HEDIS® (Healthcare Effectiveness Data Information Set) team, we will be expanding Datalink capability to get more encounter and screening data than we are otherwise able to secure through Claims.
- Congratulation to Transportation, Member Services, Pop Health, and QI staff for completing their deliverables for FY 2025/2026 Organizational Goal 5: Member Experience (MX) Fiscal Quarter 4. Special thanks to Anthony Sackett who will continue the work under new Director of Member Experience Irem Conery in Administration rather than in the Quality Improvement department.
- Partnership’s Board of Directors has just approved allocating \$2M for community reinvestment across the 10 expansion counties. More information will be forthcoming.
- Thank you to everyone who labored on the various pieces of the “QI Trilogy” this past year. The QI Trilogy will be the presentation focus of August IQI and Q/UAC meetings.

Enhanced Care Management Quality Incentive Program (ECM QIP) CY 2025 Program Evaluation – Deanna Watson, Program Manager I, Quality Improvement

Partnership’s ECM QIP is an extension of the Department of Health Care Services (DHCS) California Advancing and Innovating Medi-Cal (CalAIM) multi-year initiative to improve quality of life and health outcomes for California’s most vulnerable residents (e.g., individuals experiencing homelessness, behavioral health care access, children with complex care needs, the growing justice-involved population, etc.). ECM providers are incentivized for meeting program measures. The 2025 measurement set included the following:

- Gateway measure: Timely reporting
- Measure 1: Care plan and ROI upload into PointClickCare within 60 days of a Treatment Authorization Referral (TAR) request date
- Measure 2: Depression screening
- Measure 3: Blood pressure screening
- Measure 4: Timely review of emergency department and admissions notifications in PointClickCare (This measure was introduced in Q4 2024.)

The program’s gateway measure, which requires the timely submission of three monthly reports, determines the size of the incentive pool available for earning through the program’s remaining performance measures. Providers meeting the gateway measure generated \$18.16 million in available incentive pool dollars in 2025, of which providers earned 76% (\$13.74 million).

Since its inception in 2022, the ECM QIP has experienced substantial growth. In its first year, 23 provider sites serving 1,461 members earned \$778,978 in incentive dollars. By the end of 2025, the program had expanded to 209 provider sites serving 24,006 ECM-enrolled members and earned more than \$13.74 million in incentive dollars. Marin, Sonoma, and Shasta counties generated the highest incentive earnings, driven in part by the participation of larger ECM provider organizations within those counties.

Providers that earned 100% on the gateway measure and all performance measures were designated as 2025 Top Performers. Three providers achieved this status in two quarters: Eastern Plumas Health Care in Portola (Q1 and Q2), Freed Center for Independent Living in Grass Valley (Q2 and Q4), and Santa Rosa Memorial (Q2 and Q3).

For all measures except Measure 4, participating providers earned a higher percentage of available incentive pool dollars in 2025 compared to 2024. This improvement was driven by increased provider engagement through onboarding trainings, ongoing outreach to low-performing providers, and individualized training sessions. These efforts continue in 2026, with the addition of refresher training offerings.

Dr. Netherda expressed surprise about the size of the incentive pool. IQI had no questions for Deanna.

MY2025/RY2026 Healthcare Effectiveness Data and Information Set (HEDIS®) Summary of Performance

Kristine Gual, PMP, CPHQ, Director of Quality Measurement, and Sue Quichocho, Manager of Quality Measurement

Kristine began by saying she would go over both our Managed Care Accountability Set (MCAS) and Health Plan Accreditation (HPA) rates, the latter of which drives our NCQA STAR rating. (These minutes, however, do not capture the HPA discussion as Quality leadership prefers not to make public our projected STAR rating until such time that NCQA publishes this fall. Thus, HPA rates will not be mentioned at all at July 15 Q/UAC, which is a public Brown Act meeting.) Kristine thanked Sue and her team, noting that Partnership's HEDIS® efforts are much more extensive than that of any other managed care plan in California. Moreover, priorities continue to shift in our differing DHCS and NCQA accountabilities.

Historically, we have thought of these accountabilities in terms of DHCS imposed financial sanctions. Today, program accountabilities encompass so much more from plan-wide Clinical Efficiencies, to DHCS's consideration of Partnership's three "Quality Rating Regions" driving quality withholds and incentive programs, to county-level performance in Community Reinvestments and Quality Sanctions. Accountability triggers vary from low performance to failure to show significant year-over-year improvement. Altogether, Partnership has approximately \$70M to \$80M potentially at risk over the program as a whole, Kristine said.

The HEDIS® Measure Set of 18 (nine of which are subject to quality withholds) has not significantly changed for several years across behavioral health, pediatric, chronic disease, and reproductive/cancer prevention domains. What is new is that DHCS now evaluates Partnership's plan-wide performance by county and regional measure rate improvement within three Quality Rating Regions:

- North Bay Area (Fairfield and Santa Rosa)
- Rural Upper North (Redding and Eureka, minus Tehama County)
- Rural Upper Central (Auburn and Chico, plus Tehama County)

Based on MY2025 performance, the HEDIS® team set goals for each Quality Rating Region for MY2026 onwards. The North Bay Area's goal is high achievement (> 67th percentile) on all MCAS measures. The Rural Upper North's goal is moving toward the 67th percentile on Quality Withhold measures, and the Rural Upper Central's goal is movement towards the 50th percentile on Quality Withhold measures.

Sue noted that, plan-wide, six MCAS measures (four of them categorized as quality withholds) fell below the 50th percentile national benchmark. Still, the MCAS aggregated composite performance scores have steadily improved since MY2023. (Brandy Isola asked if MY2024 wasn't when Partnership lost some members to Kaiser? Sue replied yes: that, while also taking on the 10 expansion counties, attributed to Partnership falling below some other MCPs' performance that year.) Plan-wide, Partnership's MCAS performance exceeded the 90th percentile benchmark for Prenatal and Postpartum Care: Postpartum Care (PPC-Post). Kristine noted that as alignment is at the regional level, results may look different at the provider and county levels. Persons with questions are welcome to reach out offline.

Childhood Immunization Status - Combination 10 (CIS-E) plan-wide improved 2.16% above MY 2024 as the North Bay Area went from the 67th to the 90th percentile and the Upper Central from <25th to the 50th percentile. (Upper North remained below the 25th.) Similarly, Well-Child Visits in the First 30 Months (W30-2) improved 4.42% plan-wide above MY 2024, with the North Bay moving from the 67th to the 75th percentile, and Upper Central from <5th to the 50th percentile. (Upper North remained at the 50th percentile and is identified as an improvement opportunity.) The Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD) stood at the 50th percentile across all three regions and is also identified as an improvement opportunity. Dr. Kermit Jones asked for details on the CIS-10 and vaccines. Kristine responded that, although we can still improve, we are "high" compared to the MY2025 benchmarks in our babies' influenza vaccination rates.

Dr. Folo Akintan asked what are our future plans for Topical Fluoride for Children (TFL)? Kristine replied that the Center for Medicare and Medicaid Services (CMS) scoring methodology puts one either under or over the 50th % benchmark, adding that it would be nice to prioritize this in the Upper North; but we are instead prioritizing well-child measures to drive the rest. Still, TFL improved by 8.67% plan wide. (Sue noted that these CMS touchpoints are not the NCQA composite benchmarks.) Dr. Akintan expressed surprise that the postpartum achievements were higher than the pre-partum, as she said the opposite usually is true. Kristine replied that one of our challenges is that the prenatal visit has to happen in the first trimester (determined by working backwards from the baby's birthdate), and that geography can hamper timely visits. She suggested that this could be a breakout conversation with Dr. Colleen Townsend.

The highest priority opportunities for performance improvement vis-à-vis quality withhold measures exist in Child and Adolescent Well-Care Visits (WCV), Immunizations for Adolescents – Combination 2 (IMA-E), Well-Child Visits in the First 30 Months of Life – 6+ visits in 0-15 Months (W30-6), Controlling High Blood

Pressure (CBP), and Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre). In response to a question from Irem Conery, Kristine said we are endeavoring to meet providers “where they are” in the Upper Central to get the region to the 50th percentile or above across each of these five withhold measures. The Upper North is at the 67th for W30-6; however, the other four measures present improvement opportunities.

Regional strengths defined as “newly above” the 50th percentile were attained in three non-withhold MCAS measures: Follow-Up After Emergency Department Visit for Substance Use – 30-Days (FUA-30), Asthma Medication Ration (AMR), and Chlamydia Screening in Women (CHL). (The latter two are removed from the MY2026 MCAS set.) FUA-30 improved 8.08% plan-wide and was one of our most improved scores in the Upper North regions in large part to the success of Federally Qualified Health Center (FQHC) funding and interventions. Another four non-withhold measures present opportunities for improvement: Developmental Screening in the First Three Years of Life (DEV), Lead Screening in Children (LSC), TFL, and Cervical Cancer Screening (CCS-E). Rates varied region to region but plan-wide DEV, LSC and TFL results improved several percentage points in MY2025. CCE-E rates improved in Upper North but fell in the North Bay and plan wide. As self-swabbing opportunities increase, these rates are expected to rise.

Lastly, data completeness issues marred regional performance in two non-withhold measures, Follow-Up After Emergency Department Visit for Mental Illness – 30 Days (FUM-30) and Breast Cancer Screening (BCS-E), although FUM-30 rose 21 points plan wide.

Questions may be directed to the HEDIS® team at hedisteam@partnershiphp.org.

VI. Adjournment

Dr. Netherda adjourned the meeting at 3:33 p.m. IQI will meet next Tuesday, Aug. 11, 2026.

Respectfully Submitted by Leslie Erickson, Program Coordinator II, Quality Improvement

Approval Signature:

Date:

Mark Netherda, MD

Medical Director for Quality and Committee Vice Chair

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

Date: July 15, 2026

Time: 7:30 – 9:00 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
1000 Fortress St., Chico, CA 95973 | Stony Creek Conference Room

Other Locations:

2330 W. Covell Blvd., Davis, CA 95616

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 Partnership locations

	Item	Lead	Time	Page #
I.	Call to Order – Welcome/Introductions/Announcements/Approval/Acceptance of Minutes			
1	Approval of June 17, 2026 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	5 – 16
2	Acknowledgment and acceptance of draft minutes of the - June 9 Internal Quality Improvement (IQI) Committee - May 28 Member Grievance Review Committee (MGRC) - April 29 Over/Under Utilization Workgroup			17 – 42
3	Announcements			--
II.	Standing Updates			
1	Quality and Performance Improvement Program Update	James Devan	7:36	43 – 56
2	HealthPlan Update	Robert Moore, MD	7:41	--
III.	Old Business –			
1	MPUP3111 – Pulmonary Rehabilitation – <i>pulled at June 15 Q/UAC – synopsis of subsequent changes begins on p. 57</i>	Tony Hightower, CPhT		59 – 64
IV.				
Health Services	Consent Calendar	All		65
	Enhanced Care Management Quality Incentive Program (ECM QIP) 2025 Program Evaluation – <i>direct questions to Deanna Watson</i>			67 – 78
	Population Health Management			
	MPND9002 – Cultural & Linguistic Program Description – Attachment D – <i>updated by translation vendor after April PAC approval; updated PD cover page on p. 79</i>			81 – 92
	Quality Improvement			
	MCQP1025 – Substance Use Disorder (SUD) Facility Site Review and Medical Record Review			93 – 152
	MPXG5009 – Lactation Clinical Practice Guideline			153 – 158

	Item	Lead	Time	Page #
	Utilization Management			
	MCUG3007 – Authorization of Ambulatory Procedures and Services			159 – 162
	MCUG3134 – Hospital Bed/Specialty Mattress Guidelines			163 – 167
	MCUP3015 – Family By-Pass Services			169 – 173
	MCUP3114 – Physical, Occupational and Speech Therapies			175 – 180
	MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21			181 – 193
	MCUP3141 – Delegation of Inpatient Management			195 – 200
	MPUP3042 – Technology Assessment			201 – 206
	MPUP3138 – External Independent Medical Review			207 – 210
V.	New Business – Discussion Policies – Health Services			
	Synopsis of Changes		--	211 – 214
	Quality Improvement			
	MPXG5008 – Clinical Practice Guideline: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing – <i>clean copy of the policy begins on p. 249</i>	Marshall Kubota, MD		215 – 255
	Utilization Management			
	MPUG3025 – Insulin Infusion Pump and Continuous Glucose Monitor Guidelines	Tony Hightower, CPhT		257 – 273
	MPUP3039 – Direct Members			275 – 287
VI.	Presentations			
1	Grievance & Appeals Department Annual Report CY 2025	Kory Watkins, MBA-HM		289 – 308
2	Healthcare Effectiveness Data Information Set (HEDIS ®) Annual Summary of Performance • MY2025 Managed Care Accountability Set (MCAS) – <i>begins on p. 327</i> • <i>The MY2025 HealthPlan Accreditation (HPA) white paper will come to committees in the fall</i>	Kristine Gual / Sue Quichocho		309 – 380
Adjournment scheduled for 9:00 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Aug. 19, 2026				

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
Quality and Utilization Advisory Committee (Q/UAC) Meeting Minutes

Wednesday, July 15, 2026 / 7:33 a.m. – 9:04 a.m.

Fairfield: Napa/Solano Room, Redding: Airpark, Chico: Story Creek, Santa Rosa Huddle

<u>Voting Members Present:</u>		
Choudhry, Sara, MD	Lane, Brandy, Consumer Member	Thomas, Randy, MD
Gwiazdowski, Steven, MD, FAAP	Strain, Michael, Consumer Member	Wilson, Jennifer, MD, MPH
	Swales, Chris, MD	
<u>Voting Members Absent:</u> Emma Hackett, MD, FACOG; Murphy, John, MD; Montenegro, Brian, MD; Mulligan, Meagen, FNP-BC; Quon, Robert, MD, FACP		
<u>Partnership Ex-Officio Members Present:</u>		
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, Assoc. Dir., Credentialing	
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management	O’Connell, Lisa, Director, Enhanced Health Services	
Glickstein, Mark, MD, Associate Medical Director	Ribordy, Jeff, MD, Regional Medical Director (Northwest)	
Hightower, Tony, CPhT, Associate Director, UM Regulations	Ruffin, DeLorean, DrPH, MPH, Director of Population Health	
Jalloh, Mohamed “Moe”, Pharm.D, Dir. of Health Equity (Health Equity Officer)	Townsend, Colleen, MD, Regional Medical Director (Southeast)	
Jones, Kermit, MD, JD, Medical Director for Medicare Services	Ward, Lisa, MD, Regional Medical Director (Southwest)	
Katz, Dave, MD, Associate Medical Director	Watkins, Kory, MBA-HM, Director, Grievance & Appeals	
Leung, Stan, Pharm.D, Director of Pharmacy Services		
<u>Partnership Ex-Officio Members Absent:</u>		
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Guillory, Ledra, Senior Manager of Provider Relations Representatives	
Bontrager, Mark, Senior Director of Behavioral Health	Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination	
Brown, Isaac, MBA/MHA, Interim Senior Director of Q & P Improvement	Randhawa, Manleen, Senior Health Educator, Population Health	
	Spiller, Bettina, MD, Associate Medical Director	
<u>Guests:</u>		
Beard, Alyssa, RN, Manager of CC Regulatory Performance	Kubota, Marshall, MD, Reg. Medical Director	
Brincko, Aaron, Director of Provider Relations	Lee, Sue, Manager, Quality Performance & Accreditation, QI	
Brunkal, Monika, Associate Director, Population Health	Lucero, Sarah, Intern, Population Health Management	
Campbell, Anna, Health Policy Analyst, UM Regulations	Matthews, Richard, MD, Regional Medical Director (Chico)	
Chishty, Shahrukh, Sr. Mgr, Child Welfare programs, Behavioral Health	Morris, Matthew, MD, Regional Medical Director (Auburn)	
Cunningham, Aryana, Policy Analyst, Care Coordination	O’Leary, Hannah, Manager of Population Health, Pop Health	
Devan, James, Director of Quality Management	Quichocho, Sue, Manager of Quality Measurement, QI	
Durst, Jennifer, Manage of Performance Improvement (Fairfield)	Rednic, Hanny, Program Manager I, Utilization Management	
Elder, Alaina, Manager of Provider Network Services, Provider Relations	Selig, Barb, Manager, Quality Improvement Programs, QI	
George, Michael, MD, Associate Medical Director	Smith, Christine, Community Health Needs Liaison, Pop Health	
Gual, Kristine, Director of Quality Measurement	Stites, Jaylyn, Program Manager II, Provider Relations	
Kim, Amanda, Improvement Advisor, QI (Redding)	Thornton, Aaron, MD, Associate Medical Director	
Krznarich, Jackie, RN, <i>Interim</i> Mgr, Member Safety – Quality Inspections	Zamani, Fatema, Health Services Analyst I, Population Health	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – <i>none made</i> Approval/ Acceptance of Minutes	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:33 a.m. • June 17, 2026 Q/UAC Minutes were approved without any corrections. • <i>Acknowledgment and acceptance of draft meeting minutes of the</i> ○ June 9 Internal Quality Improvement (IQI) Committee ○ May 28 Member Grievance Review Committee (MGRC) ○ April 29 Over/Under Utilization Workgroup	Motion to approve the Q/UAC minutes: Steven Gwiazdowski, MD Second: Chris Swales, MD <i>Approved unanimously</i> Motion to accept other minutes: Jennier Wilson, MD Second: Chris Swales, MD <i>Accepted unanimously</i>
II. Standing Updates		
Quality and Performance Improvement Program – James Devan, Director, Quality Management, QI		
• Contract amendments have necessitated taking our Hospital Quality Incentive Program (HQIP) and Perinatal QIP (PQIP) from a fiscal year calendar to a calendar year, effective Jan. 1, 2027. Thus, six-month “bridge” programs began July 1. Kick-off webinars have occurred for each. • Director of Member Experience Irem Conery is leading a new team under Administration to improve the Member experience. The team has several goal deliverables around transportation, the Consumer Assessment of Healthcare Providers and Systems (CAHPS®), Member Services’ phone options, dental access and engagement, and health equity. • The Expansion Counties Reinvestment in Quality (E-RIQ) program is a strategic \$2M community reinvestment initiative aimed at improving health outcomes and member experience across the 10 expansion counties: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Tehama, Yuba, and Sutter. The \$500,000 Phase I (\$50K to each county to strengthen community based engagement and access across priority focus areas) application period closed July 10. Phase II – \$1.5M for Provider opportunities to drive measurable improvements in quality priority measures through target initiatives and activities – is anticipated to begin in late July. Next steps (Phase III) include connecting with a vendor to develop the business case/proposal to share with the Executive Committee to pilot a vendor-supported gap closure initiative. • Annually, the Quality Improvement (QI) department updates three core documents – often referred to as the QI Trilogy – that collectively describe the program structure, priorities and performance. The Program Description outlines the overall QI framework, the Work Plan details active and planned initiatives aligned with strategic priorities, and the Program Evaluation assesses progress, outcomes and opportunities for improvement. The current Trilogy – FY2026/27 Program Description, the FY2025/26 Work Plan, the FY2025/26 Evaluation, and the FY2026/27 Work Plan – are scheduled for review and approval at the Aug. 11 IQI, Aug. 19 Q/UAC, Sept. 9 PAC, and the Oct. 28 Board of Commissioners.		
Health Plan – Kermit Jones, MD, JD – Deputy Chief Medical Officer & Medical Director for Medicare Services		
• Current federal prohibitions impinging Managed Care Plans (MCPs) caring for California’s 2M Medi-Cal members of Uncertain Immigration Status (UIS) will be expiring soon. Partnership is looking at the legal implications of resuming contracting with Planned Parenthood. • The Department of Healthcare Services (DHCS) is hyper-focused on the MCPs as the Federal government focuses on fraud, waste and abuse (FWA). • DHCS is crusading on correcting fundamental inefficiencies, making sure that primary care needs can be addressed in other ways when necessary. Some changes in durable medical equipment (DME) will be coming, changes that will affect some of our policies. • We are still working on updating our core claims system.		

III. Old Business																								
Policy Owner: Utilization Management – Presenter: Tony Hightower, Associate Director, UM Regulations																								
MPUP3111 – Pulmonary Rehabilitation coming back from June 15 Q/UAC	Quality/Utilization Advisory Committee voter Randolph Thomas, MD, concerned that three sets of Medi-Cal coverage criteria seemed out of sync with one another, pulled this policy from the June 15 Q/UAC consent calendar. The first two sets of criteria are now combined into VI.E.1. and the second set is now defined for Members with moderate functional pulmonary disability at VI.E.2. Attachment A is further modified to clarify that the physician filling out the form should state the diagnosis. VI.E.1 - Chronic pulmonary conditions eligible for pulmonary rehabilitation include, but are not limited to, the following: Chronic Obstructive Pulmonary Disease (COPD) – chronic bronchitis or emphysema Interstitial lung disease or idiopathic pulmonary fibrosis <table><tr><td>c. Alpha-1-antitrypsin deficiency</td><td>n. Radiation pneumonitis</td></tr><tr><td>d. Asbestosis</td><td>o. Ankylosing spondylitis</td></tr><tr><td>e. Asthma</td><td>p. Bronchopulmonary dysplasia</td></tr><tr><td>f. Bronchiectasis</td><td>q. Guillain-Barre syndrome or other infective polyneuritis</td></tr><tr><td>g. Chronic airflow obstruction</td><td>r. Lung cancer</td></tr><tr><td>h. Cystic fibrosis</td><td>s. Muscular dystrophy</td></tr><tr><td>i. Fibrosing alveolitis</td><td>t. Myasthenia gravis</td></tr><tr><td>j. Lung Reduction Surgery</td><td>u. Pulmonary Arterial Hypertension (PAH)</td></tr><tr><td>k. Pneumoconiosis</td><td>v. Paralysis of the diaphragm</td></tr><tr><td>l. Pulmonary alveolar proteinosis</td><td>w. Sarcoidosis</td></tr><tr><td>m. Pulmonary hemosiderosis</td><td>x. Scoliosis</td></tr></table> VI.E.2 - A Member will also qualify for pulmonary rehabilitation if they meet the criteria detailed in Attachment A and have at least moderate functional pulmonary disability, with appropriate medical management, as demonstrated by one of the following within 12 months prior to the TAR (unless there are special considerations as noted in Section VI.F): - Obstructive disorders: Moderate to very severe COPD (defined as GOLD classification II, III, IV) - Restrictive/fibrotic disorders FEV1, FVC, TLC, or DLCO less than 60% of predicted - Either: A maximal pulmonary exercise stress test under optimal bronchodilatory treatment, as indicated, that demonstrates limitation to exercise with a maximal oxygen uptake (VO2max) equal to or less than 20ml/kg/min, or about 5 metabolic equivalents (METS) Tony went through the synopsis, adding that Medi-Cal generally limits pulmonary rehab to no more than 72 sessions over a lifetime.	c. Alpha-1-antitrypsin deficiency	n. Radiation pneumonitis	d. Asbestosis	o. Ankylosing spondylitis	e. Asthma	p. Bronchopulmonary dysplasia	f. Bronchiectasis	q. Guillain-Barre syndrome or other infective polyneuritis	g. Chronic airflow obstruction	r. Lung cancer	h. Cystic fibrosis	s. Muscular dystrophy	i. Fibrosing alveolitis	t. Myasthenia gravis	j. Lung Reduction Surgery	u. Pulmonary Arterial Hypertension (PAH)	k. Pneumoconiosis	v. Paralysis of the diaphragm	l. Pulmonary alveolar proteinosis	w. Sarcoidosis	m. Pulmonary hemosiderosis	x. Scoliosis	<i>Q/UAC voters posed no questions.</i> Motion to approve as presented: Steven Gwiazdowski, MD Second: Jennifer Wilson, MD <i>Approved unanimously</i> <u>Next Step:</u> Aug. 12 Physician Advisory Committee (PAC)
c. Alpha-1-antitrypsin deficiency	n. Radiation pneumonitis																							
d. Asbestosis	o. Ankylosing spondylitis																							
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AGENDA ITEM	DISCUSSION	RECOMMENDATIONS/ ACTIONS																																																
Old Business (Continued)																																																		
CY2025 UM 1F Rate Workbook Update coming back from April 15 Q/UAC approval	Tony Hightower noted that during the April 15, 2026 Q/UAC meeting, Partnership UM presented to the Committee a summary of UM rates for calendar year 2025 as part of the annual UM Grand Analysis process. The rates presented were accepted by the Committee as presented. In June 2026, NCQA released an FAQ that provided further clarification regarding the calculations and, based on this clarification, Partnership re-calculated the non-behavioral UM rates to determine if there was a need to re-review the findings. This re-calculation found minimal changes to the previously reviewed rates as detailed in the table below. The re-calculated results remained at or above goal and would not appear to change the prior findings/recommendations of the Committee. <table><tr><th>Rates</th><th>Denominator</th><th>Numerator</th><th>NEW Rate</th><th>PRIOR Rate</th><th>Impact</th></tr><tr><td>Overall Denial Rate</td><td>77,067</td><td>323,068</td><td>23.85%</td><td>22.42%</td><td>+1.43%</td></tr><tr><td>Overall Timeliness of Notification</td><td>78,401</td><td>77,736</td><td>99.15%</td><td>99.34%</td><td>-0.19%</td></tr><tr><td>Urgent Concurrent</td><td>9,750</td><td>9,260</td><td>94.97%</td><td>95.87%</td><td>-0.9%</td></tr><tr><td>Urgent Preservice</td><td>5,606</td><td>5,452</td><td>97.25%</td><td>97.54%</td><td>-0.29%</td></tr><tr><td>Nonurgent Preservice</td><td>61,621</td><td>61,603</td><td>99.97%</td><td>99.97%</td><td>No difference</td></tr><tr><td>Post-Service</td><td>1,424</td><td>1,421</td><td>99.97%</td><td>99.78%</td><td>+0.19%</td></tr><tr><td>Overall Appeal Rate</td><td>79,641</td><td>2,186</td><td>2.74%</td><td>2.91%</td><td>-0.17%</td></tr></table>	Rates	Denominator	Numerator	NEW Rate	PRIOR Rate	Impact	Overall Denial Rate	77,067	323,068	23.85%	22.42%	+1.43%	Overall Timeliness of Notification	78,401	77,736	99.15%	99.34%	-0.19%	Urgent Concurrent	9,750	9,260	94.97%	95.87%	-0.9%	Urgent Preservice	5,606	5,452	97.25%	97.54%	-0.29%	Nonurgent Preservice	61,621	61,603	99.97%	99.97%	No difference	Post-Service	1,424	1,421	99.97%	99.78%	+0.19%	Overall Appeal Rate	79,641	2,186	2.74%	2.91%	-0.17%	Q/UAC voters posed no questions. Motion to approve as presented: Randy Thomas, MD Second: Chris Swales, MD <i>Approved unanimously</i>
Rates	Denominator	Numerator	NEW Rate	PRIOR Rate	Impact																																													
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IV. New Business – Consent Calendar (Committee Members as Applicable)		
Enhanced Care Management Quality incentive Program (ECM QIP) 2025 Program Evaluation – <i>direct questions to Deanna Watson</i> Health Services Policies <u>Population Health</u> MPND9002 – Cultural & Linguistic Program Description <i>revised cover page & Attachment D updated by vendor</i> <u>Quality Improvement</u> MCQP1025 – Substance Use Disorder (SUD) Facility Site Review and Medical Record Review MPXG5009 – Lactation Clinical Practice Guideline <u>Utilization Management</u> MCUG2007 – Authorization of Ambulatory Procedures and Services MCUG3134 – Hospital Bed/Specialty Mattress Guidelines MCUP3015 – Family By-Pass Services MCUP3114 – Physical, Occupational and Speech Therapies MCUP3140 – Palliative Care: Pediatric Program for Members Under the Age of 21 MCUP3141 – Delegation of Inpatient Management MPUP3042 – Technology Assessment MPUP3138 – External Independent Medical Review		<i>Q/UAC voters posed no questions.</i> Motion to approve the slate as presented: Steven Gwiazdowski, MD Second: Randy Thomas, MD <i>Approved unanimously</i> <u>Next Step:</u> Aug. 12 PAC
V. New Business – Discussion Policies		
Policy Owner: Quality Improvement – Presenter: Marshall Kubota, MD, Associate Medical Director		
MPXG5008 – Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing	This policy, like MCQP1025 on today’s consent calendar, does not change the Drug Medi-Cal Organized Delivery System (DMC-ODS) language. Both policies may come back to committees when Partnership sunsets this program. Section III. The Partnership Advantage definition is updated to note the additional line: Coverage criteria apply on implementation of D-SNP (Dual-eligible Special Needs Plan), effective January 1, 2028 and subject to CMS and DHCS (Centers for Medicare and Medicaid Services and Department of Health Care Services) approval. Section IV. Primary Care and Emergency Department attachments (i.e., A & C) updated to reflect policy changes. Section VI.B.8 (Primary Care Clinician (PCP)) is edited: The CDC (Centers for Disease Control) recommends that clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, with a suggested interval of every three months for most patients. For those at higher risk for (Opioid Use Disease) OUD or overdose (depression or other mental health conditions, a history of (Substance Use Disorder) SUD or overdose, taking ≥50 MME/day, or taking other CNS depressants), a greater frequency of reevaluation is recommended. Section VI.C.4 (Specialist Referral) is edited: Partnership Behavioral Health Access Line replaces	<i>QUAC voters posed no questions.</i> Motion to approve as presented: Steven Gwiazdowski, MD Second: Randy Thomas, MD <i>Approved unanimously</i> <u>Next Step:</u> Aug. 12 PAC

	Carelon reference. For residents of all other Partnership HealthPlan counties, contact the relevant county behavioral health access department: <i>a list of phone numbers may be found under “Benefits: Alcohol and Drug Treatment” at https://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx</i>. Deleted mention of the no-longer-required Drug Enforcement Agency (DEA) waiver (aka “X-Waiver) for buprenorphine prescribing. Section VI.D.2e. added: Recommend, furnish, or prescribe naloxone to patients at risk of overdose, family and friends who may witness an overdose or are themselves at risk of overdose. As of 2026, naloxone is available over the counter (OTC) at pharmacies, online retailers and community organizations without a prescription. Medi-Cal Rx covers both prescription and OTC naloxone with no copayments. Medicare Part D may cover the cost of prescribed forms of naloxone. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose, including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set to, in regulations, require employers to include naloxone in workplace first-aid kits by December 2028. Section VI.D.4.d: deleted incomplete list of validated screening tools, instead suggesting that “Validated screening tools for substance misuse or substance use disorder can be helpful. Please refer to <u>Attachment A of policy MPBP8007 Screening and Treatment for Substance Use Disorders</u> for a table of <u>Recommended Tools and Training Resources for Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT)</u>, including validated tools for pregnant people. Section VI.G.1. adds two hyperlinked articles recommended for ED personnel’s consideration in screening for SUD and initiating Medication-Assisted Treatment (MAT). References: two are deleted and another is added. Hyperlink accessibility verified on each.-	
Policy Owner: Utilization Management – Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations		
MPUG3025 – Insulin Infusion Pump and Continuous Glucose Monitor Guidelines	III.D: Definition of Direct Member was updated to include Partnership Advantage and to say that Partnership supports coordination of care among providers for Direct Members. III.F: Definition of Partnership Advantage program was updated to add “Coverage criteria apply on implementation of D-SNP, effective January 1, 2028 and subject to CMS and DHCS approval. “ III.G. Definition of Whole Child Model was updated IV.B.: Attachment B, which was the CCS Numbered Letter (N.L.) 15-1222 regarding Continuous Glucose Monitors (CGMs), was removed because DHCS has discontinued sharing that particular N.L. on their website. Partnership submitted an inquiry to DHCS for the missing N.L. and received a response saying N.L.15-1222 is still active policy, but several N.L.’s were removed from the DHCS website because they were no longer compliant with the American Diabetes Association 2025 release of Standards of Care in Diabetes. DHCS did say they are in the process of updating NLs to be ADA compliant, but they have not completed this item yet. Therefore, Partnership is removing Attachment B at this time. VI. B.2.c.4): TAR information required for an insulin infusion pump was updated. Requirement for a 30 consecutive day self-test blood glucose log was removed and replaced with a requirement for “Documentation that Member is insulin dependent or on agents that are associated with hypoglycemia.”	<i>QUAC voters posed no questions.</i> Motion to approve as presented: Randy Thomas, MD Second: Jennifer Wilson, MD <i>Approved unanimously</i> <u>Next Step:</u> Aug. 12 PAC

	VI.C.1.a.4): Because CGMs are now covered by Medi-Cal Rx, statement was added to TAR requirements for a CGM supplied under DME as follows: “Documentation that the device is not available from a Medi-Cal Rx pharmacy.” VI.C.2.a.: Language was updated to describe how CGMs are dispensed through a Pharmacy Provider. VI.C.3.c.: Criteria description was simplified in this section describing long-term continuous glucose monitoring for patients with type 2 or gestational diabetes. VII.A., B., and H: Additional References were added for DHCS guidelines and the Medi-Cal Rx Manual. The Reference for the CCS N.L. 15-1222 was removed, and the Reference for APL 22-012 was updated to reflect 25-013. Attachment B: As described above for IV.B., this attachment was archived for now because this DHCS guidance is not currently available.	
MPUP3039 – Direct Members	Section I. C.,E. and F.: In the Related Policies section, Policy MPCP2002 California Children’s Services was removed because the Whole Child Model now applies to all Partnership counties as per policy MCCP2024. Our policy regarding Foster Children was updated in name and number to MCBP8015 Coordination of Care for Child Welfare-Involved Members. Policy MCUP3051 Long Term Care SSI Regulation was removed as that policy been archived, with information added to policy MCUG3038 Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities. Section III. C. and D.: Definitions for Partnership Advantage and Whole Child Model were updated Section VI.A.: Definition of Direct Members was updated to say that “When a PCP is not assigned, Partnership supports coordination of care among providers. Section VI.E.1.c.: Clarification was added to say that if a request for Direct Member status is denied, the Member will receive written notice that includes the reason for the decision and appeal rights. Section VII.D: Reference was added for Code of Federal Regulation, Title 42 § 438.206 Attachment A: Partnership’s Direct Member / Health Conditions Category Designation Grid was updated throughout for upcoming HRP category descriptions. H13 terminology was updated to say “birthing Member.” H18 requirements were clarified for Native Americans Redding Rancheria Liberty site. H20 requirements were clarified for Medi-Medi Members H28 Aid codes for Long Term Care were clarified H32 Holderman Patients was deleted	<i>QUAC voters posed no questions.</i> Motion to approve as presented: Randy Thomas, MD Second: Steve Gwaizdowski, MD <i>Approved unanimously</i> <u>Next Step:</u> Aug. 12 PAC
V. Presentations		
Grievance & Appeals Department Annual Report CY 2025 – Kory Watkins, MPB-HM, Director of Grievance & Appeals		
<i>Originally scheduled for June 17 Q/UAC, this report was pulled from that agenda to allow time for presentation of the Population Health Grand Analysis.</i> The Grievance & Appeals (G&A) department ensures that member concerns are heard, addressed, and resolved in alignment with regulatory standards and health plan policies. G&A manages member grievances and appeals with a focus on timeliness, fairness, and improving the overall member experience. G&A		

accomplishes this with the help of other Partnership departments, including Transportation, Compliance, QI, the Medical Directors, Member Services, and Provider Relations.

CY 2025 case volume increased 18% above CY 2024 and is likely to continue to grow as our member numbers increase. Trinity, Shasta, and Placer counties, although they presented no new issues, were the top three counties for grievances per 1,000 members. Fourteen percent of civil rights allegations were substantiated in 2025, up from 10% in 2024.

Most G&A cases are non-clinical in nature. Transportation constitutes 50% of these cases, Provider Service 25%, Access 15%, and Partnership Service 19%. Sixty-five percent of cases start with a member expressing a grievance: 90 percent of these come in by phone via Transportation and Member Services. Kory noted that we can now drill down on transportation data to the driver's name. G&A shares monthly reports with Transportation to support trend analysis and oversight with the goal of improving the member experience. Partnership provided 1,562,928 rides in 2025 and received 5,947 transportation-related concerns, representing less than 0.4% of total rides.

G&A tracks member demographics. Historically, White English speakers are over-represented and Spanish speaking Hispanics are underrepresented. This trend continued in 2025.

G&A investigates all allegations of discrimination. There were 384 concerns that fell under federally protected civil rights laws expressed altogether in 2025: just 52 were found to have some merit. "Disability" was the highest category where G&A found likely discrimination.

Kory also explained the appeals process, breaking down the outcomes and disposition of appeals and state hearings.

Goals and focus areas for 2026 include adding to the G&A auditing team to expand quality oversight and collaborating with organizational stakeholders to prepare for the 2028 implementation of Partnership's Medicare program.

Dr. Moore asked if there was anything in the last DHCS audit that would influence G&A? Kory said that yes, G&A's outgoing letters could be improved and that is why two auditors have been requested. G&A is working on how to escalate concerns to other departments if and when providers may not be cooperating with timely proceedings.

Medical Director for Quality Mark Netherda, MD, noted that in the past three months he has not received any complaints from providers that our letters seem accusatory. **Q/UAC voter Jennifer Wilson, MD, remarked** that her organization received 12 such letters in June alone, and that language and tone do matter. She said she found it "hard" that 25% of grievances had to do with Provider Services (e.g., treatment plans disputes, communication issues, etc.). "It's not that we are not available," Dr. Wilson said. "It is a mix of supply and demand." Dr. Netherda responded that the 25% is what members are alleging, not what Partnership is actually finding. Dr. Wilson concluded by suggesting that Partnership could do more with the language around our expectations of providers.

Q/UAC voter Randy Thomas, MD, wondered at the cost of proving more than 1.5M rides, and asked if utilizing Uber might be less expensive. Dr. Moore said the figures vary by county. **Q/UAC voter Steven Gwiazdowski, MD, wondering** how much transportation related complaints deter us from our mission to provide service, asked if there was a way to partner with DHCS to find better solutions. Dr. Moore demurred, saying aspirational goals should not become policies. The presentation concluded with additional conversation about inefficiencies.

MY2025/RY2026 Healthcare Effectiveness Data and Information Set (HEDIS®) Summary of Performance

Kristine Gual, PMP, CPHQ, Director of Quality Measurement, and Sue Quichocho, Manager of Quality Measurement

Kristine began by saying she would go over our Managed Care Accountability Set (MCAS) rates. She said she would not be presenting our projected Health Plan Accreditation (HPA) rates until after the National Committee for Quality Assurance (NCQA) publishes its findings and our STAR rating this fall. Kristine thanked Sue and her team, noting that Partnership's HEDIS® efforts are much more extensive than that of any other managed care plan in California. Moreover, priorities continue to shift our differing DHCS and NCQA accountabilities.

Historically, we have thought of these accountabilities in terms of DHCS imposed financial sanctions. (This is the second year that active sanctions may be applied at the county level.) Today, however, program accountabilities encompass so much more from plan-wide Clinical Efficiencies, to DHCS's consideration of Partnership's three "Quality Rating Regions" driving quality withholds and incentive programs, to county-level performance in Community Reinvestments and Quality Sanctions. Accountability triggers vary from low performance to failure to show significant year-over-year improvement. Altogether, Partnership has approximately \$70M to \$80M potentially at risk over the program as a whole, Kristine said.

The HEDIS® Measure Set of 18 (nine of which are subject to quality withholds) has not significantly changed for several years across behavioral health, pediatric, chronic disease, and reproductive/cancer prevention domains. What is new is that DHCS now evaluates Partnership's plan-wide performance by county and regional measure rate improvement within three Quality Rating Regions:

North Bay Area (Fairfield and Santa Rosa)

Rural Upper North (Redding and Eureka, minus Tehama County)

Rural Upper Central (Auburn and Chico, plus Tehama County)

Based on MY2025 performance, the HEDIS® team set goals for each Quality Rating Region for MY2026 onwards. The North Bay Area's goal is high achievement (> 67th percentile) on all MCAS measures. The Rural Upper North's goal is moving toward the 67th percentile on Quality Withhold measures, and the Rural Upper Central's goal is movement towards the 50th percentile on Quality Withhold measures.

Sue noted that, plan-wide, six MCAS measures (four of them categorized as quality withholds) fell below the 50th percentile national benchmark. Still, the MCAS aggregated composite performance scores have steadily improved since MY2023. Plan-wide, Partnership's MCAS performance exceeded the 90th percentile benchmark for Prenatal and Postpartum Care: Postpartum Care (PPC-Post). Kristine noted that as alignment is at the regional level, results may look different at the provider and county levels. Persons with questions are welcome to reach out offline.

Although our composite score on all 18 MCAS measures has improved year-over-year since MY 2023, some other MCPs fared better in MY 2024 over MY 2023 (MY 2025 is not available as yet) than did Partnership largely due to our 10 county expansion in 2024.

Childhood Immunization Status - Combination 10 (CIS-E) plan-wide improved 2.16% above MY 2024 as the North Bay Area went from the 67th to the 90th percentile and the Upper Central from <25th to the 50th percentile. (Upper North remained below the 25th.) Similarly, Well-Child Visits in the First 30 Months (W30-2) improved 4.42% plan-wide above MY 2024, with the North Bay moving from the 67th to the 75th percentile, and Upper Central from <5th to the 50th percentile. (Upper North remained at the 50th percentile and is identified as an improvement opportunity.) The Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD) stood at the 50th percentile across all three regions and is also identified as an improvement opportunity.

The highest priority opportunities for performance improvement vis-à-vis quality withhold measures exist in Child and Adolescent Well-Care Visits (WCV), Immunizations for Adolescents – Combination 2 (IMA-E), Well-Child Visits in the First 30 Months of Life – 6+ visits in 0-15 Months (W30-6), Controlling High Blood Pressure (CBP), and Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre). Kristine said we are endeavoring to meet providers "where they are" in the Upper Central to get the region to the 50th percentile or above across each of these five withhold measures. The Upper North is at the 67th for W30-6; however, the other four measures present improvement opportunities.

Regional strengths defined as "newly above" the 50th percentile were attained in three non-withhold MCAS measures: Follow-Up After Emergency Department Visit for Substance Use – 30-Days (FUA-30), Asthma Medication Ration (AMR), and Chlamydia Screening in Women (CHL). (The latter two are removed from the MY2026 MCAS set.) FUA-30 improved 8.08% plan-wide and was one of our most improved scores in the Upper North regions in large part to the success of Federally Qualified Health Center (FQHC) funding and interventions. Another four non-withhold measures present opportunities for improvement: Developmental Screening in the First Three Years of Life (DEV), Lead Screening in Children (LSC), TFL, and Cervical Cancer Screening (CCS-E). Rates varied region to region but plan-wide DEV, LSC and TFL results improved several percentage points in MY2025. CCE-E rates improved in Upper North but fell in the North Bay and plan-wide. As self-swabbing opportunities increase, these rates are expected to rise.

Lastly, data completeness issues marred regional performance in two non-withhold measures, Follow-Up After Emergency Department Visit for Mental Illness – 30 Days (FUM-30) and Breast Cancer Screening (BCS-E), although FUM-30 rose 21 points plan-wide.

Key Takeaways

- High achievement or year-over-year improvements on MCAS Withhold measures at the Regional Level is the highest priority for the network. This will drive success in all DHCS accountability programs and our NCQA STAR rating.
- 2026 priority improvement areas for rating regions will align provider-specific priorities with this strategy:

North Bay Area (Marin, Napa, Solano, Sonoma, Yolo)	Rural Upper Central (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba)	Rural Upper North (Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Trinity)
Towards Regional 67th percentile: 1. Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) 2. Child and Adolescent Well-Care Visits (WCV) 3. Lead Screening in Children (LSC) 4. Cervical Cancer Screening (CCS-E) 5. Follow-Up After Emergency Department Visit for Substance Use - 30-Days (FUA-30) 6. Colorectal Cancer Screening (COL) – New in MY2026!	Towards Regional 50th percentile: 1. Child and Adolescent Well-Care Visits (WCV) 2. Immunizations for Adolescents - Combination 2 (IMA-E) 3. Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months (W30-6) 4. Controlling High Blood Pressure (CBP) 5. Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) – select counties 6. Timeliness of Prenatal Care (PPC-Pre)	Towards Regional 67th percentile: 1. Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) 2. Controlling High Blood Pressure (CBP) 3. Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months 4. Child and Adolescent Well-Care Visits (WCV) 5. Immunizations for Adolescents - Combination 2 (IMA-E) 6. Timeliness of Prenatal Care (PPC-Pre)

Dr. Moore commented that the financial implications are important to Partnership but behind the numbers are members who may not be getting the services they need. **Q/UAC voter Randy Thomas, MD**, asked if other MCPs calculate their numbers differently. Kristine replied that the HEDIS® audit takes six months and thus minimizes any differentiation: the rates we report actually reflect the work we are doing. This is why data completeness is so very important. She added that Partnership is also learning from other plans. (There was an aside on single-county plans along the California coast.)

Dr. Moore referenced the national benchmarks and pronounced California’s general performance above those benchmarks “a victory.” He concluded that comparing Partnership to Inland Empire in Southern California is better than comparing Partnership to the single-county Contra Costa MCP.

Questions may be directed to the HEDIS® team at hedisteam@partnershiphp.org.

The [MY2025 MCAS Annual Summary of Performance](#) will soon be posted to Partnership’s website.

VI. Adjournment to 7:30 – 9:00 a.m. Aug. 19, 2026

Dr. Moore adjourned the meeting at 9:04 a.m.

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

Signature of Approval: _____

Date: _____

Chief Medical Officer Robert Moore, MD, MPH, MBA



QI DEPARTMENT UPDATE
JULY 2026
PREPARED BY ISAAC BROWN
SENIOR DIRECTOR, QUALITY AND PERFORMANCE IMPROVEMENT

<u>QUALITY INCENTIVE PROGRAMS (QIPs)</u>	
PROGRAM	UPDATE
PRIMARY CARE PROVIDER QUALITY INCENTIVE PROGRAM (PCP QIP)	Program Overview Pay for performance program incentivizing improved performance on Clinical, Non-Clinical, and Unit of Service (UOS) measures in the Primary Care setting. Program Update • The PCP QIP provider comment period for the MY2027 proposed measure set will run from 6/29/26 through 7/10/26. Providers will have the opportunity to comment on the proposed measure set and share any questions or concerns during this period. Feedback will be shared with internal stakeholders for consideration in the measure proposal process. • PCP QIP MY2025 Top Performers have been identified as providers who scored at least 90% of their QIP points. This year, 37 top performers were identified. They will be recognized on August 26, 2026, at the MY2025 Top Performer Recognition Ceremony. • The MY2025 eReports upload audit is currently in progress. The PCP QIP team is analyzing the results and will share outcomes with internal stakeholders.
PALLIATIVE CARE QUALITY INCENTIVE PROGRAM (PALLIATIVE CARE QIP)	Program Overview Pay for performance program which offers significant financial incentives to support and improve the access to and quality of palliative care provided by our contracted palliative care providers. Program Update • No new updates
PERINATAL QUALITY INCENTIVE PROGRAM (PQIP)	Program Overview The Perinatal QIP offers financial incentives to participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers providing quality and timely prenatal and postpartum care to Partnership members Program Update Program Update • The fiscal year program ended June 30th, and the 6-month bridge program will start July 1st with a Kickoff Webinar scheduled for July 7th. The final Enhancing Perinatal Care Webinar in the series was held on June 17th focusing on Parenting Education. The webinar included information on a wide range of topics that included education about stages of development, resources for parents, safe sleep practices and sleep training, discipline, social determinants of health, trauma informed care and more.

	Partnership continues to host Fostering Connections meetings with perinatal practices explaining Partnership’s programs for perinatal care to continue promoting timely prenatal and postpartum care.
ENHANCED CARE MANAGEMENT QUALITY INCENTIVE PROGRAM (ECM QIP)	Program Overview The ECM QIP offers financial incentives to motivate, modify, and improve the health outcomes of seven identified groups of individuals by standardizing a set of care management services and interventions Program Update 1st quarter 2025 payments are scheduled to be sent by the end of July. The ECM Program evaluation will be available for Q/UAC and will be presented at PAC.
HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)	Program Overview The Hospital QIP offers financial incentives to improve performance related to Readmissions, Advance Care Planning, Clinical Quality, Patient Safety, Operations and Efficiency, and Patient Experience Program Update - The fiscal year program ended June 30th, and the new 6-month program will start July 1st with a kickoff webinar scheduled for July 14th. - The 2025-26 measure set included a measure incentivizing birthing hospitals to enroll in California’s Vaccines for Children (VFC) program. To increase engagement, the HQIP program manager worked with staff at the State’s VFC Enrollment department to create a promotional flyer encouraging them to enroll in the VFC program, and the VFC staff started an enrollment campaign to hospitals reminding them of the benefits of the program and that hospitals have the opportunity to earn incentive dollars by enrolling in VFC by June 30, 2026. This measure will continue in the 6-month Bridge program with the hopes that more hospitals will take advantage of the VFC program.
EXTENDED CARE FACILITY INCENTIVE PROGRAM (EXT QIP)	Program Overview The EXT QIP offers financial incentives to support and improve the quality of long-term care provided to our members, with measures in the following domains: Clinical, Functional Status, Resource Use, and Operations / Satisfaction. Program Update - The Good Standing review has been completed, and the data will be presented in the next SNF Workgroup Meeting. - Gateway Measure QAPI Plan and Attestation full point will conclude on 6/30/2026, documents sent after the due date will receive partial points. - The EXT team will attend the in-person luncheon on September to meet with our providers and to provide an overview of the program.
<u>QUALITY DATA TOOLS</u>	

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	Program Overview The Partnership Quality Dashboard (PQD) is a Tableau designed to inform, prioritize, and evaluate quality improvement efforts. Dashboards and performance metrics built into the PQD provide the ability to track and trend QIP data. Program Update No new updates
EREPORTS	Program Overview eReports is a web application that allows providers to see their quality metrics in Partnership's PCP QIP program. eReports updates twice a week for near real-time visibility to quality metrics while PQD refreshes monthly for historical trending. Program Update No new updates
<u>PERFORMANCE IMPROVEMENT (PI)</u>	
ACTIVITY	UPDATE
STATE MANDATED WORK: <i>PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE</i>	Program Overview All plans in California are required to conduct PIPs as part of their agreements. DHCS has assigned Partnership two PIPs: a non-clinical PIP for BH and a disparity PIP. DHCS can also require plans to do mandated improvement PDSA projects Program Update No new updates.
QUALITY MEASURE SCORE IMPROVEMENT	Program Overview Internal measure-focused workgroups, which bring together perspectives across Partnership's services delivery continuum with the goal of strategically improving measures that align with the strategic priorities of Partnership HealthPlan. Current Priority Measures: - Child and Adolescent Well Care Visits (WCV) - Adolescent Immunizations (IMA-2) - Controlling High Blood Pressure (CBP) - Glycemic Status Assessment for People with Diabetes (GSD) - Timely Prenatal Care (PPC-Pre) Workgroup Updates Pediatrics: No new updates Women's Health & Perinatal: No new updates Chronic Disease: No new updates Behavioral Health: No new updates
IMPROVEMENT ACADEMY	Program Overview

The Partnership Improvement Academy launched in 2014 to offer various programs which provide training and technical assistance designed to help practices optimize population health, enhance the patient experience, promote provider and care team satisfaction, and foster a culture of continuous quality improvement. These programs are designed for a variety of audiences, including clinicians, administrators, and staff to gain quality improvement expertise from industry leaders and peers.

Current Offerings

QI Project Management Training Program

The Quality Improvement (QI) Project Training Program is designed to help provider organizations and community partners strengthen their skills to lead and manage QI initiatives by offering training and use of standardized tools, templates, and best practices. The program features a 6-session webinar series delivered over 12 weeks, covering all phases of the project life cycle and focuses on applying those methods to real-world QI efforts.

Program Update

- No new updates.

Improving Measure Outcomes Webinar Series

This series is designed to help Quality Improvement teams turn knowledge into action. These sessions focus on Partnership’s Primary Care and Perinatal Provider Quality Incentive Program (QIP) measures, offering practical strategies to close care gaps, advance health equity, and improve clinical outcomes. Each session highlights proven strategies and best practices from peer clinics that are actively achieving measurable improvements in patient care.

Program Update – This program sunset in FY 25/26.

ABCs of Quality Improvement

Program Overview

The ABCs of Quality Improvement (QI) is a full day in-person training designed to introduce participants to key QI methodologies with a specific focus on the Model for Improvement – a widely used framework for driving measurable change in health care settings.

Program Update – No new updates

	Microlearnings Program Overview These short, focused modules deliver key concepts in easily digestible formats. Program Update • Pre-visit Planning Microlearning was launched in June and available on the Improvement Academy Page (https://www.partnershiphp.org/Providers/Quality/Pages/PIAcademyLandingPage.aspx)
JOINT LEADERSHIP INITIATIVE (JLI)	Program Overview The Performance Improvement team facilitates Joint Leadership Initiative meetings with seven parent organizations across the Partnership network. Four of the seven organizations are in our expansion counties (Chico and Auburn Regions). This is a quality improvement strategy to collaborate with the largest parent organizations providing primary care who did not earn at least 75% of their PCP QIP scores in the previous year. This number could change once final 2025 PCP QIP scores are finalized. Update • No new update
REGIONAL IMPROVEMENT MEETINGS	Program Overview Regional Quality Improvement meetings are held quarterly at each of our 6 regional offices (Eureka, Redding, Chico, Auburn, Fairfield, and Santa Rosa) or online with the goal of bringing together regional health center quality leaders to share and discuss strategies to improve measures that are regionally important and learn from Partnership regarding any program changes and/or priorities. Update • Santa Rosa Region: June’s meeting focused on Colorectal Cancer screening and featured Peer Sharing from practices that have successfully used Cologuard Care Gap (bulk) ordering to improve screening rates. The next quarterly meeting is in September. • Fairfield Regions – June’s meeting focused on annual Well Child Visits and featured a discussion about flipping acute visits to close well child gaps in care, billing, and documentation requirements. The next quarterly meeting is in September. • Chico and Auburn Regions – Scheduled for July 13th and 15th • Redding and Eureka Regions –

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

CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS® (CAHPS) PROGRAM -MEDI-CAL PRODUCT LINE & ORG GOALS – FY 24/25 MEMBER EXPERIENCE AND ACCESS ORG GOALS – FY 25/26 MEMBER EXPERIENCE	Program Overview <i>The CAHPS team oversees NCQA Accreditation requirements for Member Experience (ME) 7 (Elements C and D) and conducts annual regulated and non-regulated CAHPS® surveys for Medi-Cal members, to assess patient experiences. Results aim to drive improvements in care quality and member experience</i> Program Updates CAHPS® Regulated Measurement Year (MY) 2025 / Report Year (RY) 2026 Survey - No new update. Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX) Fiscal Quarter 4: (Goal Met) This work was led by champions across Transportation, Member Services, Population Health and Quality Improvement, with a shared focus on improving access, benefit navigation and member experience. Summary of goal deliverables: Transportation Services Completed a pilot analyzing over 7,000 trips showing low grievance rates and improved driver performance. Findings are now being used to set performance standards and guide ongoing improvements. Quality Improvement (CAHPS Program) Used member feedback, including call data, community input and member interviews to: - Improve call routing and tracking - Standardized equity-focused questions - Develop a roadmap to address key experience gaps Member Services Improved how members access services by enhancing the phone system (IVR), including - Added new option for direct routing to dental, transportation, and mental health services (added new remark codes to track reductions in dental-related inquiries.) Dental Access & Engagement Increased preventative care and provider engagement through trainings and outreach, contributing to a 24.7% preventative dental visit rate among 61,791 members in 2025. Health Equity Advanced culturally responsive outreach by incorporating member feedback, hosting community sessions and strengthening partnerships to address access and awareness barriers. - For more insights on goal progress and milestone accomplishments, please visit the OpEx PMO internal goal dashboard (Partnership4Me, under Smart Links).

EQUITY & PRACTICE TRANSFORMATION PROJECT	Program Overview <i>The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative aimed at advancing health equity while reducing COVID-19 driven care disparities. During the three (3) year program, practices receive payments for achieving population health milestones that enable the implementation of improvements across their infrastructure, data capabilities and care management processes to promote patient well-being, health equity and whole-person care.</i> <i>Currently, 22 providers are participating in the EPT Program, with total estimated funding of \$10.9 million over the three-year project period. These providers are expected to receive payments tied to milestone achievements that support sustainable practice transformation. The last and final opportunity to submit eligible deliverables for milestone achievement is in November 2026 when the program concludes. Payments for the November 2026 successfully completed milestones will be paid out early 2027.</i> Program Updates • PHLC established minimum requirements for providers to remain in the program. Deliverables, due 05/01/2026, included: - o 2026 PhmCAT - o Milestone 3: Empanelment Policy & Procedure - o Milestone 4: Data Governance & HEDIS Policy & Procedure - o Milestone 6: Data Implementation Plan - o Milestone 8: Disparity Reduction Plan - o One Model of Care Document (Milestones 9-12) • Currently two (2) providers are at risk for being removed from the program, for not submitting the required deliverables by 05/01/26: Baechtel Creek Medical Clinic and K’ima:w Medical Center - o K’ima:w currently has an external consultant that they’ve engaged to help support submission of their outstanding deliverables and expect to have their submissions completed prior to the due date. - o Due to competing organizational priorities, Baetchel Creek has communicated an inability to complete required deliverables. They have been formally notified of the risk of removal from the program for continued non-compliance. No deliverables have been completed since May 2025. • MCPs are still pending to receive the deliverable submission report for the May 2026 deliverables from PHLC, which should have been available by June 2026. • The next CaTS Report for MY 10/1/24-09/30/2025 will be due on 07/31/26. A request for this data has already been submitted through the data reporting process.

EXPANDED COUNTIES REINVESTMENT IN QUALITY (E-RIQ)	Program Overview <i>The Expansion Counties Reinvestment in Quality (E-RIQ) program is a strategic \$2 million community reinvestment initiative aimed at improving health outcomes and member experience across the ten expansion counties: Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Tehama, Yuba, and Sutter.</i> <i>Funding is allocated through two pathways:</i> • Phase I: \$500,000 (\$50K allocated to each county) to strengthen community-based engagement and access across priority focus areas • Phase II: \$1.5 million for Provider opportunities to drive measurable improvements in quality priority measures through targeted initiatives and activities. • Phase III: Currently under exploration: Piloting a vendor-supported gap closure initiative. Program Updates: • Phase I - Kickoff webinar conducted and application period is currently open through July 10. • Phase II - Proposed framework has been developed and currently in review. Informational webinar anticipated in late-July. • Phase III – Next steps include connecting with vendor to develop business case / proposal to share with Executives.
PREVENTIVE CARE BRIDGE PROJECT (FORMERLY: LOCUM PILOT INITIATIVE)	Overview of the Preventive Care Bridge Project <i>The Preventive Care Bridge Project was developed as a short-term solution to address access challenges by providing targeted locum support with the goal of improving performance on preventive care measures, specifically well-child visits and cervical cancer screenings. By proactively guiding providers to maximize the locum resources through clear onboarding, scope alignment, and data tracking, the pilot explored a potential model for supporting improved measure performance, reducing withholds and sanctions associated with unmet benchmarks, and enhancing the overall member experience.</i> Project Update • No new updates
MOBILE MAMMOGRAPHY PROGRAM	Program Overview <i>Aims to boost breast cancer screening (BCS) rates for providers performing below the 50th percentile benchmark. Partnership collaborates with Alinea Medical Imaging and providers to host Mobile Mammography events, helping members complete preventive screenings.</i> Program Updates • Event Days for FY 25/26 Q4 (April – June)

	Current Event Days 04/01/2026 – 06/30/2026				
	Region	# of Provider Organizations	# of Provider Sites	# of Provider Event Days	# of Community Event Days
	Auburn	2	3	3	0
	Chico	2	7	7	0
	Eureka	9	16	19	0
	Fairfield	3	4	4	0
	Redding	10	11	11	1
	Santa Rosa	1	1	1	0
	Plan Wide	27	42	45	1
	* Totals may not match across columns due to provider orgs hosting event days at multiple sites and regions within the quarter. ** Community event days are reported separately and not included in provider totals. Scheduling for FY 26/27 Q1 (July - September) is currently in process.				
PARTNERING FOR PEDIATRIC LEAD PREVENTION PROGRAM (PPLP)	Program Overview Provides LeadCare II POC devices to qualified providers and enrolls them in a year-long program with coaching and education. Offers lead poisoning prevention education to all and collaborates with local agencies. Program Updates No new updates at this time.				
EXACT SCIENCES: PROMOTING COLORECTAL CANCER SCREENINGS	Offering Overview Providers can place care-gap orders for Cologuard kits directly through Exact Sciences or via facilitated orders through Partnership to eliminate the minimum requirement of 200 members. Any provider interested in more information can fill out the Partnership's Cologuard Facilitated Order Interest Form on our Cologuard Care-Gap Orders page. Program Updates Partnership Facilitated Orders The next Facilitated Order is scheduled to launch on 07/20/2026 and is aligned with QIP's timeline for addressing 2026 and 2027 PCP QIP Measures .				

QI TRILOGY PROGRAM	Program Overview <i>Annually, the Quality Improvement (QI) department updates three core documents – often referred to as the QI Trilogy Documents, that collectively describe the program structure, priorities and performance. The Program Description outlines the overall QI framework, the Work Plan details active and planned initiatives aligned with strategic priorities, and the Program Evaluation assesses progress, outcomes and opportunities for improvement.</i> Program Updates • The FY2026–2027 QI Program Description is complete and ready for submission for committee and Board approval. Scheduled review and approval dates are as follows: 1. Internal Quality Improvement (IQI) Committee – 08/11/2026 2. Quality Utilization Advisory Committee (Q/UAC) – 08/19/2026 3. Physician Advisory Committee (PAC) – 09/09/2026 4. Board of Directors – 10/28/2026 • Submissions for the FY2025-2026 QI Program Evaluation have been received and internal reviews are underway. • Goal submissions for the FY2026-27 QI Work Plan have been finalized. • All Trilogy documents (FY2026/27 QI Program Description; FY2025/26 QI Work Plan; FY2025/26 QI Evaluation; and FY2026/27 QI Work Plan) are on track to be submitted by 07/28/26 for formal quality committee approval.
SAGE GRANT	Program Overview The Systems Advancement for General EHR (SAGE) Grant is designed to assist healthcare providers in implementing or upgrading their EHR systems, to help modernize and enhance their ability to deliver high-quality, efficient, and member-centered care. This grant will help providers overcome common barriers to EHR adoption by offering financial support and implementation guidance. The recipient of the SAGE grant, K’ima:w Medical Center, signed the agreement on 12/5/2025. The first payment installment of \$125,000 was initiated. The SAGE Grant team will continue to conduct regular check-ins and monitor implementation milestones. The SAGE Grant Timeline can be found here. Program Updates Partnership conducted the January – June Progress Check-In with K’ima:w on 06/15/2026. • The K’ima:w OCHIN EPIC EMR Implementation is on track without any identified risks. However, there are a few operational areas in which their internal teams are working to provide clearer structure and follow-up to prevent delays in integrating external systems into their EMR (e.g., ECM Program workflows, PRC referrals, patient engagement tools, and AI scribe use). • Core staff are up to date with required OCHIN EPIC training. They are working to close gaps in communication which was an identified barrier in having all staff

	engaged and leveraging the virtual training option. K’ima:w plans to work with their HR teams as a targeted approach to improve the completion rate of the training.																									
D-SNP MEDICARE	<u>D-SNP</u> Program Overview The D-SNP Quality team is responsible for 1) Development and finalization of the Model of Care document, 2) Management of Partnership’s CMS Medicare Star quality program, and 3) Developing D-SNP readiness for all Quality Improvement teams. The team has revised QI Department D-SNP Project plans to reflect the launch postponement with vendor-related projects TBD. All QI D-SNP related project plans can be found on the Partnership Advantage Share Point Project plan site.																									
ACTIVITY	UPDATE																									
<u>QUALITY ASSURANCE AND PATIENT SAFETY</u>																										
ACTIVITY	UPDATE																									
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 5/29/2026 TO 6/24/2026	Program Overview To identify, report, and manage Potential Quality Issues (PQI), to determine opportunities for improvement in the provision of care and services to our members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity. Program Update • 27 referrals were received with 21 coming from Grievance and Appeals, 1 from Utilization Management, 1 from Care Coordination, 1 from an Associate Director, 2 from a Regional Medical Director and 1 from other. • 30 cases were processed and closed • 111 cases are currently open • There was no PRC meeting in June, as there were no cases to present. We are currently awaiting three cases for PRC review.																									
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: 4/1/2026 TO 6/19/2026	Program Overview Site Review and Medical Record Review performed for monitoring of providers. Primary and OB Reviews: <table><tr><th>Region</th><th># of FSR conducted</th><th># of MRR conducted</th><th># of FSR CAP issued</th><th># of MRR CAP issued</th></tr><tr><td>Auburn</td><td>10</td><td>9</td><td>2</td><td>7</td></tr><tr><td>Chico</td><td>6</td><td>6</td><td>3</td><td>4</td></tr><tr><td>Eureka</td><td>6</td><td>7</td><td>0</td><td>3</td></tr><tr><td>Fairfield</td><td>5</td><td>5</td><td>4</td><td>4</td></tr></table>	Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued	Auburn	10	9	2	7	Chico	6	6	3	4	Eureka	6	7	0	3	Fairfield	5	5	4	4
Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued																						
Auburn	10	9	2	7																						
Chico	6	6	3	4																						
Eureka	6	7	0	3																						
Fairfield	5	5	4	4																						

	Redding	16	12	5	9
	Santa Rosa	0	0	0	0
New sites opened this period → 3 new reviews Program Update - No new updates					

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	Program Overview HEDIS is used to evaluate clinical quality in a standardized way. This program shares performance measurement rates with the intent of improving the quality of care delivered to members. Program Update
HEDIS® Program Overall	Program Updates

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	Program Overview The State of California requires all Managed Care Plans (MCPS) to be Health Plan (HP) Accredited. The process involves completing a Renewal Survey every three (3) years, and reporting HEDIS and CAHPS results every year for a Health Plan Rating (HRP) score. Partnership's next HPA Renewal Survey is scheduled for 09/15/2026. Program Update - There were six (6) milestones for the FY 25-26 NCQA-related HPA Key Activities tied to maintaining compliance with all assigned NCQA HPA Standards and Guidelines and an ensuring readiness for HPA Renewal Survey. All milestones were completed by participating departments before the end of the fiscal year. - There are five (5) milestones for the FY 26-27 NCQA-related HPA Key Activities that focus on preparing for the HPA Renewal Survey in September 2026 and maintaining compliance of all assigned HPA Standards and Guidelines. These Key Activities were shared with all Business Owners during the May 2026 Business Owner Check-in Meetings. The milestones are:

	○ Partnership obtains an Accredited status by December 2026. ○ If the accreditation status is Provisional or Accredited under Corrective Action, Partnership will prepare and implement a Corrective Action Plan and/or resurvey to receive an Accredited status. ○ Review the 2027 HPA Standards and Guidelines, evaluate the updates, assess impact, and complete the Gap Analysis tied to the assigned requirements. ○ Update the annual HPA Workbook (Work Plan, Evidence Submission Library and Report Schedule), based on the 2027 HPA Standards and Guidelines. ○ Achieve HPA compliance and maintain readiness as demonstrated by strict oversight of Partnership and non-Accredited delegates' files and completed analysis reports based on the approval date indicated in the HPA Report Schedule. ● All Business Owners submitted the look-back Year 2 HPA Renewal Survey evidence by the agreed-upon timeline. The NCQA Program Management Team reviewed the evidence and shared feedback with impacted Business Owners for clarification and/or revisions as needed. The NCQA Program Management Team will continue to work with the Business Owners of a subset of evidence that is not yet available to ensure timely submission prior to HPA Renewal Survey. Business Owners will also be tasked to approve the combined evidence packages for Year 1 and Year 2 prepared by the NCQA Program Management Team by 07/31/2026. All submissions will be finalized by 09/11/2026. Specific instructions on how to submit the file review universe and documents for the selected delegates have been reviewed with the impacted departments during the bi-monthly Business Owner Check-in Meetings. Instructions will also be shared with Business Owners via email in early August 2026.
NCQA Health Outcome Accreditation (HOA)	Program Overview NCQA Health Outcomes Accreditation focuses on using a data-driven approach to understand populations and improve care. The program intends to identify and address gaps and disparities in clinical quality, access, and patient experience. Partnership's next HOA Renewal Survey is tentatively scheduled for 05/16/2028. Program Update ● There were three (3) milestones for the FY 25-26 NCQA-related HOA Key Activities tied to maintaining compliance with all assigned NCQA HOA Standards and Guidelines. All milestones were completed before the end of the fiscal year. The NCQA Program Management Team continues to work with selected department(s) to address a few outstanding areas under the 2026 HOA Workbook, and to ensure no issues identified based on the proposed timeline and documentation(s) required to meet survey compliance.

	The NCQA Program Management Team shared a three (3)-year HOA Renewal Survey timeline with all Business Owners during the May 2026 Business Owner Check-in Meetings. Per the 2028 HOA Renewal Survey Timeline, BOs are currently preparing Year 1 evidence as outlined in their Evidence Submission Libraries (ESLs). In preparation for HOA Renewal Survey, a HOA Mock Renewal Survey is scheduled for 03/22/2027-03/23/2027. The Mock Renewal Survey serves as a full-scope review of all “Year 1” evidence by our NCQA Consultant.
NCQA Health Plan Accreditation (HPA) and Health Outcomes Accreditation (HOA)	N/A

Partnership

Policy & Procedure Updates

August
2026

Policy Number	Policy/Procedures/Guidelines
The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in June and July 2026. Highlighted policies have significant changes, new attachments, or were amended during the Q/UAC meeting. Redline versions contain attachments. Please review the redline drafts and the detailed Synopsis of Changes in the packet. The current policies shown in the online Provider Manual are hyperlinked.	
Population Health Management	
MPNP9002-D	Cultural & Linguistic Program Description Process for Culturally and Linguistically Appropriate Translations - Attachment
MPND9007	Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)
MPNP9008	Women, Infants and Children (WIC) Supplemental Food Program
Pharmacy Operations	
MCRP4064	Continuation of Prescription Drugs
MPRP4062	Drug Wastage Payments
MPRP4065	Drug Utilization Review (DUR) (Not yet published online)
Provider Relations	
MPPR207	Annual Physician Satisfaction Survey
Quality Improvement	
MPXG5008	Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing
MPXG5009	Lactation Clinical Practice Guideline
MCQP1025	Substance Use Disorder (SUD) Facility Site Review and Medical Record Review
MCQP1052	Physical Accessibility Review Survey – SR Part C

Utilization Management	
MCUP3041	Treatment Authorization Request (TAR) Review Process
MCUP3140	Palliative Care: Pediatric Program for Members Under the Age of 21
MPUG3025	Insulin Infusion Pump and Continuous Glucose Monitor Guidelines
MPUP3039	Direct Members
MPUP3111	Pulmonary Rehabilitation
MPUP3139	Criteria and Guidelines for Utilization Management
MCUG3007	Authorization of Ambulatory Procedures and Services
MCUG3134	Hospital Bed/ Specialty Mattress Guidelines
MCUP3015	Family Planning Bypass Services
MCUP3114	Physical, Occupational and Speech Therapies
MCUP3141	Delegation of Inpatient Utilization Management
MPUG3010	Chiropractic Services
MPUP3042	Technology Assessment
MPUP3138	External Independent Medical Review

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the June 17, 2026 Quality/Utilization Advisory Committee (Q/UAC) meeting. It is recommended that you 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 #	Summary of Revisions (include why the changes were made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Population Health – Presenter: Christine Smith, Community Health Needs Liaison, Pop Health			
MPNP9007 – Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)	197 – 205	I. Related Policies: Updated policy code (“MC to MP”) for relevant policies, updated reference to MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program. III.D Definitions: Updated Partnership Advantage (D-SNP) effective date to 1/1/2028; Updated Partnership Advantage “members” to “enrollees.” Also added that coverage criteria apply upon implementation, subject to CMS and DHCS approval. V.A Purpose: Added language clarifying lactation services and supplies covered preventive services provided without cost sharing VI.E Policy/Procedure: Added requirement for culturally and linguistically appropriate delivery of lactation services, aligned with California Advancing and Innovating Medi-Cal (CalAIM) and DHCS health equity standards; included reference to MPND9002 VI.I.1B Policy/Procedure: Clarified Electronic Visit Verification (EVV) applies only to home-based lactation services; excluded facility/office settings VI.I. Policy/Procedure: Added language recognizing doulas as Medi-Cal providers for lactation support; referenced MPNP9006 and MPCR15 VI.C.1 Timing of Lactation Support Services: Clarified eligibility for lactation support services during pregnancy and up to one year post-partum. VI.C.2 Providers of Lactation Support Services: Clarified provision of lactation education and support across prenatal, delivery, and postpartum periods; added reference to APL 26-005. VI.C.2D Providers of Lactation Support Services: Added telehealth guidance for lactation services; ensured access to in-person care is maintained VI.C.5A-B Lactation Support Services: Clarified lactation services as a covered preventive benefit without cost sharing per APL 26-005; defined preventive services versus medically necessary services requiring authorization VI.C.6B3 Breast Pumps: Replace CPSP with PHPS health education codes for reimbursement of breast pump education. VI.C.6C Breast Pumps: Clarified breast pump coverage without a Treatment Authorization Request; added three-year limit, and defined TAR requirement for early replacement VII. References: Added APL 25-013 - Medi-Cal Rx Pharmacy Benefits, And Cell and Gene Therapy Coverage (09/18/2025) – supersedes (APL) 22-012	Member Services Pharmacy Utilization Management Quality Improvement Care Coordination

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
		Added APL 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members (03/25/2026) IX. Position Responsible for Implementing Procedure: Updated to Chief Medical Officer.	
MPNP9008 – Women, Infants and Children (WIC) Supplemental Food Program	297 – 210	I. Related Policies: Updated policy code (“MC to MP”) for MPNP9006 – Doula Services Benefit. III. Definitions: Updated terminology to reflect “nutritious food packages” and removed reference to prescriptive checks; Updated Partnership Advantage (D-SNP) effective date to Jan. 1, 2028 and updated Partnership Advantage “members” to “enrollees.” Also added that coverage criteria apply upon implementation, subject to CMS and DHCS approval. VI.A.1 Coverage Guidelines: Clarified Partnership responsibility to identify, refer, and follow up with eligible members to support access to WIC services VI.B.1 Identification and Referral: Added provider requirement to assess nutritional risk and food insecurity for WIC eligibility VI.B.5 Identification and Referral: Added requirement to follow up on WIC referrals and document member access to services in the medical record VI.B.6 Identification and Referral: Clarified documentation of WIC referrals and outcomes; added reference to MPNP9007 VI.C.1 Follow-up : Clarified provider training requirements for WIC referrals, follow-up, and documentation VI.C.3 Follow-up: Added QI monitoring of WIC referral and follow-up practices VI.D.1 MOU Requirements: Reverted to original WIC MOU execution language, removing the “good faith effort” standard. VII.F References: Added APL 26-005 - Maternity Services for Pregnant and Postpartum Medi-Cal Members (03/25/2026) IX. Position Responsible for Implementing Procedure: Updated to Chief Medical Officer.	Member Services Pharmacy Utilization Management Quality Improvement Care Coordination
Policy Owner: Utilization Management <i>Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations</i>			
MCUP3041 – Treatment Authorization Request (TAR) Review Process	211 – 229	Section I. B. and L.: Policy MPUP3014 Emergency Services was added as a Related Policy and policy MCUP3064 Communication Services was removed, because that policy has been archived and the information is included in policy MPU3001 UM Program Description, which is already listed. VI. A.2.b.: Clarification was added to say that Partnership’s Online Services (OLS) portal is available “24 hours per day, 7 days per week.” VI.B.1.a. – c.: Clarification was added to specify that Partnership requires TARs for certain procedures in three categories: Non-behavioral (medical) healthcare, Behavioral healthcare, and Pharmacy.	Provider Relations Providers

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i>)	External Documentation (Notice required outside of originating department)
		VI.B.2.: Additional language was added in paragraph regarding exhaustion of Medicare coverage to say “This requirement applies only when Medicare coverage is primary and applicable to the requested service.” VI.C.2.b.: Redundant sentence regarding the assignment of a specified number of days for an inpatient TAR was deleted because the same information was stated below at VI.C.2.b.1). VI.C.3.a.: Language regarding long term care facility was removed because Partnership does not typically see emergency or obstetrical admissions to an LTC facility. VI.C.4.b.: CCR Title 22 section 50777 was added as a regulation requiring that Medi-Cal beneficiaries apply for any available health care coverage when no cost is involved. VI.C.4.d.: Language was updated to clarify that Partnership assigns Members with ESRD to a Direct Member status (rather than issuing a lifetime TAR) to ensure that dialysis services are approved in an efficient manner. VI.C.5.: Hospice Services section was updated to include language from recent APL 25-008. VI.C.6.: Terminology was updated from Long Term Care to Extended Care nursing services. VI.D.6.a.3): Language was changed to say “as soon as possible” rather than “within 24 hours” for Partnerships attempts to obtain any missing necessary information for urgent concurrent care. VI.D.6.a.4): Language was clarified to describe how Partnership will inform the hospital Utilization Review department staff of denial decisions for urgent concurrent reviews. VI.D.6.c.1): Time frame for rendering a decision for a non-urgent pre-service review was changed from 5 business days to 7 calendar day as per CMS-0057-F. VI.D.6.c.4): Language describing a second pend time frame up to 28 days was removed as this is no longer applicable according to CMS-0057-F. VI.D.6.c.5)a): Time frame for rendering a decision for a non-urgent pre-service review was changed from 5 business days to 7 calendar days as per CMS-0057-F and option to extend a pend up to 28 days was removed. VI.E.4.: Policy language was updated to include description of IRR audits for pharmacist reviewers and lead pharmacy technicians, in addition to the IRR audits already described for physician and nurse reviewers. VII.A.: Reference to DHCS Contract was updated. VII.B.: Date of APL 21-011 was updated for revision. VII.C.: Reference for APL 22-012 was updated to reflect current APL 25-013. VII.E.: Reference to Title 42 CFR 438.114 was updated to include description VII.F.: Reference was added for Title 22 CCR 50763 and 50777 VII.G.: Reference to Title 28 CCR 1300.71.4 was updated to include description VII.H.: Reference to CMS Final Rule CMS-0057-F was updated Attachment A:	

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i>)	External Documentation (Notice required outside of originating department)
		• Various policy numbers and names were updated throughout. • Updated the Diagnostic Studies section H. on page 1 of policy Attachment to define and clarify three acronyms we were using at A.B. and C. as follows; A. Magnetic Resonance Angiography (MRA) B. Mass Spectrometry Imaging (MSI) C. Magnetoencephalography (MEG) and also added a Note to specify that “No TAR is required for CT scans for MRIs.” • References to APL 22-012 were updated to reflect APL 25-013 for Medi-Cal Rx	

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the July 15, 2026 Quality/Utilization Advisory Committee (Q/UAC) meeting. It is recommended that you 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 #	Summary of Revisions (include why the changes were made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
Policy Owner: Quality Improvement		<i>Presenter: Marshall Kubota, Associate Medical Director</i>	
MPXG5008 – Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing	215 – 255 <i>CLEAN copy begins on p. 327</i>	This policy, like MCQP1025 on today’s consent calendar, does not change the Drug Medi-Cal Organized Delivery System (DMC-ODS) language. Both policies may come back to committees when Partnership sunsets its Wellness & Recovery program. Section III. The Partnership Advantage definition is updated to note the additional line: Coverage criteria apply on implementation of D-SNP (Dual-eligible Special Needs Plan), effective January 1, 2028 and subject to CMS and DHCS (Centers for Medicare and Medicaid Services and Department of Health Care Services) approval. Section IV. Primary Care and Emergency Department attachments (i.e., A & C) updated to reflect policy changes. Section VI.B.8 (Primary Care Clinician (PCP)) is edited: The CDC (Centers for Disease Control) recommends that clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, with a suggested interval of every three months for most patients. ~~For those at higher risk for (Opioid Use Disorder) OUD or overdose (depression or other mental health conditions, a history of (Substance Use Disorder) SUD or overdose, taking ≥50 MME/day, or taking other CNS depressants), a greater frequency of reevaluation is recommended.~~ Section VI.C.4 (Specialist Referral) is edited: Partnership Behavioral Health Access Line replaces Carelon reference. For residents of all other Partnership HealthPlan counties, contact the relevant county behavioral health access department: <i>a list of phone numbers may be found under “Benefits: Alcohol and Drug Treatment” at https://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx</i>. Deleted mention of the no-longer-required Drug Enforcement Agency (DEA) waiver (aka “X-Waiver) for buprenorphine prescribing. Section VI.D.2e. added: Recommend, furnish, or prescribe naloxone to patients at risk of overdose, family and friends who may witness an overdose or are themselves at risk of overdose. As of 2026, naloxone is available over the counter (OTC) at pharmacies, online retailers and community organizations without a prescription. Medi-Cal Rx covers both prescription and OTC naloxone with no copayments. Medicare Part D may cover the cost of prescribed forms of naloxone. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose, including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set to, in regulations, require employers to include naloxone in workplace first-aid kits by December 2028.	Health Services Claims Member Services Provider Relations

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
		Section VI.D.4.d: deleted incomplete list of validated screening tools, instead suggesting that “Validated screening tools for substance misuse or substance use disorder can be helpful. Please refer to Attachment A of policy MPBP8007 Screening and Treatment for Substance Use Disorders for a table of Recommended Tools and Training Resources for Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT), including validated tools for pregnant people. Section VI.G.1. adds two hyperlinked articles recommended for ED personnel’s consideration in screening for SUD and initiating Medication for Addiction Treatment (MAT). References: two are deleted and another is added. Hyperlink accessibility verified on each. Further edits were made at July 7 IQI: • MAT, when spelled out in this and other policies should use the industry standard “Medication for Addiction Treatment.” (The “A” should not be “Assisted”). • End of Section VI.B.8 is rewritten to clarify “higher risk of overdose”: For those at higher risk for OUD or overdose, more frequent clinical reassessments are recommended. “Higher risk” includes those enumerated by CDC Clinical Practice Guideline for Prescribing Opioids for Pain and the American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder (2020) (e.g., those with family history of substance use disorders, history of trauma, age between 18-25 years old, co-occurring depression or other mental health conditions, a history of SUD or overdose, taking ≥50 MME/day, or taking other CNS depressants). In addition, the National Institute on Drug Abuse (NIDA) offers the Opioid Risk Tool (ORT-OUD) that providers can administer at an initial visit to assess risk for future opioid use disorder prior to beginning or continuing opioid therapy for pain management. • The ASAM and NIDA hyperlinks above have been added to the References section.	
Policy Owner: Utilization Management <i>Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations</i>			
MPUG3025 – Insulin Infusion Pump and Continuous Glucose Monitor Guidelines	257 – 273	Sections VI.C. and VI.C.2a.4) were rewritten after July7 IQI discussion. III.D: Definition of Direct Member was updated to include Partnership Advantage and to say that Partnership supports coordination of care among providers for Direct Members. III.F: Definition of Partnership Advantage program was updated to add “Coverage criteria apply on implementation of D-SNP, effective January 1, 2028 and subject to CMS and DHCS approval. “ III.G. Definition of Whole Child Model was updated	Provider Relations Configuration

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, i.e., NCQA, APL, Medi-Cal guidelines, clarification, etc.)	External Documentation (Notice required outside of originating department)
		IV.B.: Attachment B, which was the CCS Numbered Letter (N.L.) 15-1222 regarding Continuous Glucose Monitors (CGMs), was removed because DHCS has discontinued sharing that particular N.L. on their website. Partnership submitted an inquiry to DHCS for the missing N.L. and received a response saying N.L.15-1222 is still active policy, but several N.L.'s were removed from the DHCS website because they were no longer compliant with the American Diabetes Association 2025 release of Standards of Care in Diabetes. DHCS did say they are in the process of updating NLs to be ADA compliant, but they have not completed this item yet. Therefore, Partnership is removing Attachment B at this time. VI.B.2.c.4): TAR information required for an insulin infusion pump was updated. Requirement for a 30 consecutive day self-test blood glucose log was removed and replaced with a requirement for "Documentation that Member is insulin dependent or on agents that are associated with hypoglycemia." VI.C.: Because CGMs are covered by Medi-Cal Rx, this section was rearranged and updated to emphasize that providers should first request CGMs through Medi-Cal Rx, and then only request through Partnership (as DME) if the CGM system cannot be provided by Medi-Cal Rx. VI.C.2.a.4): A TAR requirement was added to the list for when a CGM supplied under DME as follows: "Documentation that the device is not available from a Medi-Cal Rx pharmacy." VI.C.3.c.: Criteria description was simplified in this section describing long-term continuous glucose monitoring for patients with type 2 or gestational diabetes. VII.A., B., and H: Additional References were added for DHCS guidelines and the Medi-Cal Rx Manual. The Reference for the CCS N.L. 15-1222 was removed and the Reference for APL 22-012 was updated to reflect 25-013. Attachment B: As described above for IV.B., this attachment was archived for now because this DHCS guidance is not currently available.	
MPUP3039 – Direct Members	275 – 287	Section I. C.,E. and F.: In the Related Policies section, • Policy MPCP2002 California Children's Services was removed because the Whole Child Model now applies to all Partnership counties as per policy MCCP2024. • Our policy regarding Foster Children was updated in name and number to MCBP8015 Coordination of Care for Child Welfare-Involved Members. • Policy MCUP3051 Long Term Care SSI Regulation was removed as that policy been archived, with information added to policy MCUG3038 Review Guidelines for Member Placement in Extended Care (Custodial/Long Term Care, Skilled or Subacute) Facilities.	Member Services Configuration Claims

Synopsis of Changes to Discussion Policies

Policy Number & Name	Page #	Summary of Revisions (include why the changes were made, <i>i.e.</i> , NCQA, APL, Medi-Cal guidelines, clarification, <i>etc.</i>)	External Documentation (Notice required outside of originating department)
		Section III. C. and D.: Definitions for Partnership Advantage and Whole Child Model were updated Section VI.A.: Definition of Direct Members was updated to say that “When a PCP is not assigned, Partnership supports coordination of care among providers. Section VI.E.1.c.: Clarification was added to say that if a request for Direct Member status is denied, the Member will receive written notice that includes the reason for the decision and appeal rights. Section VII.D: Reference was added for Code of Federal Regulation, Title 42 § 438.206 Attachment A: Partnership’s Direct Member / Health Conditions Category Designation Grid was updated throughout for upcoming HRP category descriptions. • H13 terminology was updated to say “birthing Member.” • H18 requirements were clarified for Native Americans Redding Rancheria Liberty site. • H20 requirements were clarified for Medi-Medi Members • H28 Aid codes for Long Term Care were clarified • H32 Holderman Patients was deleted	



Written Documents: Translation Process and Quality Assurance

April 2026



Written Documents-Certifications and Quality Procedures

Propio, formerly known as United Language Group (ULG) has nearly four decades of experience providing qualified written translation and language accessibility services for the U.S. healthcare, health insurance, and medical industries in over 235 languages. We approach language access with evidence-based solutions, initiative-taking 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, Propio delivers high service standards with every translation project, delivering language translation with quality, service, and speed. Our ISO-aligned 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. Our long history in the healthcare and medical industry has enabled us to achieve a large and diverse healthcare customer base as well as a specialized and dedicated healthcare team of account managers, project managers, translators, cultural adaptation specialists, and technologists that provide truly authentic and meaningful communication services. Each staff member and our team of 10,000 linguists have been hired for their customer-service orientation and healthcare terminology expertise. They are further trained and empowered to ensure that special care will be taken to ensure cultural nuance and appropriate literacy levels are applied to your translations. Healthcare translations will aim to match the literacy level of the English source content to further ensure readability and consistency, which is generally around the 6th grade reading level for most materials.

1. [Translator Qualifications and Language Proficiency Assessments](#)

Propio 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 Propio. 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, Propio linguists are continuously assessed at the project level as part of the QA step.

Additionally, Propio looks to ensure the following:

- ATA Accreditation: Many of our translators are certified by the American Translators Association (ATA) where applicable. 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 and validate a potential linguist's qualifications and skill level.
- Technical capabilities: We require translators to 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.

2. Metrics and KPI's For Consistent Service Delivery

Propio's Quality/Information Security Management System (QMS/ISMS) guides our policies, principles, processes, and procedures which describe how PROPIO manages organizational goals, meets applicable customer and regulatory requirements, and follows ISO quality processes.

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: Propio maintains a 99+% on-time delivery (OTD) rating. On-time delivery is automatically tracked through our HITRUST secure portal and Translation Management System.



Propio translation services and timelines are aligned to meet customer-specific, compliance/regulatory-driven or even product-specific timelines, such as NOA/NAR's, Grievance and Appeals, annual enrollment materials and more.

- **Translation Quality:** Measuring translation quality is vital to ensuring consistent, accurate final deliverables. Our ongoing quality-level audits identify potential issues with processes or resources and enable us to identify when immediate corrective actions are required.
- **Customer Satisfaction:** Gathering feedback directly from our clients allows us to identify potential issues which are not visible/identifiable from other reports/KPIs. Also, 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 and term/translation consistency for each client.
- **Utilization:** Comparing translation volumes against utilization numbers is a great way to identify Propio's capacity for scalability and helps with planning for growth and/or with high volume requests.

3. Language Quality Control and Quality Assessment Process

Language quality control is at the heart of Propio's ability to provide accurate, effective, and culturally appropriate communications. Our documented quality-driven policies, procedures, evaluation standards, and multi-step translation workflows ensure consistent quality in every language. Propio knows the importance of ensuring linguistic accuracy, readability, and cultural appropriateness in written healthcare communications. We prioritize patient/member comprehension, taking special care to ensure cultural nuance and appropriate literacy levels are applied to enhance understanding of complex health information. Our teams also follow industry-leading best practices from the healthcare industry, and have a goal of providing clear, simple, and inclusive communications, which is further supported by the following:

- Utilizing qualified, subject-matter professional translators who have the appropriate cultural knowledge, translation and writing skills needed 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 signs off on the process once completed and then saved for tracking purposes.

Wendy Dulaney

Wendy Dulaney
Account Manager
Healthcare Accounts
Propio, April 6, 2026

Propio LS, LLC
10801 Mastin Boulevard, Suite 580
Overland Park, KS 66210

Local: 913-381-3143 | Fax: 866-231-8176
10801 Mastin St. #580 Overland Park, KS 66210

propio.com



PRESCIENT
ASSURANCE

Prescient Assurance LLC
25 W 36th Street Floor 11
New York, NY 10018

August 4, 2025

Propio LS, LLC
10801 Mastin St. #580, Overland Park, KS 66210
Name of Signatory: Christopher Pesce
Phone and Email of Signatory: 913-381-3143, cpesce@propio.com

Letter of Attestation SOC 2 Type 2 Compliance

Unqualified Opinion

In our opinion, in all material respects:

- a) The description presents Propio LS, LLC's system that was designed and implemented throughout the period April 1, 2025 to June 30, 2025 in accordance with the description criteria.
- b) The controls stated in the description were suitably designed throughout the period April 1, 2025 to June 30, 2025, to provide reasonable assurance that Propio LS, LLC's service commitments and system requirements would be achieved based on the applicable trust services criteria, if its controls operated effectively throughout the period, and if the subservice organization and user entities applied the complementary controls assumed in the design of Propio LS, LLC's controls during that period.
- c) The controls stated in the description operated effectively throughout the period April 1, 2025 to June 30, 2025, to provide reasonable assurance that Propio LS, LLC's service commitments and system requirements were achieved based on the applicable trust services criteria, if the complementary subservice organization and complementary user entity controls assumed in the design of Propio LS, LLC's controls operated effectively throughout the period.

Prescient Assurance LLC confirms SOC 2 Type 2 compliance by Propio LS, LLC in accordance with the AICPA's Trust Service Criteria for Security, Confidentiality and Availability.

Prescient Assurance

Prescient Assurance, LLC.





HITRUST 6175 Main Street
Suite 400
Frisco, TX 75034

View this assessment in the
HITRUST Report Center



Letter of HITRUST Essentials, 1-year (e1) Certification

November 13, 2025

Propio Language Services
10801 Mastin Street
Suite 580
Overland Park, Kansas 66210-1843 USA

HITRUST has developed the HITRUST CSF, a certifiable security and privacy framework which incorporates information protection requirements based on input from leading organizations. HITRUST identified a subset of the HITRUST CSF requirements that an organization must meet to be HITRUST Essentials, 1-year (e1) Certified for a defined assessment scope. Propio Language Services ("the Organization") has chosen to perform a HITRUST CSF v11.6.0 e1 validated assessment utilizing a HITRUST Authorized External Assessor Organization ("External Assessor").

Scope

The following platforms of the Organization were included within the scope of this assessment ("Scope") which included a review of the referenced facilities and supporting infrastructure for the applicable information protection requirements:

Platforms:

- AILP residing at Amazon Web Services and Microsoft Azure
- Propio Analytics residing at Amazon Web Services
- Propio One residing at Amazon Web Services
- Sync residing at Amazon Web Services
- Translation Portal residing at Amazon Web Services and Microsoft Azure
- Workforce OS residing at Amazon Web Services

Facilities:

- Amazon Web Services (AWS) (Data Center) managed by Amazon located in US East 2, United States of America
- Microsoft Azure (Data Center) managed by Microsoft located in US Central, United States of America

Confidential
Propio Language Services

Page 1 of 4

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Certificate

Issued by Indian Register Quality Systems



Certificate No.
IRQS/254901988

To certify that the HIPAA Compliance of

Propio LS, LLC

ADDRESS

10801 Mastin St. #580 Overland Park,
KS 66210, Kansas,
United States

has been assessed and found complying to the requirement of HIPAA (Health Insurance Portability and Accountability Act)

INITIAL CERTIFICATION DATE	CURRENT DATE OF GRANTING	EXPIRY DATE
DECEMBER 16, 2025	DECEMBER 16, 2025	DECEMBER 15, 2026

CERTIFICATION SCOPE

- Provision of Interpretation, Translation and Localization Services
- Propio ONE, Propio Analytics, Workforce OS, AILP, Translation Portal, Sync and supporting backend systems
- AWS-hosted infrastructure supporting Propio's applications, including EC2, S3, ECS, ELB, RDS/VPC/networking components, IAM configurations, and associated security controls
- GitLab, used for development, version control, CI/CD, and security scanning
- Corporate IT environment, including:
 - Workforce identity and access management
 - Endpoints and device controls
 - Logging, monitoring, vulnerability management, and patching
 - Security operations, incident response, and risk management processes



Indian Register Quality Systems



Shashi Nath Mishra
CEO

Condition Comment

Indian Register Quality Systems (A Division of IRCLASS Systems and Solutions Private Limited)
Head Office: SCA, Adil Sherkaracharya Marg, Upo. Powai Lake, Powai Mumbai - 400 072, India. website: www.iqrs.co.in, www.irclass.org

CHIRCSI-HIPAA/Rev0



Certificate of Approval

Issued by Indian Register Quality Systems



Certificate No.
IRQS/250101882

To certify that the Quality Management Systems of

Propio LS, LLC

ADDRESS

10801 Mastin St. #580 Overland Park,
KS 66210, Kansas,
United States

has been assessed and found conforming to the requirement of ISO 9001: 2015

INITIAL CERTIFICATION DATE

NOVEMBER 21, 2025

CURRENT DATE OF GRANTING

NOVEMBER 21, 2025

EXPIRY DATE

NOVEMBER 20, 2028

CERTIFICATION SCOPE

Provision of Translation and Localization Services



AUTHORISED CERTIFICATION BODY SIGNATURE

Shashi Nath Mishra
Chief Operating Officer (COO)

This approval is subject to continued satisfactory maintenance of the Quality Management Systems of the organization to the above requirements which will be monitored by IRQS during annual surveillance audits. Validity of the Certificate is subject to successful completion of annual surveillance audits. The use of the Accreditation Mark indicates accreditation in respect to activities covered by the certificate with IRQS accreditation no. QP/005.

Condition Precedent:

Indian Register Quality Systems (A Division of IRCLASS Systems and Solutions Private Limited)

Head Office: 52A, Acti Stenkaracharya Marg, Opp. Powai Lake, Powai, Mumbai - 400 072, India. Website: www.irs.com, www.irclass.org

COMPROS/IRQS/250101882/01



Certificate of Approval

Issued by Indian Register Quality Systems



Certificate No.
IRQS/260760429

To certify that the Medical Devices – Quality Management Systems of

Propio LS LLC

ADDRESS
10801 Mastin St. #580,
Overland Park, KS 66210

has been assessed and found conforming to the requirement of ISO 13485: 2016

INITIAL CERTIFICATION DATE

MARCH 16, 2026

CURRENT DATE OF GRANTING

MARCH 16, 2026

EXPIRY DATE

MARCH 15, 2029

CERTIFICATION SCOPE

Provision of Translation and Localization Services for
Medical Device IFUS, Labels, and Related
Documentation, Ensuring Compliance with Applicable
Regulatory and Customer Requirements



Indian Register Quality Systems

AUTHORISED CERTIFICATION BODY SIGNATURE

Shashi Nath Mishra
Chief Operating Officer (COO)

This approval is subject to continue satisfactory maintenance of the Medical Devices – Quality Management Systems of the organization to the above requirements which will be monitored by IQS during annual surveillance audits. Validity of the Certificate is subject to successful compliance of annual surveillance audits. Certification Juristic.

Indian Register Quality Systems (A Division of IRCLASS Systems and Solutions Private Limited)
Head Office: 52A, Adi Shankaracharya Marg, Opp. Preeti Lake, Powai, Mumbai - 400 072, India, website: www.iqrs.co.in, www.irclass.org

QA/IRMS/MDQPS/Ken JJ



Certificate of Registration

Issued by Indian Register Quality Systems



Certificate No.
IRQS/265100451

To certify that the Management Systems of

Propio LS LLC

ADDRESS
10801 Mastin St. #580,
Overland Park, KS 66210,
Kansas, United States

has been assessed and found conforming to the requirement of ISO 18587:2017 - Translation services — post-editing of machine translation output — Requirements

INITIAL CERTIFICATION DATE	CURRENT DATE OF GRANTING	EXPIRY DATE
MARCH 17, 2026	MARCH 17, 2026	MARCH 16, 2029

CERTIFICATION SCOPE

Provision of Translation and Localization Services




Shashi Nath Mishra
COC

This approval is subject to continuous satisfactory maintenance of the Translation services — Post-editing of machine translation output — Requirements organization to the above requirement(s) which will be monitored by IRQS during annual Surveillance audits. Validity of the completion of annual compliance audits.
Certificate Validity:

Indian Register Quality Systems (A Division of IRCLASS Systems and Solutions Private Limited)
Head Office: S2A, Pili Shambharkrishna Marg, Dny. Powai Lake, Powai, Mumbai - 400 072, India. Websites: www.inqcs.com, www.irclass.org

COC/RQSVTSPMT/Rev 2



Certificate of Approval

Issued by Indian Register Quality Systems



Certificate No.
IRQS/254801948

To certify that the Translation Services of

Propio LS, LLC

ADDRESS

10801 Mastin St. #580 Overland Park,
KS 66210, Kansas United States

has been assessed and found conforming to the requirement of ISO 17100 : 2015

INITIAL CERTIFICATION DATE

DECEMBER 02, 2025

CURRENT DATE OF GRANTING

DECEMBER 02, 2025

EXPIRY DATE

DECEMBER 01, 2028

CERTIFICATION SCOPE

Provision of Translation and Localization Services



Indian Register Quality Systems

Shashi Nath Mishra
COO

This approval is subject to continued satisfactory maintenance of the Translation Services of the organization to the above requirements which will be monitored by IRQS during annual Surveillance audits. Validity of the Certificate is subject to successful completion of annual surveillance audits.
Continued Overleaf

Indian Register Quality Systems (A Division of IRCLASS Systems and Solutions Private Limited)
Head Office: 32A, Adil Shikharanagar, Mang. Opp. Powai Lake, Powai, Mumbai - 400 027, India. Website: www.irqs.in, www.irqs.org

00000001 - 2025-02

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPNP9007 (previously MCCC2020; MCUP3009; MPUG3009; UG100309)			Lead Department: Health Services Business Unit: Population Health	
Policy/Procedure Title: Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)			☒ External Policy ☐ Internal Policy	
Original Date: 04/19/2000		Next Review Date: ~~08/13/2026~~ <u>08/12/2027</u> Last Review Date: ~~08/13/2025~~ <u>08/12/2026</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO ☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~08/13/2025~~ <u>08/12/2026</u>	

I. RELATED POLICIES:

- A. MPXG5009 ~~—~~ Lactation Clinical Practice Guideline
- B. MPCR16 ~~—~~ Lactation Consultant Credentialing Policy
- C. MCUG3118 ~~—~~ Prenatal and Perinatal Care
- D. MCUP3041 ~~—~~ Treatment Authorization Request (TAR) Review Process
- ~~E. MCCP2021 — Women, Infants and Children (WIC) Supplemental Food Program~~
- E. MCUP3113 — Telehealth Services
- F. MCUP3013 — Durable Medical Equipment (DME) Authorization
- G. ~~MP~~UG3011 — Criteria for Home Health Services
- H. MPNP9008 — Women, Infants and Children (WIC) Supplemental Food Program
- ~~H.I. MP~~NP9006 ~~—~~ Doula Services Benefit
- I.J. MPCR15 — Doula Credentialing and Re-Credentialing Criteria

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims
- C. Member Services

III. DEFINITIONS:

- A. Electronic Visit Verification (EVV): A federally mandated telephone and computer-based application program that electronically verifies in-home service visits for Medicaid-funded personal care services and home health care services for in-home visits by a provider. In California, this is known as CalEVV.
- B. Essential Health Benefits: ~~—~~ A set of health care service categories that must be covered by certain plans - Categories include, among others, ambulatory patient services, emergency services, hospitalization, maternity and newborn care, and mental health and substance use disorder services.
- ~~C. WIC - Women, Infants and Children Supplemental Nutrition Program~~: ~~—~~ The Special Supplemental Nutrition Program for Women, Infants, and Children, ~~a~~ 100% federally funded program providing nutritious food (via prescriptive checks), individual counseling and nutrition education, breastfeeding promotion and support, and referrals to other needed services to at-risk, low- to moderate-income (up to 185% of the federal poverty level) pregnant, postpartum, and breastfeeding members, children up to the age of five; and parents/guardians and other family members in households with a child under age five.
- C. ~~B.D.~~ Partnership Advantage (PA): Effective January 1, 2028~~7~~, 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

Policy/Procedure Number: MPNP9007 (previously MCCP2020; MCUP3009; MPUG3009; UG100309)			Lead Department: Health Services Business Unit: Population Health
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Original Date: 04/19/2000			Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

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 ~~Members~~ Enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage ~~Member~~ Enrollee Handbook. [Coverage criteria apply on implementation of D-SNP, subject to CMS and DHCS approval.](#)

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

- A. To support optimal nutrition in the healthy infant by appropriately supporting the parent's efforts to initiate and sustain breastfeeding exclusively for about 6 months and with complementary foods (not formula) for at least 12 months per American Academy of Pediatrics (AAP) recommendations. Lactation services and supplies are covered preventive services and are provided without cost sharing to the member.
- B. To give the policy framework around provisions of the Affordable Care Act (ACA), Section 4106a, Women's Health Preventive Services. It is the goal of Partnership HealthPlan of California (Partnership) to be fully compliant with this portion of the ACA. This section states that pregnant and postpartum members are eligible to receive the following as preventive services:
 1. Comprehensive lactation services including counseling by a trained health care provider or allied health professional during pregnancy and/or the postpartum period.
 2. To have access to breast pumps and breastfeeding equipment and supplies, as indicated to support lactation.

VI. POLICY / PROCEDURE:

- A. General Breastfeeding Guidelines
 1. Introduction: Human breast milk is uniquely specific to the needs of the human infant. Breastfeeding is acknowledged as the preferred method of infant feeding by Partnership and the AAP. Research has demonstrated numerous health benefits of breastfeeding. Additional to health benefits breastfeeding also provides social, economic and environmental benefits for both parent and infant.
- B. Promotion and Support of Breastfeeding
 1. Lactation Education and Support Services: Each county served by Partnership has a local Women Infants and Children (WIC) Nutrition Program that includes lactation education, support and provision of breast pumps, for low-income individuals, including Partnership members. All pregnant members should be referred to WIC. Lactation support for Partnership members is a shared goal and responsibility of WIC and the health delivery system provided through Partnership, by the following providers and support services:
 - a. Primary care providers (PCPs) are encouraged to provide opportunities for members to learn about the advantages of breastfeeding through educational materials. Referrals for all pregnant members to prenatal breastfeeding classes will ensure they have current evidence-based information about breastfeeding.
 - b. Prenatal care providers should specifically assess a pregnant member's knowledge and interest in breastfeeding at the first prenatal visit. Obstetrical care includes documentation of a complete breast exam and anticipatory guidance for any condition that could affect breastfeeding. Education regarding the advantages of breastfeeding should be ongoing. Pregnant members and their families should be referred to a breastfeeding class and have access to one-on-one breastfeeding education prenatally and postnatally. This is especially important for members

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Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

who are first-time parents or have not breastfed in the past.

- c. The Comprehensive Perinatal Services Program (CPSP) has divided authority between the California Department of Health Services (DHCS) and the California Department of Public Health (CDPH). -It is an enhanced program of perinatal services to be offered through the Medi-Cal program and reimbursed (by DHCS) at higher rates than traditional obstetrical services. -The CPSP provider certification process is administered and approved by the CDPH. -*Note:* Partnership HealthPlan of California (Partnership) encourages, but does not require, providers to be CPSP certified in order to provide obstetrical and perinatal services, however, obstetrics providers need to provide CPSP-like services or refer to another CPSP provider for non-obstetric CPSP or CPSP-like services. (*See also the Partnership HealthPlan Perinatal Services (PHPS) definition below*)
- d. Partnership Population Health: Through specific programs and general case management support, Partnership Population Health supports breastfeeding in accordance with current guidelines and evidence-based practices. Members who are planning to breastfeed and need specific resources are encouraged to call for assistance with breastfeeding when wanted.
- e. Partnership HealthPlan Perinatal Services (PHPS): CPSP-like services that are equivalent to, or substantially similar to, the services defined by the CDPH-defined CPSP program. (*See also the Comprehensive Perinatal Services Program (CPSP) definition above*).
- e. Health Equity and Cultural Responsiveness: Lactation services must be delivered in a culturally and linguistically appropriate manner, consistent with CalAIM and DHCS health equity expectations and in accordance with MPND9002 Cultural & Linguistic Program Description. Description and MCNP9003 Cultural and Linguistic Services.
- ~~f.~~
- ~~f.g.~~ Postpartum follow-up: Calls are made to Partnership members and Partnership Advantage enrollees within the first month after delivery, when possible, to encourage a timely postpartum visit. If needed, referrals are made for lactation assistance, support, education and information.
- ~~g.h.~~ Hospitals providing obstetrical care play a key role in supporting successful initiation of breastfeeding. Standards of care for hospitals in this area are fully outlined in the UNICEF/WHO Baby Friendly Hospital Initiative) (<https://www.unicef.org/documents/baby-friendly-hospital-initiative>) and will also include:
 - 1) The hospital should receive information on the member's prenatal record stating the infant feeding plan. That plan should be confirmed when a member is admitted for delivery.
 - 2) Family centered childbirth practices allowing for early parent-infant contact and breastfeeding within one half-hour of birth as well as rooming in. Hospitals are encouraged to view initiation of breastfeeding as a process accomplished over several days and offer support, assistance, and education accordingly.
 - 3) Newborns should be nursed whenever they show signs of hunger/interest approximately 8-12 times every 24 hours after the first 24 hours. Parents can be encouraged to hold their infants even when not feeding to better assist them as they begin the process of learning and understanding their infant's feeding cues.
 - 4) Members need access to qualified nursing staff and/or International Board Certified Lactation Consultant (IBCLC) to assist with initiation of breastfeeding, evaluate breastfeeding progress and to give ongoing information during the hospital stay.
 - 5) Supplements such as formula should not be given to breastfeeding newborns unless there is an order from the Health Care Provider.
 - 6) Discharge planning includes the assessment of the need for follow-up with WIC, a peer counselor, the infant care office, an IBCLC, home health, or public health nurse visit specifically to assist the parent with breastfeeding. Whenever possible this should occur within 1-2 days of discharge.

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Original Date: 04/19/2000			Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

- 7) The lactating parent leaves the hospital with a list of resources for support and assistance with breastfeeding, information on how to tell if the baby is getting enough milk, and referral to a breastfeeding support group.

- h.i. Infant Care providers should encourage exclusive breastfeeding for about six months and breastfeeding with complementary foods (not formula) for at least 12 months per AAP recommendations. Infant Care providers should consider a referral to a qualified lactation consultant, Home Health Nurse or Public Health Nurse for evaluation before suggesting supplementation with formula or cessation of lactation. Providers need to consider the parent's health and well-being when giving recommendations. If a baby needs to stop feeding at the breast, the parent is to be provided with a breast pump and instructions on how to use it to maintain the milk supply.
- i.j. Home Health Nurse or Public Health Nurse Visit: All members are eligible to receive Home Health Nurse visits or Public Health Nurse visits after discharge from the hospital for assistance with breastfeeding. It is strongly recommended that home visiting nurses have specific training in lactation/breastfeeding support. The first parent-baby home health visit by a Home Health Nurse does not require prior authorization and subsequent visits are easily available through the authorization process. Public Health Nurse visits do not require authorization and can be ordered in a variety of ways including by notation on the postpartum discharge orders at time of discharge or by contacting the local county Public Health Department.
 - 1) Electronic Visit Verification (EVV) Requirements:
 - a) Effective January 1, 2023, as per APL 22-014, EVV requirements must be implemented for all Medi-Cal personal care services and home health care services that are delivered during in-home visits by a provider, which includes visits that begin in the community and end in the home, or vice versa.
 - a)b) EVV requirements apply only to lactation services delivered as part of covered home health or personal care services. Facility-based and office-based lactation services are not subject to EVV.
 - b)c) Please refer to policy MCUG3011 Home Health Services for further information on EVV requirements.
 - i. Doulas are recognized Medi-Cal providers who may offer various types of support, including lactation support, education, and care coordination. For more details, refer to Partnership policy MPENP9006 Doula Services Benefit and MPCR15 Doula Credentialing and Re-credentialing Criteria.

C. Partnership HealthPlan of California Breastfeeding Services

1. Timing of Lactation Support Services: Partnership members are eligible to receive lactation support during and after pregnancy and for up to 1 year after delivery. Lactation Education and Support is different in the prenatal, immediate postpartum (in the hospital), early postpartum (from hospital discharge to 84 days after delivery), and late post-partum periods (from 84 days to 365 days post-delivery). From a Partnership standpoint, care during the postpartum period includes two specifically defined postpartum visits, one occurring prior to 21 days after delivery and the second between 21 to 84 days after delivery. This postpartum review and examination includes obtaining a history, performing a physical exam and evaluation of infant feeding. Additionally, earlier post discharge follow-up lactation visits should be encouraged, preferably in the first few days after discharge home. Some parents also need lactation education and support after 84 days post-delivery. Lactation visits independent of the standard postpartum visits are covered by Partnership. See billing and codes section for specific requirements.
2. Providers of Lactation Support Services:
 - a. Perinatal clinical providers and facilities provide education and lactation support during pregnancy, at the time of delivery and after delivery to ensure individuals have information

Policy/Procedure Number: MPNP9007 (previously MCCP2020; MCUP3009; MPUG3009; UG100309)			Lead Department: Health Services Business Unit: Population Health
Policy/Procedure Title: Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)			☒ External Policy ☐ Internal Policy
Original Date: 04/19/2000			Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

[needed to support shared decision making and a successful initiation of breast feeding when that is chosen by the member. See DHCS APL 26-005.](#)

a.b. Basic lactation support services may be provided in a provider office by a medical professional as follows: Physician, Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife (LM).

- 1) Providers offering lactation support services will ensure that the services are provided by an individual who has the appropriate education and knowledge.
- 2) Registered Nurse (RN), Registered Dietician (RD), International Board Certified Lactation Consultants (IBCLC), Lactation Educators and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a Partnership contracted Physician.

b.c. IBCLCs with an underlying health professional licensure (RN, RD, Doctor of Medicine [MD], Doctor of Osteopathic Medicine [DO], CNM, NP, PA) may become contracted/credentialed to provide lactation support services through Partnership.

- 1) Contracted/credentialed IBCLC will ensure that any services provided by an individual within their employment has appropriate education and knowledge.
- 2) Lactation Educators and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a Partnership contracted /credentialed IBCLC.

3) IBCLCs must be credentialed by the credentials committee, as described under policy MPCR-#16 Lactation Consultant Credentialing Policy.

b.d. [Lactation services may be delivered via telehealth when clinically appropriate, consistent with DHCS telehealth policy. Telehealth shall not be used to reduce access to in-person care when requested or clinically necessary. Refer to Partnership MCUP3113 Telehealth Services policy.](#)

3. **Other Health Professionals** who are Certified Lactation Consultants or trained Lactation Educators, under the supervision of a Partnership contracted/credential IBCLC or provider office, may perform lactation consultation services outside of the hospital setting.
4. **Lactation Educators:** A Lactation Educator may provide basic lactation education services. The Lactation Educator must always work under the supervision of a Partnership contracted/credentialed IBCLC or provider office, who is ultimately responsible for the patients seen by lactation educators.
 - a. If an IBCLC is supervising lactation educators, the following documentation must be maintained in the lactation educator's personnel file:
 - 1) Documentation of successful completion of a basic lactation education program.
 - 2) A letter from their supervising IBCLC describing the training and experience of the Lactation Educator, and the manner in which they are supervised.
 - b. The IBCLC must maintain written protocols for the Lactation Educator, listing:
 - 1) Documentation standards
 - 2) Topics that the Lactation Educator may address
 - 3) Indications for referral to the IBCLC, with standards for timeliness of referrals.
5. **Lactation Support Services:**
 - a. [Per APL 26-005, lactation services are a covered preventative benefit and must be provided without member cost-sharing and without unreasonable administrative barriers.](#)
 - b. **Lactation Service Types:**
 - 1) [Preventative services: lactation services including routine lactation education, counseling and support that do not require prior authorization.](#)
 - 2) [Medically necessary services are : Additional or specialized lactation support that covered without an approved referral authorization or TAR. -may require authorization- based on Medi-Cal guidelines. Additional or specialized lactation support may require authorization based on Medi-Cal guidelines.](#)

Policy/Procedure Number: MPNP9007 (previously MCCP2020; MCUP3009; MPUG3009; UG100309)			Lead Department: Health Services Business Unit: Population Health
Policy/Procedure Title: Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)			☒ External Policy ☐ Internal Policy
Original Date: 04/19/2000			Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

- ~~— No Referral Authorization is required for up to 60 calendar days of services; however, a Treatment Authorization Request (TAR) is required for visits after 60 calendar days, with a written treatment plan and specific request for additional visits. These TARs will be reviewed for medical necessity, according to the usual TAR process.~~
- ~~a. Prior authorization requirements shall not be applied to routine preventative lactation services. Authorization shall be required for extended or medically necessary services beyond standard preventative care, consistent with DHCS guidance.~~
- ~~b.c. Services provided in a contracted hospital outpatient services, physician office, IBCLC private office, [via telehealth](#) or member's home may be billed to Partnership using the S9445 HCPCS code, billed in 15 minute increments, up to a maximum of 4 units per day. In addition, lactation services provided by a Comprehensive Perinatal Service Program (CPSP) after the post-partum member's eligibility for CPSP has expired, may also use the S9445 HCPCS Code.~~
6. **Breast Pumps:** When breastfeeding is interrupted or discontinued the use of Breast Pumps and alternative feeding fluids may be necessary. If lactating parent is unable to feed the baby at the breast due to a medically based separation or a physical problem of varying duration, and until resolution of any of these problems are achieved, providing a breast pump in a timely fashion is appropriate and a covered benefit.
- a. Electric breast pumps may be recommended for infants with feeding problems where a lactating parent must be separated from or is unable to nurse the baby. Partnership strongly recommends the use of an electric breast pump for adequate maintenance of milk supply when a baby is not able to breastfeed.
- b. In partnership with local WIC agencies, multi-user electric breast pumps and the breast pump equipment (Kits) are provided through each county's WIC program, when available. They provide the pump, equipment and education to support appropriate use.
- ~~— Single-user personal double electric breast pumps are also available for Partnership members, or for lactating parents whose infant is a Partnership member (who is 12 months old or younger). These pumps are available by prescription from a number of Partnership contracted durable medical equipment (DME) providers. No TAR is required. [The Partnership breast pump benefit has a frequency limit of 1 pump for every 3 years. - Replacement pumps needed prior to 3 years will require submitting a TAR showing the medical need for replacement.](#)~~
- c. ~~Partnership breast pump benefit is limited to one pump every three years.~~
- 1) Providers will utilize DME order form with prescription to submit request for pump no sooner than 30 calendar days prior to the Estimated Due Date (EDD), up to 12 months after delivery.
- 2) Providers will provide supportive pump education on how to successfully use the selected pump at a health education visit prior to the EDD.
- 3) Providers will be reimbursed up to 1 hour for breast pump education utilizing [CPSP-PHPS](#) health education codes, or billing code S9445. Office visit codes may also be used, for appropriate providers.
- d. When infants are born at less than 36 weeks gestation and remain hospitalized, arrangements will be made on an individual case by case basis to use a multi-phase hospital grade electric pump for the initiation and maintenance of the lactating parent's milk supply while the infant is hospitalized. Specific instruction and support for the use of this pump will be provided by the hospital staff.
7. **Alternate Feeding Fluids:**
- a. Banked Human Milk is available in limited supplies for infants with specific conditions and for whom their lactating parent's milk is temporarily not available.
- 1) Banked Human Milk for newborns whose lactating parents are unable to breastfeed due to medical reasons is a covered benefit under Partnership. Prior Authorization is required.

Policy/Procedure Number: MPNP9007 (previously MCCP2020; MCUP3009; MPUG3009; UG100309)			Lead Department: Health Services Business Unit: Population Health
Policy/Procedure Title: Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)			☒ External Policy ☐ Internal Policy
Original Date: 04/19/2000			Next Review Date: 08/13/2026 Last Review Date: 08/13/2025
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

- 2) Donor/processed banked breast milk requires a prescription from a physician. The prescription must specify *Processed human milk* __# of ounces per day for __# of weeks as well as the infant's name and Client Identification Number (CIN) along with the parent/guardian's name and phone number and a diagnosis. The prescription can be faxed or scanned and emailed to the milk bank.
 - 3) If the infant requires an increase in supply, a new prescription is needed.
 - 4) For outpatient infants, the first shipment is usually for one week of milk. The parent/guardian can request up to a 2 week supply on subsequent orders.
 - 5) When a hospital orders the milk, a purchase order number is required, along with the parent's address, attending physician, and whether the order is for premature milk or mature milk. The hospital can provide a verbal order and then fax a written doctor's order to the milk bank. Partnership does not pay for Banked Human Milk in hospitalized recipients as the bank will bill the hospital directly in those instances.
 - 6) For some newborn intensive care units (NICUs) in California, the physician may want to have a supply of processed donor milk stored in the freezer at all times. Other hospitals order donor milk when a patient needs it. The processed milk has a six-month expiration period.
- b. Special infant formulas for specific medical conditions must be prescribed by an approved Medi-Cal prescriber and dispensed to the member by a Medi-Cal Rx pharmacy provider (when approved through the State Medi-Cal Pharmacy TAR process).
- 1) The pharmacy (prescription) benefit is carved-out to State Medi-Cal as of January 1, 2022. For State Medi-Cal authorization requirements, please refer to the State Medi-Cal Enteral Nutrition policy <https://medi-calrx.dhcs.ca.gov/home/enteral-nutrition-products/>
 - 2) WIC may be able to provide specialty infant formulas when authorization for a pharmacy TAR is pending with State Medi-Cal. -Providers should check with the local WIC office for availability of interim product in urgent cases.

VII. REFERENCES:

- A. American Academy of Pediatrics, Clinical Practice Guidelines: <https://publications.aap.org/pediatrics/collection/523/Clinical-Practice-Guidelines>
- B. Affordable Care Act, Section 4106a, Women's Health Preventive Services
- C. Hale, Thomas Wright, Krutsch, Kaytlin. *Hale's Medications & Mothers' Milk 2023: A Manual of Lactational Pharmacology*. 20th ed., New York, NY: Springer Publishing Company, 2022.
- D. Kimberlin, David W., editor. *Red Book: 2021-2024 Report of the Committee on Infectious Diseases*. 32nd ed., Itasca, IL: American Academy of Pediatrics, 2021.
- E. Infant Risk Center: <https://infantrisk.com/breastfeeding> Call 806-352-2519
- F. CA WIC Association: Ramping up for Reform-Quality Breastfeeding Support in Preventive Care. <https://thewichub.org/ramping-up-for-reform-quality-breastfeeding-support-in-preventive-care/>
- G. Department of Health and Human Services/Center for Medicaid and CHIP Services
- H. Medicaid Coverage of Lactation Services. CMS Bulletin
- I. DHCS All Plan Letter (APL) 22-012 Revised 25-013 – [Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits, and Cell and Gene Therapy Coverage From Managed Care to Medi-Cal Rx \(12/30/2022/09/18/2025\)](#)
- J. DHCS [APL 22-014](#) Electronic Visit Verification Implementation Requirements (07/21/2022)
- K. Partnership Website: Pregnancy & Breastfeeding - Breastfeeding Booklet <https://www.partnershipphp.org/Members/Medi-Cal/Pages/Health%20Education/Pregnancy--Breastfeeding.aspx>
- L. 42 CFR § 422.107, Requirements for dual eligible special needs plans

Policy/Procedure Number: MPNP9007 (previously MCCP2020; MCUP3009; MPUG3009; UG100309)			Lead Department: Health Services Business Unit: Population Health
Policy/Procedure Title: Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)			☒ External Policy ☐ Internal Policy
Original Date: 04/19/2000			Next Review Date: 08/13/2026 Last Review Date: 08/13/2025
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~~L.M.~~ [DHCS APL 26--005 Maternity Services for Pregnant and Postpartum Medi-Cal Members \(03/25/2026\)](#)

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

X. REVISION DATES:

Medi-Cal (MPNP9007)
~~MPNP9007 (Effective 08/13/25); 08/12/26~~
N/A

Partnership Advantage (Program effective January 1, 2028)
~~08/13/25; 08/12/26~~
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:

MCCP2020 (02/15/17 to 08/12/25)
*03/14/18; 06/12/19; 06/10/20; 08/11/21; 03/09/22; 03/08/23; 03/13/24; 03/12/25

Medi-Cal (UG100309; MPUG3009; MCUP3009: -04/19/2000 to 02/15/2017)
05/16/01; 05/15/02; 10/20/04; 10/19/05; 08/20/08; 04/21/10; 09/15/10; 10/01/10; 06/20/12; 11/20/13;
08/20/14; 04/15/15; 01/20/16; 10/19/16 to 02/15/17

Healthy Families:
MPUG3009 - 10/01/2010 to 03/01/2013

~~*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.~~

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 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 Partnership.

Policy/Procedure Number: MPNP9007 (previously MCCP2020; MCUP3009; MPUG3009; UG100309)			Lead Department: Health Services Business Unit: Population Health
Policy/Procedure Title: Lactation Policy and Guidelines (formerly Breastfeeding Guidelines)			☒ External Policy ☐ Internal Policy
Original Date: 04/19/2000			Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

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

Policy/Procedure Number: MPNP9008 (previously MCCP2021; MCUP3100)			Lead Department: Health Services Business Unit: Population Health	
Policy/Procedure Title: Women, Infants and Children (WIC) Supplemental Food Program			☒ External Policy ☐ Internal Policy	
Original Date: 04/21/2010		Next Review Date: ~~08/13/2026~~ <u>08/12/2027</u> Last Review Date: ~~08/13/2025~~ <u>08/12/2026</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIALS	☒ PAC
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~08/13/2025~~ <u>08/12/2026</u>	

I. RELATED POLICIES:

- A. MCUG3118 – Prenatal & Perinatal Care
- B. MCQG1015 ~~–~~ Pediatric Preventive Health Guidelines
- C. ~~MPNP~~9006 – Doula Services Benefit
- D. MCCP2036 ~~–~~ Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims
- C. Members Services

III. DEFINITIONS:

- A. ~~WIC – Women, Infants and Children Supplemental Nutrition Program:~~ – The Special Supplemental Nutrition Program for Women, Infants, and Children - A 100% federally funded program providing nutritious food ~~packages-(via prescriptive checks)~~, individual counseling and nutrition education, breastfeeding promotion and support, and referrals to other needed services to at-risk, low- to moderate-income (up to 185% of the federal poverty level) pregnant, postpartum, and breastfeeding members, children up to the age of five; and parents/guardians and other family members in households with a child under age five.
- B. Partnership Advantage (PA): Effective January 1, 202~~8~~7, 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 ~~Members~~ Enrollees will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage ~~Member-Enrollee~~ Handbook. Coverage criteria apply on implementation of D-SNP, subject to CMS and DHCS approval.

IV. ATTACHMENTS:

N/A

V. PURPOSE:

To define the responsibilities of Partnership HealthPlan of California (Partnership) and the respective

Policy/Procedure Number: MPNP9008 (previously MCCP2021; MCUP3100)			Lead Department: Health Services Business Unit: Population Health
Policy/Procedure Title: Women, Infants and Children (WIC) Supplemental Food Program			☒ External Policy ☐ Internal Policy
Original Date: 04/21/2010			Next Review Date: 08/13/2026 Last Review Date: 08/13/2025
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

Women, Infants and Children (WIC) Providers in the counties Partnership serves.

VI. POLICY / PROCEDURE:

A. Coverage Guidelines:

1. WIC services are not covered by Partnership. However, Partnership shall identify eligible members, make referrals, and follow-up as appropriate to support access to WIC services. Partnership members and Partnership Advantage enrollees who are eligible for WIC supplemental food services will be referred to their respective County WIC Providers.
2. WIC serves pregnant, postpartum, and breastfeeding members, as well as children up to age five and parents/guardians and/or other family members in households with a child under age five.

B. Identification and Referral

1. Providers shall assess members for nutritional risk and food insecurity during applicable visits to support identification of WIC eligibility.
- ~~1-2.~~ The primary care provider (PCP) or obstetrician (OB) is responsible for identifying and referring members who are pregnant, breastfeeding or postpartum and children under the age of five who are eligible for WIC supplemental food.
- ~~2-3.~~ During a well-child visit, PCPs will perform a nutritional assessment, as well as hemoglobin or hematocrit laboratory tests following the AAP Bright Futures Periodicity schedule (refer to link: https://downloads.aap.org/AAP/PDF/periodicity_schedule.pdf for further details), ~~and~~ and refer each WIC-eligible member to a county WIC program per Federal WIC requirements for program eligibility.
- ~~3-4.~~ Partnership will be responsible for the cost of hemoglobin or hematocrit laboratory value and lead test. Lab results will be documented in the member's medical record with the PCP.
- ~~4-5.~~ PCP/OB will refer all eligible Partnership members to WIC and include the member's hemoglobin or hematocrit lab results. Referrals shall be followed up to confirm whether member assessed accessed WIC services, and this status shall be documented in the medical record.
- ~~5-6.~~ Partnership refers the members and enrollees who are pregnant, breastfeeding, or postpartum, or a legal guardian for a member under the age of five, to the WIC program either as part of the initial evaluation of newly pregnant members pursuant to 42 CFR section 431.635(c) and APL 26--005, PL 98-010. Referrals also occur during various outreach activities. All referrals and follow-up outcomes shall be ~~are~~ documented in the member's medical record. Refer to Partnership policy MPNP9007 for lactation guidelines and support services.

C. Follow-up, Education and Training

1. As part of ongoing provider training, Partnership ~~will shall work to~~ ensure that providers understand the WIC program, eligibility requirements, ~~and~~ the referral process, and the expectation to document and follow up on referrals.
2. Partnership, through its member handbook, newsletters, and brochures, seeks to promote member understanding of the WIC program, the need for and how to obtain services, and the benefits to be realized by following instructions received.
- ~~2-3.~~ Partnership shall monitor referral and follow-up practices as part of Quality Improvement activities.

D. Memorandum of Understanding (MOU) Requirements

1. Per APL 23-029 Attachment G WIC MOU, Partnership and the respective WIC Providers in the counties Partnership serves shall make a good faith effort to execute maintain executed a ~~MOUs with WIC providers, or document when an MOU cannot be established,~~ outlining respective responsibilities and obligations. MOUs shall be reviewed periodically and define roles, responsibilities, and referral processes.
2. Refer to Partnership policy MCCP2036-- Memorandum of Understanding (MOU) Requirements ~~For~~ for Medi-Cal Managed Care Plans and Third-Party Entities for more details.

Policy/Procedure Number: MPNP9008 (previously MCCP2021; MCUP3100)			Lead Department: Health Services Business Unit: Population Health
Policy/Procedure Title: Women, Infants and Children (WIC) Supplemental Food Program			☒ External Policy ☐ Internal Policy
Original Date: 04/21/2010			Next Review Date: 08/13/2026 Last Review Date: 08/13/2025
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

VII. REFERENCES:

- A. Title 42 Code of Federal Regulations (CFR) Section [431.635\(c\)](#)
- B. Title 22 California Code of Regulations (CCR) Sections [50157](#) and [50184](#)
- C. Contract between Department of Health Care Services (DHCS) and Partnership: Contract Exhibit A, Attachment III Section 4.3.19
- D. California Department of Public Health WIC Program Overview:
<https://www.cdph.ca.gov/Programs/CFH/DWICSN/Pages/AboutWIC.aspx>
- E. DHCS [APL 23-029– Memorandum of Understanding Requirements for Medi-Cal Managed Care Plans and Third-Party Entities](#) (01/08/2025)
 - Attachment G: [Women, Infant, & Children Memorandum of Understanding- Template](#)
- F. ~~DHCS Policy Letter (PL) 98-010: Breastfeeding Promotion (12/10/1998)~~ DHCS APL 26-005 [Maternity Services for Pregnant and Postpartum Medi-Cal Members](#) (03/25/2026)
- G. 42 CFR § 422.107, Requirements for dual eligible special needs plans

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

X. REVISION DATES:

Medi-Cal ([MPNP9008](#))
~~MPNP9008 (Effective 08/13/25); 08/12/26~~
 N/A

Partnership Advantage (Program effective January 1, 2028)
~~08/13/25; 08/12/26~~ 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:

MCCP2021 (02/15/17 to 08/12/25)

*03/14/18; 03/13/19; 03/11/20; 03/10/21; 03/09/22; 03/08/23; 03/13/24; 03/12/25

MCUP3100 (04/21/2010 to 02/15/2017)

05/15/13; 05/20/15; 05/18/16 to 02/15/2017

*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.

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:

Policy/Procedure Number: MPNP9008 (previously MCCP2021; MCUP3100)		Lead Department: Health Services Business Unit: Population Health	
Policy/Procedure Title: Women, Infants and Children (WIC) Supplemental Food Program		☒ External Policy ☐ Internal Policy	
Original Date: 04/21/2010		Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

- 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 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 Partnership.

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

Policy/Procedure Number: MCRP4064			Lead Department: Health Services	
Policy/Procedure Title: Continuation of Prescription Drugs			☒ External Policy ☐ Internal Policy	
Original Date: 04/06/2017		Next Review Date: ~~08/13/2026~~ 08/12/2027 Last Review Date: ~~08/13/2025~~ 08/12/2026		
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage	
Reviewing Entities:	☒ IQI	☒ P & T	☐ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO	☐ COO	☐ CREDENTIALS SLING	☐ DEPT. DIRECTOR/OFFICER
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~08/13/2025~~ 08/12/2026	

I. RELATED POLICIES:

- A. MCRP4068 Medical Benefit Medication TAR Policy

II. IMPACTED DEPTS:

- A. Member Services
B. Grievance and Appeals

III. DEFINITIONS:

- A. Prescribing provider: a provider authorized to write a prescription to treat a medical condition of a member.
- B. Medi-Cal Rx: On January 7, 2019, Governor Gavin Newsom issued Executive Order N-01-19 ([EO-N-01-19](#)) for achieving cost-savings for drug purchases made by the state. A key component of EO N-01-19 requires the Department of Health Care Services (DHCS) transition all Medi-Cal pharmacy services from managed care (MC) to fee for service (FFS), which was implemented as Medi-Cal Rx on January 1, 2022.¹
- C. Physician-Administered Drug (PAD) or Medical Benefit Medications: A physician-administered drug is an outpatient drug that is typically administered by a health care provider in a physician's office or other outpatient clinical setting. For example, drugs that are infused or injected are typically physician-administered drugs. The provider bills the appropriate state Medicaid program (fee for service, managed care plan, or county operated health system) for the drug using the appropriate national drug code (NDC) and Healthcare Common Procedure Coding System (HCPCS) code.

IV. ATTACHMENTS:

- A. N/A

V. PURPOSE:

To define the conditions under which medications may be continued for coverage of a medical condition for members newly enrolled in benefits under Partnership HealthPlan of California (PHC) and when administered by a plan provider in accordance with the Welfare and Institutions Code 14185 (b, provided that the drug is appropriately prescribed and is considered safe and effective for treating the member's medical condition. This policy applies to the processing of medical claims for PAD as outlined in policy MCRP4068 Medical Benefit Medication TAR Policy.

¹ [This policy applies only to physician-administered drugs under the medical benefit and does not apply to outpatient prescription drugs under Medi-Cal Rx.](#)

Policy/Procedure Number: MCRP4064		Lead Department: Health Services	
Policy/Procedure Title: Continuation of Prescription Drugs		☒ External Policy ☐ Internal Policy	
Original Date: 04/06/2017		Next Review Date: 08/1 ~~23~~ /202 ~~76~~ Last Review Date: 08/1 ~~23~~ /202 ~~65~~	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

VI. POLICY / PROCEDURE:

Nothing in this policy shall preclude the prescribing provider from prescribing another drug covered by the plan that is medically appropriate for the member, nor shall anything in this section be construed to prohibit generic drug substitutions.

- A. This policy does not apply to coverage determinations for ~~any~~ drugs prescribed for a uses ~~that is~~ not approved for marketing by the federal Food and Drug Administration (FDA), otherwise known as “off-label” use. However, coverage for off-label-use drugs is shall be evaluated in accordance with applicable Medi-Cal requirements, including Section 1927(k)(2) of the Social Security Act and CA Health & Safety Code Section 1367.2, and remains subject to Partnership MCRP4068 - Medical Benefit Medication TAR Policy.
- B. This policy shall not be construed to restrict or impair the application of any other Partnership policy including its requirement that the plan furnish services in a manner providing continuity of care and demonstrating that medical decisions are rendered by qualified medical providers unhindered by fiscal and administrative management.
- C. New start designation in Treatment Authorization Request (TAR) Criteria:
 1. A new start is a Partnership member who has not previously been on the drug in question. A member who has been previously on a medication but with a significant lapse in treatment may be interpreted as a new start when the duration without the medication indicates the member has not been dependent upon it for treatment and the current request actually represents a restart of treatment rather than continuing treatment.
 2. A new member may also be considered a new start, in the sense that Partnership has not previously paid for the medication. Care must be exercised if the member was previously on the drug through a *state funded program* (Medi-Cal FFS or another Managed Care Medi-Cal/COHS), as it may be prudent to continue a medication the member previously had prior authorization for under a different *state payer*.
- D. Continuing care requests for existing Partnership members with claim history and previously approved Partnership TARs:
 1. Drugs with previous Partnership criteria undergoing *new start criteria revision*: members with previously approved Partnership TARs for ongoing use which have been administered in a clinical setting routinely without significant stops/breaks in therapy will be allowed to continue ongoing treatment when indicated (*i.e.*, will not have to meet revised criteria unless treatment is deemed a restart rather than continuation). This will also apply to drugs not on the Covered Medical Drug List with *new TAR criteria*, which have always not been on the Covered Medical Drug List (but without TAR criteria).
 2. Drug Criteria in which renewal criteria are revised or initiated, renewals will be considered in terms of any requirements for additional documentation or maximum durations of therapy, based on clinical references/compendia recommendations, in order to document safety and efficacy of continued treatment.
 3. Negative Changes: Since many PAD drugs are used for acute or limited duration, this section applies to maintenance or cyclical treatment drugs that would be used in an ongoing manner, such as chemotherapy, IV infusions for multiple sclerosis, rheumatoid arthritis, and all other disease treatments that require ongoing treatment with a medication affected by a negative change. -All negative changes approved by the P&T committee will also include approval of a continuation of care management plan based on that drug’s unique properties and consistent with this policy.
 - a. Addition of Prior Authorization requirement to a drug previously reimbursable without a PA: Configuration Department issues a IPN (Important Provider Notice), which is posted on the Partnership Claims/Provider web pages, and affected Members shall be notified consistent with Medi-Cal grievance and appeal requirements. Partnership will identify those members who have

Policy/Procedure Number: MCRP4064		Lead Department: Health Services	
Policy/Procedure Title: Continuation of Prescription Drugs		☒ External Policy ☐ Internal Policy	
Original Date: 04/06/2017		Next Review Date: 08/1 ~~23~~ /202 ~~76~~ Last Review Date: 08/1 ~~23~~ /202 ~~65~~	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

had recent ongoing claims (within a lookback period appropriate for the dosing frequency of the drug the past 60 days) and inform those members that prior authorization ~~is~~ may be required for future service.

~~a.b.~~ Members currently receiving the medication shall not experience interruption of therapy during the prior authorization (TAR) review process.

~~b.c.~~ Addition of billing requirements (ICD-10) or limitations (age, dose, frequency): When a drug code was previously reimbursable without any requirements or limits, and such have been added, Partnership will identify those members who have had recent ongoing claims not meeting the new requirements or limitations (within a lookback period appropriate for the dosing frequency of the drug the past 60 days), and inform those members that new requirements &/or limits have been added, which may affect future provider claim reimbursement.

- E. Continuing care for California Children's Services (CCS)-eligible members transitioning to Partnership:
1. Pursuant to State of California DHCS All Plan Letter (APL) 21-005, CCS-eligible members transitioning into Partnership Whole Child Model program are allowed continued use of any currently pharmaceutical drug therapy that is part of their medical treatment for the CCS-eligible condition. The CCS-eligible member must be allowed to continue receiving ~~receive~~ the physician administered drug therapy without interruption until Partnership and the ordering physician agree that the particular drug is no longer medically necessary or is no longer going to be administered by the county CCS program provider.

VII. REFERENCES:

- A. State of California Department of Health Care Services (DHCS) All Plan Letter (APL) 24-015, California Children's Services Whole Child Model Program (12/2/24 supersedes 23-034)
- B. DHCS APL 22-012, Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx (revised 12/30/22 supersedes 20-020)
- C. SSA 1927(k)(2): Definition of Covered Outpatient Drugs

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Director, Pharmacy Services

X. REVISION DATES:

*01/18/18; 11/14/18; 05/08/19; 02/12/20; 05/12/21; 05/11/22; 8/9/23; 08/14/24; 08/13/25, 8/12/26

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

PREVIOUSLY APPLIED TO:

N/A

XI. POLICY DISCLAIMER:

- A. 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:
 1. Consistent with sound clinical principles and processes;
 2. Evaluated and updated at least annually;

Policy/Procedure Number: MCRP4064		Lead Department: Health Services	
Policy/Procedure Title: Continuation of Prescription Drugs		☒ External Policy ☐ Internal Policy	
Original Date: 04/06/2017		Next Review Date: 08/1 ~~23~~ /202 ~~76~~ Last Review Date: 08/1 ~~23~~ /202 ~~65~~	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

3. 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 member upon request.
- B. The materials provided are guidelines used by 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 Partnership.
- C. Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

SAMPLE MEMBER LETTER

MCRP4064 ATTACHMENT A

<Date>

Dear Member,

Our records show that you have been using [insert drug name] (generic name: [insert generic name]). We want to let you know that starting [insert start date], [insert drug name] will no longer be covered or will have new coverage limits.

Your provider will need to send a treatment authorization request (TAR) to Partnership HealthPlan of California if they want you to keep using [insert drug name]. Partnership will review the TAR and decide based on medical need.

Please ignore this letter if you are not using [insert drug name] at this time. Our records may not be up to date, or your provider may have stopped this medicine.

We are here to help. If you have any questions or concerns, please call Member Services at **(800) 863-4155**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call the California Relay Service at **(800) 735-2929** or call **711**. You can also visit our website at PartnershipHP.org.

The Department of Health Care Services Managed Care Ombudsman's office can help with any questions or complaints about your health care. You can call them at **(888) 452-8609**, Monday – Friday, 8 a.m. to 5 p.m.

Sincerely,

Partnership HealthPlan of California
Pharmacy Department

Enclosures: Non-Discrimination, Language Assistance, and NOA Your Rights Under Medi-Cal Managed Care Notices

SAMPLE MEMBER LETTER

MCRP4064 ATTACHMENT B

<Date>

Dear Member,

Our records show that you have been using [insert drug name] (generic name: [insert generic name]). We want to let you know that starting [insert start date], [insert drug name] will no longer be covered or will have new coverage limits.

To keep your current treatment with [insert drug name], Partnership HealthPlan of California has given approval for you to use [insert drug name] taking [insert dose], [insert timeframe].

Before it expires, your provider will need to send a treatment authorization request (TAR) to Partnership if they want you to keep using [insert drug name]. Partnership will review the TAR and decide based on medical need.

Please ignore this letter if you are not using [insert drug name] at this time. Our records may not be up to date, or your provider may have stopped this medicine.

We are here to help. If you have any questions or concerns, please call Member Services at **(800) 863-4155**, Monday – Friday, 8 a.m. to 5 p.m. TTY users can call the California Relay Service at **(800) 735-2929** or call **711**. You can also visit our website at PartnershipHP.org.

The Department of Health Care Services Managed Care Ombudsman's office can help with any questions or complaints about your health care. You can call them at **(888) 452-8609**, Monday – Friday, 8 a.m. to 5 p.m.

Sincerely,

Partnership HealthPlan of California
Pharmacy Department

Enclosures: Non-Discrimination, Language Assistance, and NOA Your Rights Under Medi-Cal Managed Care Notices

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/ PROCEDURE

Policy/Procedure Number: MPRP4062			Lead Department: Health Services Business Unit: Pharmacy	
Policy/Procedure Title: Drug Wastage Payments			☒ External Policy ☐ Internal Policy	
Original Date: 01/21/2016		Next Review Date: ~~08/13/2026~~ <u>08/12/2027</u> Last Review Date: ~~08/13/2025~~ <u>08/12/2026</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI ☐ OPERATIONS	☒ P & T ☐ EXECUTIVE	☐ QUAC ☐ COMPLIANCE ☐ DEPARTMENT	
Approving Entities:	☐ BOARD ☐ CEO ☐ COO	☐ COMPLIANCE ☐ CREDENTIALS	☐ FINANCE ☒ PAC ☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~08/13/2025~~ <u>08/12/2026</u>	

I. RELATED POLICIES:

- A. MCRP4068 – Medical Benefit Medication TAR Policy
- B. CMP09 – Investigating & Reporting Fraud, Waste and Abuse

II. IMPACTED DEPTS:

- A. Claims
- B. Provider Relations
- C. Compliance

III. DEFINITIONS:

- A. Drug Waste means the remainder of drug or biological that has been discarded from a single use vial or other single use package after administering a dose/quantity of the drug or biological to a patient.
- B. Fraud, Waste, and Abuse (FWA):
 - 1. Fraud: In general, Medicaid fraud involves making a false statement or misrepresentation of material facts to obtain a payment to which the provider is not otherwise entitled. The rules governing Medicaid define “fraud” as follows: “... an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.” An example of fraud is knowingly billing for services not furnished or supplies not provided.
 - 2. Waste: Waste is not defined in the rules, but is “generally understood to encompass over-utilization or inappropriate utilization of services and misuse of resources, and typically is not a criminal or intentional act.” Examples of waste by a beneficiary could include making excessive office visits or accumulating more prescription medications than necessary for the treatment of specific conditions. Waste by a provider could include ordering excessive laboratory tests.
 - 3. Abuse: Abuse is defined in the Medicaid rules as follows: “... provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the Medicaid program.”

IV. ATTACHMENTS:

- A. [Allowable Waste Drug List](#)

Policy/Procedure Number: MPRP4062		Lead Department: Health Services Business Unit: Pharmacy	
Policy/Procedure Title: Drug Wastage Payments		☒ External Policy ☐ Internal Policy	
Original Date: 01/21/2016		Next Review Date: ~~08/13/2026~~08/12/2027 Last Review Date: ~~08/13/2025~~08/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

V. PURPOSE:

To define the process on how to bill for discarded drugs and biologicals in an appropriate manner that falls within the guidelines of Healthcare Fraud, Waste, and Abuse and the Plan's reporting of potential findings. [This policy only applies to drugs given by a provider \(medical benefit\), not pharmacy drugs covered under Medi-Cal Rx.](#)

- A. This policy shall apply in scope and pursuant to APL 22-012, Governor's Executive Order N-01-19 regarding Transitioning Medi-Cal Pharmacy Benefit from Managed Care to Medi-Cal Rx (the pharmacy benefit carve-out to Medi-Cal Fee-for-Service)
- Any & all policy items pertaining to pharmacy prescription claims &/or pharmacy drug Treatment Authorization Requests (TARs) shall not apply upon implementations of Medi-Cal Rx.

VI. POLICY / PROCEDURE:

A. Policy:

- Partnership HealthPlan of California (Partnership) encourages physicians, hospitals, and other providers to care for and administer to patients in such a way that they can use drugs or biologicals most efficiently, in a clinically appropriate manner. Providers should administer medications in the most cost-effective manner, utilizing the most cost-effective vial and/or combination of vial sizes in order to minimize waste.

B. Procedure:

- When a physician, hospital, or other provider must discard the remainder of a single use vial or other single use package after administering a dose/quantity of a drug or biological, Partnership will provide payment for the amount of the drug or biological discarded, as well as the dose administered listed on the Allowable Waste Drug List (Attachment A), up to the amount of the drug or biological as indicated on the vial or package label.
- When submitting claims for drugs and biologicals, the JW modifier (drug amount discarded/not administered to any patient) and National Drug Code (NDC) are required to identify unused drug or biologicals from single use vials or single use packages that are appropriately discarded.
 - The JW modifier is billed on a separate line and will provide payment for the amount of discarded drug or biological.
 - The NDC of the drug or biological used must be submitted in conjunction with the JW modifier.
 - The JW modifier is only applied to the amount of the drug or biological that is discarded. [When there is no discarded amount from a single-dose container, the JZ modifier \(no discarded drug or biological\) must be reported in accordance with billing requirements, consistent with CMS requirements effective July 1, 2023.](#)
 - The JW modifier is not permitted when the actual dose of the drug or biological administered is less than the billing unit.
- The Allowable Waste Drug List (Attachment A) is not an exclusive list and will undergo review and revision as needed throughout the year, due to the Healthcare Common Procedure Coding System (HCPCS) code changes and market availability of single-dose vs multi-dose vials.
 - When the JW modifier is used for a drug or biological which is *not* listed on the Allowable Waste Drug List (Attachment A), a TAR must be submitted for consideration of approval of drug waste. Pharmacy department will review the request

Policy/Procedure Number: MPRP4062		Lead Department: Health Services Business Unit: Pharmacy	
Policy/Procedure Title: Drug Wastage Payments		☒ External Policy ☐ Internal Policy	
Original Date: 01/21/2016		Next Review Date: ~~08/13/2026~~08/12/2027 Last Review Date: ~~08/13/2025~~08/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

to determine if waste reimbursement is allowable based on the [drug used, amount wasted, and standard billing rules for discarded drugs outlined in this policy](#). ~~NDC submitted and waste considerations outlined in this policy.~~

4. Partnership will not reimburse for discarded drugs or biologicals under the following situations:
 - a. The drug or biological is administered from a multi-dose vial
 - b. The drug or biological is not administered to the patient
 - c. An inappropriate vial size or combination of vials is used to deliver the administered dose
 - d. The drug or biological is contaminated, or is compromised due to improper storage.
 - e. If a second or subsequent vial that is used to complete a weight or body surface area (BSA_ -based dose, and less than 5% of the dose is in the last vial prescribed (i.e., exact dose not rounded down to nearest whole vial, when the dose used from the partial vial is within range of drug being ordered)
 5. The patient's medical record must document the following items:
 - a. The physician's order for the drug. If the order is written based on patient specific factors (weight, body surface area, etc.), current measurement of those factors must also be documented.
 - b. The date and time that the drug or biological was administered to the patient
 - c. The amount of the drug or biological administered to the patient
 - d. The route of administration of the drug or biological.
 - e. The amount of the drug or biological that was discarded or wasted and the reason for wastage.
 - f. [The name and credentials of the person administering the drug](#)
~~f.g.~~ [How much of the drug was given and how much was wasted for that specific patient.](#)
 6. TAR requests for non-formulary drugs and biologicals should include the following information:
 - a. The amount of drug or biological to be administered to the patient per treatment.
 - b. The amount of drug or biological that will be wasted per treatment, listed separately.
 - c. [The NDC of the drug or biological that will be used.](#)
 - e-d. [Note: if a drug or biological is on the allowable waste list, medication TAR approval will NOT include additional units for waste. The TAR is ONLY to include the dose necessary for administration and should NOT include additional units for waste. Please see billing procedure VI.B.2. above for claims billing.](#)
- C. Reporting:
1. Pharmacy department clinical staff, in conjunction with Claims department staff, may identify claims after payment is rendered with billing errors as described above.
 2. All claims identified by Pharmacy department staff for recovery of overpayment will be reviewed quarterly for accuracy and reported annually to the Chief Compliance Officer via RAC_Inbox by the Pharmacy Director or his/her designee.
 3. All potential FWA cases identified will be reported by the Pharmacy department staff immediately via RAC Reporting as described by Policy #CMP0

VII. REFERENCES:

- A. CMS. Medicare Claims Processing Manual, Chapter 17-Drugs and Biologicals, § 40.
- B. [California Department of Health Services \(DHCS\) All Plan Letter \(APL\) 22-012 Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Pharmacy Benefits from Managed Care to Medi-Cal Rx \(revised 12/30/22\)](#) (supersedes APL 20-020)
- B.C. [CA Welf & Inst Code § 14185 - Drug Utilization Under Medi-Cal Managed Care Programs](#)

Policy/Procedure Number: MPRP4062		Lead Department: Health Services Business Unit: Pharmacy	
Policy/Procedure Title: Drug Wastage Payments		☒ External Policy ☐ Internal Policy	
Original Date: 01/21/2016		Next Review Date: ~~08/13/2026~~ <u>08/12/2027</u> Last Review Date: ~~08/13/2025~~ <u>08/12/2026</u>	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

VIII. DISTRIBUTION:

- A. PHC Provider Manual
- B. PHC Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Director Pharmacy Services

X. REVISION DATES:

Medi-Cal

01/12/17; 04/06/17; *06/13/2018; 05/08/19; 05/13/20; 11/11/20; 11/10/21, 11/09/22, 11/08/23, 11/13/24;
08/13/25; 08/12/26

Partnership Advantage (effective Jan. 1, 2028⁷)

N/A

*Through 2017, Approval Date reflective of the Pharmacy & Therapeutics Committee Meeting date.
Effective January 2018, Approval Date reflects that of the Physician Advisory Committee's meeting date.

PREVIOUSLY APPLIED TO:

Healthy Kids

01/21/2016 to 12/01/2016 (Healthy Kids Program ended 12/01/16)

XI. POLICY DISCLAIMER:

- A. 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:
 - 1. Consistent with sound clinical principles and processes
 - 2. Evaluated and updated at least annually
 - 3. 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.
- B. The materials provided are guidelines used by 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 Partnership.
- C. 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

Allowable Waste Drug List

Procedure Code	Generic Name	Brand Name
J0129	abatacept, 10mg	Orencia
J0586	abobotulinumtoxina, 5 units	Dysport
J0138	acetaminophen 10mg and ibu 3mg (IV)	Combogesic
J0132	acetylcysteine, 100mg	Acetylcysteine
J0133	acyclovir, 5mg	Acyclovir Sodium
J7171	adamts13, recombinant-krhn, 10 iu	Adzynma
J0153	adenosine, 1mg	Adenosine
J9354	ado-trastuzumabemtansine, 1mg	Kadcyla
J0172	aducanumab-avwa, 2mg	Aduhelm
J0180	agalsidase beta, 1mg	Fabrazyme
J9015	aldesleukin, per single use vial	Proleukin
J0221	alglucosidase alfa, 10mg	Lumizyme
J0206	allopurinol sodium, 1mg	Aloprim
J0257	alpha 1 proteinase inhibitor (human), 10mg	Glassia
J0256	alpha 1 proteinase inhibitor (human), not otherwise specified, 10mg	Aralast NP; Prolastin C; Zemaira
J2997	alteplase recombinant, 1mg	Activase
J0278	amikacin sulfate, 100mg	Amikacin Sulfate
J0280	aminophyllin, up to 250mg	Aminophylline
J0283	amiodarone Hcl, 30mg	Nexterone
J0282	amiodarone Hcl, 30mg	Cordarone
J9061	amivantamab-vmjw, 2mg	Rybrevant
J0287	amphotericin b lipid complex, 10mg	Abelcet
J0289	amphotericin b liposome, 10mg	AmBisome
J0348	anidulafungin, 1mg	Eraxis
J0491	anifrolumab-fnia, 1mg	Saphnelo
C9145	aprepitant, 1mg	Aponvie
J0891	argatroban (accord), not therapeutically equivalent to J0883, 1mg (for non-esrd use)	Argatroban In Sodium Chloride
J0892	argatroban (accord), not therapeutically equivalent to J0884, 1mg (for esrd on dialysis)	Argatroban In Sodium Chloride
J0898	argatroban (auromedics), not therapeutically equivalent to J0883, 1mg (for non-esrd use)	Argatroban In Sodium Chloride
J0899	argatroban (auromedics), not therapeutically equivalent to J0884, 1mg (for esrd on dialysis)	Argatroban In Sodium Chloride
J0884	argatroban, 1mg (for esrd on dialysis)	Acova
J0883	argatroban, 1mg (for non-esrd use)	Acova
J9017	arsenic trioxide, 1mg	Trisenox
J9021	asparaginase, recombinant, 0.1mg	Rylaze

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Allowable Waste Drug List

J0462	atropine sulfate, not therapeutically equivalent to J0461, 0.01 mg	Accord 505(b)(2) atropine sulfate
J0461	atropine sulfate, 0.01mg	Atropine Sulfate
J0219	avalglucosidase alfa-ngpt, 4mg	Nexviazyme
J9023	avelumab, 10mg	Bavencio
J9038	axatilimab-csfr 0.1 mg	Niktimvo
J9025	azacitidine, 1mg	Vidaza
J0457	aztreonam, 100mg	Azactam
J0458	aztreonam/avibactam, 7.5 mg/2.5 mg (10 mg)	Emblaveo
J0475	baclofen, 10mg	Lioresal
J0485	belatacept, 1mg	Nulojix
J0490	belimumab, 10mg	Benlysta
J9032	belinostat, 10mg	Beleodaq
J9033	bendamustine Hcl, 1mg	Treanda
J9035	bevacizumab, 10mg	Avastin
Q5129	bevacizumab-adcd, biosimilar, 10mg	Vegzelma
Q5107	bevacizumab-awwb, biosimilar, 10mg	Mvasi
Q5118	bevacizumab-bvzr, biosimilar, 10mg	Zirabev
Q5126	bevacizumab-maly, biosimilar, 10mg	Alymsys
Q5160	bevacizumab-nwgd, biosimilar, 10 mg	Jobevne
J0565	bezlotoxumab, 10mg	Zinplava
J0582	bivalirudin (endo), not therapeutically equivalent to J0583, 1 mg	Endo 505(b)(2)
J0583	bivalirudin, 1mg	Angiomax
J9039	blinatumomab, 1mcg	Blincyto
J9049	bortezomib (hospira), not therapeutically equivalent to J9041, 0.1mg	Bortezomib
J9054	bortezomib, 0.1 mg	Boruzu
J9041	bortezomib, 0.1mg	Velcade
J9042	brentuximab vedotin, 1mg	Adcetris
C9088	bupivacaine and meloxicam, 1mg/0.03mg	Zynrelef
J0666	bupivacaine liposome, 1mg	Exparel
C9144	bupivacaine, 1mg	Posimir
J0584	burosumab-twza, 1mg	Crysvita
J0594	busulfan, 1mg	Busulfex
J0595	butorphanol tartrate, 1mg	Stadol
J9043	cabazitaxel, 1mg	Jevtana
J0706	caffeine citrate, 5mg	Cafcit
J9118	calaspargase pegol-mknl, 10 units	Asparlas
J0636	calcitriol, 0.1mcg	Calcijex
J0618	calcium chloride, 2 mg	Calcium Chloride

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Allowable Waste Drug List

J0613	calcium gluconate(wg critical care), per 10mg	Calcium Gluconate-nacl
J0638	canakinumab, 1mg	Ilaris
J7354	cantharidin for topical administration, 0.7%, single unit dose applicator (3.2 mg)	Ycanth
J0675	carboprost tromethamine, 0.1 mg	Hemabate
J9047	carfilzomib, 1mg	Kyprolis
J9050	carmustine, 100mg	Carmustine
J1426	casimersen, 10mg	Amondys 45
J0637	caspofungin acetate, 5mg	Cancidas
J0689	cefazolin sodium, not therapeutically equivalent to J0690, 500mg	Cefazolin sodium (Baxter)
J0687	cefazolin sodium, not therapeutically equivalent to J0690, 500mg	Cefazolin sodium (WG Critical Care)
J0701	cefepime Hcl, not therapeutically equivalent to maxipime, 500mg	Cefepime Hcl (Baxter)
J0703	cefepime Hcl, not therapeutically equivalent to maxipime, 500mg	Cefepime-dextrose (B.Braun)
J0699	cefiderocol, 10mg	Fetroja
J0525	cefotetan disodium, 10 mg	Cefotan
J0712	ceftaroline fosamil, 10mg	Teflaro
J0714	ceftazidime and avibactam, 0.5g/0.125g	Avycaz
J0713	ceftazidime, per 500mg	Fortaz
J0696	ceftriaxone sodium, per 250mg	Rocephin
J9119	cemiplimab-rwlc, 1mg	Libtayo
J9055	cetuximab, 10mg	Erbitux
J1203	cipaglucosidase alfa-atga, 5mg	Pombiliti
J9065	cladribine, per 1mg	Cladribine
J0759	clevidipine butyrate, 1 mg	Cleviprex
C9248	clevidipine butyrate, 1mg	Cleviprex
J0737	clindamycin phosphate, not therapeutically equivalent to J0736, 300mg	Clindamycin phosphate (Baxter)
J9027	clofarabine, 1mg	Clolar
J0735	clonidine Hcl, 1mg	Duraclon
J0775	collagenase, clostridium histolyticum, 0.01mg	Xiaflex
J0791	crizanlizumab-tmca, 5mg	Adakveo
J1307	crovalimab-akkz, 10mg	PiaSky
J9075	cyclophosphamide, 100mg	Cytosan
J9076	cyclophosphamide, 5 mg	Cyclophosphamide (Baxter)
J9073	cyclophosphamide, 5mg	Cyclophosphamide (Ingenus)
J9071	cyclophosphamide, 5mg	Cyclophosphamide (Auromedics)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Allowable Waste Drug List

J9120	dactinomycin, 0.5mg	Dactinomycin
J0875	dalbavancin, 5mg	Dalvance
J0877	daptomycin (hospira), not therapeutically equivalent to J0878, 1mg	Daptomycin
J0878	daptomycin, 1mg	Cubicin
J0872	daptomycin, unrefrigerated, not therapeutically equivalent to J0878 or J0873, 1mg	Xellia 505(b)(2) (unrefrigerated)
J9145	daratumumab, 10mg	Darzalex
J0882	darbepoetinalfa, 1 mcg (for esrd on dialysis)	Aranesp (albumin Free)
J0881	darbepoetinalfa, 1mcg (non-esrd use)	Aranesp (albumin Free)
C9174	datopotamab deruxtecan-dlnk, 1 mg	Datroway
J9011	datopotamab deruxtecan-dlnk, 1 mg	Datroway
J9150	daunorubicin, 10mg	Cerubidine
J0589	daxibotulinumtoxina-lanm, 1 unit	Daxxify
J0893	decitabine (sunpharma) not therapeutically equivalent to J0894, 1mg	Decitabine
J0894	decitabine, 1mg	Dacogen
J0895	deferoxamine mesylate, 500mg	Desferal
J9161	denileukin diftitox-cxdl 1 mcg	Lymphir
J1095	dexamethasone 9%, intraocular, 1 mcg	Dexycu
J1190	dexrazoxane Hcl, per 250mg	Zinecard, Totect
J0879	difelikefalin, 0.1 mcg, (for esrd on dialysis)	Korsuva
J1164	diltiazem hydrochloride in 0.72% sodium chloride, 0.5 mg	Diltiazem HCl in sodium chloride
J1163	diltiazem hydrochloride, 0.5 mg	Cardizem
J1245	dipyridamole, per 10mg	Persantine IV
J1250	dobutamine Hcl, per 250mg	Dobutamine In D5w
J9171	docetaxel, 1mg	Taxotere
J1265	dopamine Hcl, 40mg	Dopamine In D5w
J9000	doxorubicin Hcl, 10mg	Adriamycin
Q2050	doxorubicin Hcl, liposomal, not otherwise specified, 10mg	Doxil
J9173	durvalumab, 10mg	Imfinzi
J1290	ecallantide, 1mg	Kalbitor
J1299	eculizumab 2 mg	Soliris
J1300	eculizumab, 10mg	Soliris
Q5151	eculizumab-aagh, biosimilar, 2mg	Epysqli
Q5152	eculizumab-aeeb, biosimilar, 2 mg	Bkemv
J1301	edaravone, 1mg	Radicava
J9332	efgartigimod alfa-fcab, 2mg	Vyvgart
J1322	elosulfase alfa, 1mg	Vimizim

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Allowable Waste Drug List

J9176	clotuzumab, 1mg	Empliciti
J1323	elranatamab-bcmm, 1mg	Elrexfio
J9210	emapalumab-lzsg, 1mg	Gamifant
J9177	enfortumab vedotin-ejfv, 0.25mg	Padcev
J0169	epinephrine (adrenalin), not therapeutically equivalent to J0165, 0.1 mg	Adrenalin
J0167	epinephrine (hospira), not therapeutically equivalent to J0165, 0.1 mg	Hospira 505(b)(2)
J0168	epinephrine (international medication systems), not therapeutically equivalent to J0165, 0.1 mg	International Medication Systems 505(b)(2)
J0164	epinephrine in sodium chloride (baxter), 0.1 mg	Baxter 505(b)(2)
J0163	epinephrine in sodium chloride (endo), 0.1 mg	Endo 505(b)(2)
J0165	epinephrine, not otherwise specified,	Epinephrine
J9178	epirubicin Hcl;, 2mg	Ellence
J0887	epoetinbeta, 1mcg, (for esrd on dialysis)	Mircera
J0888	epoetinbeta, 1mcg, (for non esrd use)	Mircera
J1325	epoprostenol, 0.5mg	Flolan; Veletri
J1327	eptifibatide, 5mg	Integrilin
J0122	eravacycline, 1mg	Xerava
J9179	eribulin mesylate, 0.1mg	Halaven
J1806	esmolol Hcl (wg critical care) not therapeutically equivalent to J1805, 10mg	Esmolol Hcl
J1805	esmolol Hcl, 10mg	Brevibloc
J1370	esomeprazole sodium, 1 mg	Nexium IV
J1428	eteplirsen, 10mg	Exondys 51
J1807	ethacrynate sodium, 1 mg	Sodium Edecrin
J1305	evinacumab-dgnb, 5mg	Evkeeza
J9358	fam-trastuzumab deruxtecan-nxki, 1mg	Enhertu
J3010	fentanyl citrate, 0.1mg	Sublimaze
J1437	ferric derisomaltose, 10mg	Monoferric
J1450	fluconazole, 200mg	Diflucan
J9185	fludarabine phosphate, 50mg	Fludara
J9190	fluorouracil, 500mg	Adrucil
J1451	fomepizole, 15mg	Fomepizole
J1456	fosaprepitant (teva), not therapeutically equivalent to J1453, 1mg	Fosaprepitant
J1455	foscarnet sodium, per 1000mg	Foscavir
J1809	fosdenopterin, 0.1 mg	Nulibry
Q2009	fosphenytoin, 50mg phenytoin equivalent	Cerebyx
J1938	furosemide 1 mg	Lasix
J1458	galsulfase, 1mg	Naglazyme

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Allowable Waste Drug List

J1460	gamma globulin, intramuscular, 1cc	Gamastan
J1560	gamma globulin, intramuscular, over 10cc	Gamastan
J9201	gemcitabine Hcl, not otherwise specified, 200mg	Gemzar
J9203	gemtuzumab ozogamicin, 0.1mg	Mylotarg
J0223	givosiran, 0.5mg	Givlaari
C9293	glucarpidase, 10 units	Voraxaze
J1597	glycopyrrolate, 0.1mg	Glyrx-PF
J1598	glycopyrrolate, not therapeutically equivalent to J1596, 0.1mg	Fresenius Kabi 505(b)(2)
J1602	golimumab, 1mg, for IV use	Simponi Aria
J1429	golodirsén, 10mg	Vyondys 53
J1640	hemin, 1mg	Panhematin
J1571	hepatitis b immune globulin, intramuscular, 0.5mL	Hepagam B
J1573	hepatitis b immune globulin, IV, 0.5ml	Hepagam B
J7177	human fibrinogen concentrate, 1mg	Fibryga
J7178	human fibrinogen concentrate, not otherwise specified, 1mg	Riastap
J3473	hyaluronidase, recombinant, 1 usp unit	Hylanex
J1720	hydrocortisone sodium succinate, up to 100mg	Solu-cortef
J1171	hydromorphone, 0.1mg	Dilaudid
J3424	hydroxocobalamin, IV, 25mg	Cyanokit
J1741	ibuprofen, 100mg	Caldolor
J9211	idarubicin Hcl, 5mg	Idamycin Pfs
J1743	idursulfase, 1mg	Elaprase
J9208	ifosfamide, 1 gram	Ifex
J0870	imetelstat, 1mg	Rytelo
J1786	imiglucerase, 10 units	Cerezyme
J0742	imipenem 4mg, cilastatin 4mg and relebactam 2mg	Recarbrio
J1551	immune globulin, 100mg	Cutaquig
J1555	immune globulin, 100mg	Cuvitru
J1559	immune globulin, 100mg	Hizentra
J1558	immune globulin, 100mg	Xembify
J1552	immune globulin, 500mg	Alyglo
J1554	immune globulin, 500mg	Asceniv
J1556	immune globulin, 500mg	Bivigam
J1566	immune globulin, IV, lyophilized (e.g., powder), not otherwise specified, 500mg	Gammagard S/D; Carimune NF

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Allowable Waste Drug List

J1576	immune globulin, IV, non-lyophilized (e.g., liquid), 500mg	Panzyga
J1459	immune globulin, IV, non-lyophilized (e.g., liquid), 500mg	Privigen
J1572	immune globulin, IV, non-lyophilized (e.g., liquid), 500mg	Flebogamma; Flebogamma DIF
J1557	immune globulin, IV, non-lyophilized (e.g., liquid), 500mg	Gammaplex
J1568	immune globulin, IV, non-lyophilized (e.g., liquid), 500mg	Octagam
J1561	immune globulin, non-lyophilized (e.g., liquid), 500mg	Gammaked; Gamunex-C
J1569	immune globulin, non-lyophilized, (e.g., liquid), 500mg	Gammagard
J1575	immune globulin/hyaluronidase, 100mg	Hyqvia
J0588	incobotulinumtoxin a, 1 unit	Xeomin
C9300	indigotindisulfonate sodium, 1 mg	Bludigo
J1823	inebilizumab-cdon, 1mg	Uplizna
J1745	infliximab, excludes biosimilar, 10mg	Remicade
Q5104	infliximab-abda, biosimilar, 10mg	Renflexis
Q5121	infliximab-axxq, biosimilar, 10mg	Avsola
J1748	infliximab-dyyb, 10mg	Zymfentra
Q5103	infliximab-dyyb, biosimilar, 10mg	Inflectra
J9229	inotuzumab ozogamicin, 0.1mg	Besponsa
J9216	interferon, gamma1-b, 3 million units	Actimmune
J9228	ipilimumab, 1mg	Yervoy
J9205	irinotecan liposome, 1mg	Onivyde
J9206	irinotecan, 20mg	Camptosar
J1750	irondextran, 50mg	Infed
J9227	isatuximab-irfc, 10mg	Sarclisa
J9207	ixabepilone, 1mg	Ixempra
C9254	lacosamide, 1mg	Vimpat
J0593	lanadelumab-flyo, 1mg	Takhzyro
J1931	laronidase, 0.1mg	Aldurazyme
J0640	leucovorin calcium, per 50mg	Leucovorin Calcium
J1953	levetiracetam, 10mg	Levetiracetam
J1955	levocarnitine, per 1gm	Levocarnitine
J0642	levoleucovorin, 0.5mg	Khapzory
J0641	levoleucovorin, not otherwise specified, 0.5mg	Fusilev
J0650	levothyroxine sodium, not otherwise specified, 10mcg	levothyroxine

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Allowable Waste Drug List

J0651	levothyroxine sodium, not therapeutically equivalent to J0650, 10mcg	Fresenius Kabi 505(b)(2)
J0652	levothyroxine sodium, not therapeutically equivalent to J0650, 10mcg	Hikma 505(b)(2)
J2002	lidocaine HCL in 5% dextrose, 1mg	Xylocaine
J2004	lidocaine hcl with epinephrine, 1mg	Xylocaine-Epinephrine
J2003	lidocaine hcl, 1mg	Xylocaine
J2021	Linezolid (hospira) not therapeutically equivalent to J2020, 200mg	Linezolid In Sodium Chloride
J2020	linezolid, 200mg	Zyvox
J0654	liothyronine, 1 mcg	Triostat
J9153	liposomal, 1mg daunorubicin and 2.27mg cytarabine	Vyxeos
J9359	loncastuximab tesirine-lpyl, 0.075mg	Zynlonta
J0224	lumasiran, 0.5mg	Oxlumo
J9223	lurbinectedin, 0.1mg	Zepzelca
J0896	luspatercept-aamt, 0.25mg	Reblozyl
J3475	magnesium sulfate, per 500mg	Magnesium Sulfate
J2151	mannitol, 250 mg	mannitol
J9353	margetuximab-cmkb, 5mg	Margenza
J9248	melphalan, 1mg	Hepzato
J9246	melphalan, 1mg	Evomela
J2186	meropenem and vaborbactam, 10mg/10mg(20mg)	Vabomere
J2185	meropenem, 100mg	Merrem
J2183	meropenem, not therapeutically equivalent to J2185, 100mg	WG Critical Care 505(b)(2)
J2184	meropenem, not therapeutically equivalent to J2185, 100mg	B.Braun 505(b)(2)
J9260	methotrexate sodium, 50mg	Methotrexate Sodium
J0616	metoprolol tartrate, 1 mg	Lopressor
J1836	metronidazole, 10mg	Metronidazole
J2246	micafungin in sodium (baxter), not therapeutically equivalent to j2248, 1mg	Micafungin Sodium
J2247	micafungin sodium(par pharm) not therapeutically equivalent to J2248, 1mg	Micafungin Sodium
J2248	micafungin sodium, 1mg	Mycamine
J2252	midazolam in 0.8% sodium chloride, IV, not therapeutically equivalent to J2250, 1mg	Midazolam 0.8%
J2260	milrinone lactate, 5mg	Milrinone Lactate

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Allowable Waste Drug List

J2265	minocycline hcl, 1mg	Minocin
J2267	mirikizumab-mrkz, 1mg	OmvoH
J9063	mirvetuximab soravtansine-gynx, 1mg	Elahere
J9280	mitomycin, 5mg	Mitomycin
J9204	mogamulizumab-kpkc, 1mg	Poteligeo
S0093	morphine sulfate, 500mg (loading dose for infusion pump)	Morphine Sulfate
J2274	morphine sulfate, preservative-free for epidural or intrathecal use, 10mg	Duramorph; Infumorph
J2277	motixafortide, 0.25mg	Aphexda
J7528	Mycophenolate mofetil, for suspension, oral, 100 mg	CellCept suspension
J2291	nafcillin sodium (baxter), 20 mg	Nallpen
S0032	nafcillin sodium, 2 grams	Nafcillin Sodium
J2290	nafcillin sodium, 20mg	Nafcillin Sodium
J9348	naxitamab-gqgk, 1mg	Danyelza
J9295	necitumumab, 1mg	Portrazza
J9261	nelarabine, 50mg	Arranon
J2711	neostigmine methylsulfate 0.1 mg and glycopyrrolate 0.02 mg	Prevduo
C9305	nipocalimab-aahu, 3 mg	Imaavy
J9256	nipocalimab-aahu, 3 mg	Imaavy
J2305	nitroglycerin, 5mg	Nitroglycerin
J9298	nivolumab and relatlimab-rmbw, 3mg/1mg	Opdualag
J9299	nivolumab, 1mg	Opdivo
J9301	obinutuzumab, 10mg	Gazyva
C9101	oliceridine, 0.1mg	Olinvyk
J0218	olipudasealfa-rpcp, 1mg	Xenpozyme
J0121	omadacycline, 1mg	Nuzyra
J2357	omalizumab, 5mg	Xolair
J0585	onabotulinumtoxinA, 1 unit	Botox Cosmetic
J2407	oritavancin, 10mg	Orbactiv
J9263	oxaliplatin, 0.5mg	Eloxatin
J9264	paclitaxel protein-bound particles, 1mg	Abraxane
J2425	palifermin, 50mcg	Kepivance
J2468	palonosetron hcl (avyxa), not therapeutically equivalent to J2469, 25mcg	Posfrea
J9303	panitumumab, 10mg	Vectibix
J2470	pantoprazole sodium, 40mg	Protonix IV
J2471	pantoprazole, not therapeutically equivalent to J2470, 40 mg	Hikma 505(b)(2)
J2440	papaverinehcl, up to 60mg	Papaverine Hcl

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Allowable Waste Drug List

J2502	pasireotide long acting, 1mg	Signifor Lar
J0222	patisiran, 0.1mg	Onpattro
J9266	pegaspargase, per single dose vial	Oncaspar
A9615	pegulicianine, 1mg	Lumisight
J9271	pembrolizumab, 1mg	Keytruda
J9296	pemetrexed (accord) not therapeutically equivalent to J9305, 10mg	Pemetrexed Disodium
J9292	pemetrexed (avyxa), not therapeutically equivalent to J9305, 10mg	Axle
J9294	pemetrexed (hospira) not therapeutically equivalent to J9305, 10mg	Pemetrexed Disodium
J9297	pemetrexed (sandoz), not therapeutically equivalent to J9305, 10mg	Pemetrexed Disodium
J9314	pemetrexed (teva) not therapeutically equivalent to J9305, 10mg	Pemetrexed
J9323	pemetrexed ditromethamine, 10mg	Hospira 505(b)(2)
J9305	pemetrexed, not otherwise specified, 10mg	Alimta
J0558	penicillin g benzathine and penicillin g procaine, 100,000 units	Bicillin C-R
J0561	penicillin g benzathine, 100,000 units	Bicillin L-A
J2540	penicillin g potassium, up to 600,000 units	Pfizerpen-G
J2516	pentamidine isethionate, 1 mg	Pentam
J9268	pentostatin, 10mg	Nipent
J2547	peramivir, 1mg	Rapivab
J2561	phenobarbital sodium, 1mg	Sezaby
J2560	phenobarbital sodium, up to 120mg	Phenobarbital Sodium
J1097	phenylephrine 10.16mg/ml and ketorolac 2.88mg/ml, 1ml	Omidria
J2373	phenylephrine hcl, 20mcg	Immphentiv
J2372	phenylephrine hcl, 20mcg	Biorphen
J1165	phenytoin sodium, per 50mg	Phenytoin Sodium
J3430	phytonadione (vitamin k), per 1mg	Aqua-Mephyton
J2998	plasminogen, human-tvmh, 1mg	Ryplazim
J0291	plazomicin, 5mg	Zemdri
J2562	plerixafor, 1mg	Mozobil
J9309	polatuzumab vedotin-piiq, 1mg	Polivy
J9600	porfimer sodium, 75mg	Photofrin
J1837	posaconazole, 1 mg	Noxafil
J3480	potassium chloride, per 2meq	Potassium Chloride
J9376	pozelimab-bbfg, 1mg	Veopoz

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Allowable Waste Drug List

J9307	pralatrexate, 1mg	Folotyn
J2704	propofol, 10mg	Diprivan
J2720	protamine sulfate, per 10mg	Protamine Sulfate
J2724	protein c concentrate, IV, human, 10iu	Ceprothin
J7168	prothrombin complex concentrate (human), kcentra, per i.u. of factor ix activity	Kcentra
J7165	prothrombin complex concentrate, human-lans, per i.u. of factor ix activity	Balfaxar
J9308	ramucirumab, 5mg	Cyramza
J2779	ranibizumab, via intravitreal implant, 0.1mg	Susvimo (implant 1st Fill)
J2783	rasburicase, 0.5mg	Elitek
J0248	remdesivir, 1mg	Veklury
J2249	remimazolam, 1mg	Byfavo
J2786	reslizumab, 1mg	Cinqair
J2792	rho d immune globulin, IV, human, solvent detergent, 100iu	WinRho SDF
J2804	rifampin 1 mg	Rifadin
J2793	riloncept, 1mg	Arcalyst
J0587	rimabotulinumtoxinb, 100 units	Myobloc
J9311	rituximab 10mg and hyaluronidase	Rituxan Hycela
J9312	rituximab, 10mg	Rituxan
Q5115	rituximab-abbs, biosimilar, 10mg	Truxima
Q5123	rituximab-arxx, biosimilar, 10mg	Riabni
Q5119	rituximab-pvvr, biosimilar, 10mg	Ruxience
J9319	romidepsin, lyophilized, 0.1mg	Istodax
J2802	romiplostim, 10mcg	Nplate
J2795	ropivacaine hcl, 1mg	Naropin
J9317	sacituzumab govitecan-hziy, 2.5mg	Trodelvy
J2820	sargramostim (gm-csf), 50mcg	Leukine
J2840	sebelipase alfa, 1mg	Kanuma
J2850	secretin, synthetic, human, 1mcg	ChiRhostim
J3247	secukinumab, IV, 1mg	Cosentyx IV
J2860	siltuximab, 10mg	Sylvant
J9331	sirolimus protein-bound particles, 1mg	Fyarro
J0209	sodium thiosulfate, 100mg	Hope Pharmaceuticals
C9482	sotalol hcl, 1mg	Sotacor
J9320	streptozocin, 1 gram	Zanosar
J1302	sutimlimab-jome, 10mg	Enjaymo
J9349	tafasitamab-cxix, 2mg	Monjuvi
J9269	tagraxofusp-erzs, 10mcg	Elzonris

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Allowable Waste Drug List

J3060	taliglucerase alfa, 10 units	Elelyso
J3055	talquetamab-tgvs, 0.25mg	Talvey
J9274	tebentafusp-tebn, 1mcg	Kimmtrak
J9380	teclistamab-cqyv, 0.5mg	Tecvayli
J3095	telavancin, 10mg	Vibativ
C9306	telisotuzumab vedotin-tllv, 1 mg	Emrelis
J9326	telisotuzumab vedotin-tllv, 1 mg	Emrelis
J9328	temozolomide, 1mg	Temodar
J9330	temsirolimus, 1mg	Temsirolimus
J3101	tenecteplase, 1mg	Tnkase
J9381	teplizumab-mzwv, 5mcg	Tzield
J3241	teprotumumab-trbw, 10mg	Tepezza
J1072	testosterone cypionate 1 mg	Azmiro
J3145	testosterone undecanoate, 1mg	Aveed
J9341	thiotepa (tepylute), 1 mg	Tepylute
J9340	thiotepa, 15mg	Thiotepa
J9342	thiotepa, not otherwise specified, 1 mg	Tepadina
J3243	tigecycline, 1mg	Tygacil
J3246	tirofiban hcl, 0.25mg	Aggrastat
J9273	tisotumab vedotin-tftv, 1mg	Tivdak
J3262	tocilizumab, 1mg	Actemra
Q5135	tocilizumab-aazg, biosimilar, 1 mg	Tyenne
J9351	topotecan, 0.1mg	Hycamtin
J3263	toripalimab-tpzi, 1mg	Loqtorzi
J9352	trabectedin, 0.1mg	Yondelis
J3291	tranexamic acid in sodium chloride, 5 mg	Exela 505(b)(2)
J3290	tranexamic acid, 5 mg	Cyklokapron
J9355	trastuzumab, excludes biosimilar, 10mg	Herceptin
Q5146	trastuzumab-strf, biosimilar, 10mg	Hercessi
J9347	tremelimumab-actl, 1mg	Imjudo
C9175	treosulfan, 50 mg	Grafapex
J0614	treosulfan, 50 mg	Grafapex
J3299	triamcinolone acetonide, 1mg	Xipere
J3300	triamcinolone acetonide, preservative free, 1mg	Triesence
J1448	trilaciclib, 1mg	Cosela
J3315	triptorelin pamoate, 3.75mg	Trelstar
Q5138	ustekinumab-auub, biosimilar, IV, 1 mg	Wezlana (IV)
Q5137	ustekinumab-auub, biosimilar, subcutaneous, 1mg	Wezlana (SC)
J3375	vancomycin hydrochloride (xellia), not therapeutically equivalent to J3373, 10 mg	Xellia 505(b)(2)

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

Allowable Waste Drug List

J3373	vancomycin hydrochloride, 10 mg	Vancocin
J3374	vancomycin hydrochloride, not therapeutically equivalent to J3373, 10 mg	Mylan 505(b)(2)
J2596	vasopressin (long grove), not therapeutically equivalent to J2598, 1 unit	Long Grove 505(b)(2)
J2601	vasopressin, 1 unit	Baxter 505(b)(2)
J3385	velaglucerase alfa, 100 units	Vpriv
J3396	verteporfin, 0.1mg	Visudyne
J3397	vestronidase alfa-vjbk, 1mg	Mepsevii
J1427	viltolarsen, 10mg	Viltepso
J9370	vincristine sulfate, 1mg	Vincasar PFS
J9390	vinorelbine tartrate, 10mg	Navelbine
J3465	voriconazole, 10mg	Vfend IV
J9276	zanidatamab-hrii, 2 mg	Ziihera
J2278	ziconotide, 1mcg	Prialt
J9400	ziv-aflibercept, 1mg	Zaltrap
J1326	zolbetuximab-clzb, 2 mg	Vyloy
J3489	zoledronic acid, 1mg	Reclast; Zometa

Policy/Procedure Number: MPRP4065 (previously MCRP4065)		Lead Department: Health Services Business Unit: Pharmacy	
Policy/Procedure Title: Drug Utilization Review (DUR) Program		☒ External Policy ☐ Internal Policy	
Original Date: 05/08/2019		Next Review Date: ~~05/13/2027~~ <u>08/12/2027</u> Last Review Date: ~~05/13/2026~~ <u>08/12/2026</u>	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage
Reviewing Entities:	☒ IQI	☒ P & T	☐ QUAC
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE ☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE ☒ PAC
	☐ CEO ☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER
Approval Signature: Robert Moore, MD, MPH, MBA		Approval Date: ~~05/13/2026~~ <u>08/12/2026</u>	

I. RELATED POLICIES:

- A. MPRP4001 - Pharmacy & Therapeutics (P&T) Committee
- B. MCRP4064 - Continuation of Prescription Drugs
- C. MCRP4068 - Medical Benefit Medication TAR Policy
- D. MPRP4034 - Pharmaceutical Patient Safety
- E. CMP09 - Investigating & Reporting Fraud, Waste and Abuse
- F. CMP36 – Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

- A. Health Services

III. DEFINITIONS:

- A. Partnership Advantage: Effective Jan. 1, 202~~8~~⁶, 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 Members will be qualified to receive both Medi-Cal and Medicare services as described in the Partnership Advantage Member Handbook.
- B. Medi-Cal Rx: The program title established by the State of California Department of Health Care Services (DHCS) for the new system of administering Medi-Cal pharmacy benefits through the fee-for-service (FFS) delivery system effective Jan 1, 2022. Refer to All Plan Letter (APL) 22-012 APL 25-013 Revised for more information.
- C. Pharmacy Benefit Manager (PBM): A third party entity that manages prescription drug benefits for health plans.

IV. ATTACHMENTS:

- A. N/A

V. PURPOSE:

DHCS APL 17-008 clarifies Medi-Cal managed care health plan contractual requirements related to Medi-Cal drug utilization review (DUR) program requirements pursuant to Title 42, Code of Federal Regulations (CFR), Section 438.3(s). Accordingly, Partnership HealthPlan of California's (Partnership) Drug Utilization Review (DUR) program was established in 2017 to educate physicians and pharmacists to better identify patterns, and reduce the frequency of fraud, waste and abuse, gross overuse, and inappropriate or medically unnecessary care, both among physicians, pharmacists, and

Policy/Procedure Number: MPRP4065		Lead Department: Health Services Business Unit: Pharmacy	
Policy/Procedure Title: Drug Utilization Review (DUR) Program		☒ External Policy ☐ Internal Policy	
Original Date: 05/08/2019		Next Review Date: ~~05/13/2027~~ 08/12/2027 Last Review Date: ~~05/13/2026~~ 08/12/2026	
Applies to:	☒ Employees	☒ Medi-Cal	☒ Partnership Advantage

patients, and fraud, abuse, associated with specific drugs or groups of drugs.

VI. **POLICY / PROCEDURE:**

A. Partnership's DUR Program meets both Medi-Cal and Medicare program requirement as described below:

1. ~~Partnership~~Partnership participates in the Global Medi-Cal DUR program pursuant to [APL 25-013](#) and [APL 23-026](#). Activities of the Global Medi-Cal DUR Board include but are not limited to:
 - a. Providing advice and feedback related to the nature and scope of the prospective and retrospective DUR programs.
 - b. Recommendations for DUR interventions.
 - c. Input regarding innovative DUR practices
 - d. Board meeting attendance and Board membership
2. Prospective DUR. is not required of Partnership due to the implementation of Medi-Cal Rx. Partnership is able to review prospective DUR alerts and overrides for members and use this information for prescriber education and interventions, which is a part of retrospective DUR. Pursuant to Medi-Cal Rx policy, Partnership will receive comprehensive claims and PA history for members and can use claims data for quality improvement and retrospective DUR activities. Partnership's Pharmacy department will create Business Object report as an automated process for retrospective claim review to monitor drug utilization and develop interventions to address identified unsafe and/or inappropriate prescribing and dispensing. Partnership will use such reports and other resources to continue to provide retrospective DUR activities to monitor coordination of care including but not limited to identifying patterns of:
 - a. Therapeutic appropriateness
 - b. Adverse events
 - c. Incorrect duration of treatment
 - d. Over and under utilization
 - e. Inappropriate or medically unnecessary prescribing
 - f. Gross overprescribing and use
 - g. Concurrent prescribing of opioids and benzodiazepines or opioids and antipsychotics or opioids and Medication Assisted Treatment (MAT)
 - h. Fraud, waste, or abuse including identifying and addressing fraud and abuse of controlled substances by MCP- Members, health care Providers who are prescribing drugs to MCP members, and pharmacies dispensing drugs to MCP Members.
 - i. Assessing medication adherence and identifying opportunities for care management interventions/outreach
 - j. Use of all psychiatric drugs to include antipsychotics, mood stabilizers, and anti-depressant medication for all children under 18 years of age and all foster children.
3. Educational Outreach. Pursuant to Medi-Cal Rx policy, Partnership will continue to provide active and ongoing outreach to educate providers on common drug therapy problems (e.g., asthma medication ratio monitoring, opioid and naloxone co-prescribing, new prescribing guidelines and advisories) with the goals of improving prescribing and dispensing practices, increasing medication compliance, and improvement of over-all beneficiary health.
4. Establishment of a DUR Board, either directly, or through a contract with a private organization, that meets the requirements of Section 1927(g) of the SSA. Partnership's P&T Committee will serve as Partnership's DUR Board to review Partnership's DUR program and activities and make recommendations where necessary to improve

Policy/Procedure Number: MPRP4065		Lead Department: Health Services Business Unit: Pharmacy	
Policy/Procedure Title: Drug Utilization Review (DUR) Program		☒ External Policy ☐ Internal Policy	
Original Date: 05/08/2019		Next Review Date: ~~05/13/2027~~ 08/12/2027 Last Review Date: ~~05/13/2026~~ 08/12/2026	
Applies to:	☒ Employees	☒ Medi-Cal	☒ Partnership Advantage

Partnership's drug utilization.

5. Annual DUR Report. Pursuant to [APL 17-008](#) and ~~APL 22-012~~[APL 25-013 Revised](#) as Medi-Cal Rx is now fully implemented, Partnership will continue to provide an annual report that summarizes and describes retrospective DUR activities and any innovative practices implemented during the prior federal Fiscal Year.
 6. Functions and activities to fully comply with the Medicaid-related DUR provisions contained in section 1004 of the SUPPORT ACT as set forth in [APL 23-026](#).
- B. Partnership Advantage Part D Quality Assurance Program, in conjunction with delegated PBM's systems, policies and procedures, includes the following:
1. Representation that network providers are required to comply with minimum standards for pharmacy practice as established by the States.
 2. Concurrent drug utilization review systems, policies, and procedures designed to ensure that a review of the prescribed drug therapy is performed before each prescription is dispensed to an enrollee in a sponsor's Part D plan, typically at the point-of-sale or point of distribution. The review must include, but not be limited to,
 - a. Screening for potential drug therapy problems due to therapeutic duplication
 - b. Age/gender-related contraindications
 - c. Over-utilization and under-utilization
 - d. Drug-drug interactions
 - e. Incorrect drug dosage or duration of drug therapy
 - f. Drug-allergy contraindications
 - g. Clinical abuse/misuse
 3. Retrospective drug utilization review systems, policies, and procedures designed to ensure ongoing periodic examination of claims data and other records, through computerized drug claims processing and information retrieval systems, in order to identify patterns of inappropriate or medically unnecessary care among enrollees in a sponsor's Part D plan, or associated with specific drugs or groups of drugs.
 4. Internal medication error identification and reduction systems.
 5. Provision of information to CMS regarding its quality assurance measures and systems according to guidelines specified by CMS.
- C. Delegation Oversight and Monitoring
1. Partnership delegates Medicare pharmacy functions to a pharmacy benefits manager.
 2. A formal agreement is maintained and inclusive of all delegated functions.
 3. Oversight/Regular monitoring activities include, but are not limited to, an audit conducted no less than annually.
 4. Results from the annual delegation oversight audit shall be presented to Partnership's Delegation Oversight Review Sub-Committee (DORS) for review and approval and reviewed by the Chief Medical Officer (CMO) or physician designee.

VII. REFERENCES:

- A. Department of Health Care Services (DHCS) All Plan Letter [\(APL\) 23-026](#) Federal Drug Utilization Review Requirements Designed To Reduce Opioid Related Fraud, Misuse, and Abuse (revised Feb. 20, 2024 *supersedes* APL 19-012)
- B. ~~Department of Health Care Services (DHCS) All Plan Letter~~ ~~Department of Health Care Services (DHCS) All Plan Letter (APL) 17-008 Requirement to Participate in~~ [\(APL\) 17-008 Requirement to Participate in the Medi-Cal Drug Utilization Review Program \(May 10, 2017\)](#) ~~the Medi-Cal Drug Utilization Review Program (May 10, 2017)~~
- C. [Department of Health Care Services \(DHCS\) All Plan Letter \(APL\) 25-013, Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy Coverage \(Sept. 18, 2025 *supersedes*](#)

Policy/Procedure Number: MPRP4065		Lead Department: Health Services Business Unit: Pharmacy	
Policy/Procedure Title: Drug Utilization Review (DUR) Program		☒ External Policy ☐ Internal Policy	
Original Date: 05/08/2019		Next Review Date: ~~05/13/2027~~ 08/12/2027 Last Review Date: ~~05/13/2026~~ 08/12/2026	
Applies to:	☒ Employees	☒ Medi-Cal	☒ Partnership Advantage

APL 22-012)

- D. SSA 1927(k): Definition of Covered Outpatient Drugs
- E. Title 42 Chapter IV Subchapter B Part 423 Subpart D

VIII. DISTRIBUTION:

- A. Partnership Pharmacy Department Directors
- B. Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Director of Pharmacy Services

X. REVISION DATES:

Medi-Cal - 05/13/20; 11/11/20; 05/12/21; 05/11/22, 05/10/23, 5/08/24, 05/14/25, 5/13/26, 8/12/26
N/A

PREVIOUSLY APPLIED TO:

N/A
~~MCRP4065 - 05/13/20; 11/11/20; 05/12/21; 05/11/22, 05/10/23, 5/08/24, 05/14/2025~~

XI. Policy Disclaimer:

- A. 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:
 - 1. Consistent with sound clinical principles and processes;
 - 2. Evaluated and updated at least annually;
 - 3. 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.
- B. The materials provided are guidelines used by 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 Partnership.
- C. 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

Policy/Procedure Number: MPPR207			Lead Department: Provider Relations	
Policy/Procedure Title: Annual Physician Satisfaction Survey			☒ External Policy ☐ Internal Policy	
Original Date: 12/01/1998		Next Review Date: <u>05/20/2027</u> Last Review Date: <u>05/12/2026</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☐ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO ☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: <u>08/13/2025</u> <u>08/12/2026</u>	

I. RELATED POLICIES:

A. N/A

II. IMPACTED DEPTS:

- A. Health Services
- B. Member Services

III. DEFINITIONS:

A. N/A

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To annually assess the level of contracted physician satisfaction with Partnership HealthPlan of California (Partnership).

VI. POLICY / PROCEDURE:

A. Partnership will conduct a Physician Satisfaction Survey for contracted primary care and specialty physicians on an annual basis. This survey will be used as a tool to measure areas of satisfaction and identify opportunities for improvement based on the feedback received. The following steps will be completed:

1. The Survey tool will be developed based on recommendations from Partnership staff from the Provider Relations (PR) ~~and Quality Improvement (QI)~~ department with input from interdepartmental leaderships. The Survey will include specific questions assessing satisfaction with timely access to medical care and ~~the Utilization Management (UM) process~~ provider feedback on improvements to the services Partnership provides. The Physician Satisfaction Survey may be conducted by an external vendor or by Partnership staff. ~~The survey response goal is a minimum of 40%.~~
- 1-2. Provider Relations staff will review the survey results and identify opportunities for improvement.
 - a. The Provider Relations department will draft improvement activities ~~a Corrective Action Plan (CAP)~~ in collaboration with all other Partnership departments to address the responses that offer opportunities for improvement. ~~The final CAP~~ Improvement activities will be monitored by the Provider Relations department ~~in collaboration with the Quality Improvement department. The CAP will and are be~~ designed to improve practitioner experience based on the survey data.

Policy/Procedure Number: MPPR207		Lead Department: Provider Relations	
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Original Date: 12/01/1998		Next Review Date: ~~05/20/2027~~ 08/12/2027 Last Review Date: ~~05/20/2026~~ 08/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

- b. The Satisfaction Survey results and [improvement activities](#)~~CAP~~ will be reported to the Partnership Internal Quality Improvement (IQI) Committee and the appropriate Partnership physician committees for their review and input. Results of the Physician Satisfaction Survey and [improvement activities](#)~~the CAP~~ are also presented to the Partnership Board of Commissioners.

VII. REFERENCES:

- A. Department of Health Care Services [\(DHCS\) Medi-Cal Managed Care Ceontract](#)
A.B. [DHCS All Plan Letter \(APL\) 24-004 Quality Improvement and Health Equity Transformation Requirements- \(April 8, 2024 supersedes APL 19-017\)](#)
B.C. [NCQA 2026](#)~~5~~ Standard QI 3, Element A

VIII. DISTRIBUTION:

Partnership Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE:

~~Senior~~ Director of Provider Relations

IX.X. REVISION DATES:

~~Medi-Cal~~: 05/08/2000; 06/20/01; 07/17/02; 09/17/03; 06/16/04; 05/18/05; 05/17/06; 6/21/06; 05/16/07; 07/16/08; 07/15/09; 07/21/10; 07/20/11; 08/08/12; 07/08/13; 11/11/14; 08/12/15; 08/10/16; 08/09/17; 08/08/18; 08/14/19; 04/08/20; 05/12/21; 06/08/22; 06/14/23; 10/09/24; 08/13/25; ~~08/12/26~~~~05/20/26~~

PREVIOUSLY APPLIED TO:

N/A

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPXG5008 (previously QG100129 & MPQG1029)			Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Clinical Practice Guidelines: Pain Management, Chronic Pain Management, and Safe Opioid Prescribing			☒ External Policy ☐ Internal Policy	
Original Date: 06/16/2004		Next Review Date: ~~06/11/2026~~ <u>06/09/2027</u> <u>08/12/2027</u> Last Review Date: ~~06/11/2025~~ <u>06/10/2026</u> <u>08/12/2026</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO ☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: 08/12/2026	

I. RELATED POLICIES:

- A. MCUP3049 – Pain Management Specialty Services
- B. ~~MCUP3101~~MPBP8007 – Screening and Treatment for Substance Use Disorders

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims
- C. Member Services
- D. Provider Relations

III. DEFINITIONS:

- A. Partnership Advantage: Effective Jan. 1, ~~2027~~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 ~~Members~~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 January 1, 2028 and subject to CMS and DHCS approval.

IV. ATTACHMENTS:

- A. Partnership Recommendations for Safe Use of Opioid Medications: Primary Care & Specialist Prescribing Guidelines
- B. Partnership Recommendations for Safe Use of Opioid Medications: Community Pharmacy Guidelines
- C. Partnership Recommendations for Safe Use of Opioid Medications: Emergency Department Guidelines
- D. Partnership Recommendations for Safe Use of Opioid Medications: Dental Prescribing Guidelines

V. PURPOSE:

The purpose of this guideline is to improve care for Partnership HealthPlan of California (Partnership) members with chronic pain by:

- A. Clarifying the roles of primary care practitioners and specialists who care for members with chronic pain. The guideline is designed to help primary care practitioners make appropriate use of pain management specialists.
- B. Summarizing best practices in opioid prescribing to create a series of recommendations for safe prescribing of opioid medications.

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Original Date: 06/16/2004		Next Review Date: 06/11/2027 Last Review Date: 06/11/ 2025 08/2/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

VI. GUIDELINE / PROCEDURE:

- A. Partnership HealthPlan is the County Organized Health System (COHS) covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 24 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have developed community-wide guidelines to promote safer use of opioid medications. In addition, Partnership supports Substance Use Disorder (SUD) treatment services through the Drug Medi-Cal (DMC) program, including administration of the DMC-ODS (Organized Delivery System) program in several counties.
1. This guideline recognizes the services and responsibilities of primary care providers (PCPs), pain management and other specialists in caring for members with chronic pain.
 2. This guideline is highly dependent upon the individual clinical circumstances and the delivery system. Because of these circumstances, expectations may appropriately deviate from the guideline.
 3. The PCP is responsible for coordinating all services required by the patient except when precipitous circumstances preclude the PCP's role. The scope of the responsibility is comprehensive (i.e., all required services including preventive services).
 - a. The PCP should provide those services which can be provided within his/her competence and should obtain consultation when additional knowledge or skills are required. Partnership recognizes that differences in skill levels exist among PCPs and that this document serves as a general guideline to define the scope of services and the indications for specialty referral to a pain management specialist. PCPs should continue to use their sound clinical judgment when considering the need for specialty evaluation.
 - 1) Consultation includes advice received from a telephone discussion with a specialist, e-consults, telehealth consultations and the referral of a patient to a specialist for services. The Centers for Disease Control (CDC) notes that in practice context where virtual visits are part of the standard of care (e.g., in remote areas where distance or other context makes follow-up visits challenging) or for patients for whom in-person follow-up visits are challenging (e.g., frail patients), follow-up assessments that allow the clinician to communicate with and/or observe the patient through telehealth modalities might be conducted.
 - 2) When care by a specialist is required, it is the responsibility of the PCP and the specialist to coordinate all services.
 - 3) PCPs and specialists may find guidance through various federal and state agencies, including the Medical Board of California, which has published its [Guidelines for Controlled Substances for Pain](#). These guidelines are updated to provide a framework for clinician use while also encouraging the development of treatment plans customized for their patients.
- B. The PCP should be responsible for providing the following basic pain management services:
1. The PCP should assess the nature of the chronic pain syndrome, including onset, duration, characteristics and intensity of the pain. Functional capacity should be evaluated and is the key target of any treatment. In addition, the PCP should assess for the presence of psychiatric disorders, substance use disorders, and substance misuse. Assessment should include a thorough medication history. The many possible causes of chronic pain, including osteoarthritis, rheumatoid arthritis, and other inflammatory conditions, degenerative disease and neuropathic pain, should be considered. When indicated, the PCP should assess for pain related to work injuries and ask about the relation to accidents or legal issues.
 2. A thorough physical exam should be performed as clinically indicated.
 3. When medications with addictive/dependence potential are being used or being considered, the PCP should distinguish between physiological dependence, tolerance, or addiction/substance use disorder.
 4. A pain management agreement is an important part of the scope of pain management. PCPs should consider a pain management agreement for all chronic pain patients who they are following.
 5. A referral to a pain management center should be considered when appropriate. Members should not

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Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

be referred to a pain management specialist until treatable underlying causes have been evaluated thoroughly by the PCP and specialists other than pain management specialists as indicated. All potential co-occurring psychiatric illnesses should be evaluated and under treatment when appropriate. Any illegal drug usage should be identified, documented and addressed. When specialty consultation is requested, the PCP is responsible for sending all relevant clinical information to the specialist. Referrals solely for purpose of reducing a PCP caseload of opioid-using patients should not be made.

6. Consider referring a member with complex pain management as indicated under Pain Management Specialist referral or whenever the PCP feels the member would benefit from pain management evaluation based on his/her/their sound clinical judgment.
7. For members who have been referred and evaluated by a pain management or other specialist, the PCP should participate in the ongoing follow-up as jointly determined by the PCP and the specialist for members with these conditions who have reached a high degree of stability.
8. ~~Both the The CDC and UpToDate recommends~~ that clinicians should regularly reassess all patients receiving long-term opioid therapy, including patients who are new to the clinician but on long-term opioid therapy, with a suggested interval of every three months ~~or more frequently~~ for most patients. For those at higher risk for OUD or overdose, more frequent clinical reassessments are recommended. (depression or other mental health conditions, a history of SUD or overdose, taking >50 MME/day, or taking other CNS depressants). "Higher risk" includes those enumerated by CDC Clinical Practice Guideline for Prescribing Opioids for Pain and the American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder (2020) (e.g., those with family history of substance use disorders, history of trauma, age between 18-25 years old, co-occurring depression or other mental health conditions, a history of SUD or overdose, taking >50 MME/day, or taking other CNS depressants). In addition, the National Institute on Drug Abuse (NIDA) offers the Opioid Risk Tool (ORT-OUD) that providers can administer at an initial visit to assess risk for future opioid use disorder prior to beginning or continuing opioid therapy for pain management.

C. Specialist Referral

Referral to an appropriate specialist should be considered appropriate in the following situations:

1. Pain Management Specialist
 - a. Complex pain management where the diagnosis is unclear, or the condition is unresponsive to standard medication and non-pharmacologic therapy for a period of 3 to 6 months.
 - b. Complex pain management compromised by severe functional impairment.
 - c. Complex Regional Pain Syndrome (CRPS).
 - d. Complex pain management complicated by mental health condition or substance use disorder unresponsive to usual therapy and treatment by an appropriate behavioral health specialist.
 - e. For performance and/or supervision of procedures done by pain management specialists.
(See MCUP3049 Attachment A: [Medical Necessity Criteria for Pain Management Procedures](#).)
2. Refer to other specialists such as neurology, orthopedics, rheumatology, physical medicine and rehabilitation or behavioral health. Specific indications for referral to specialties other than pain management are beyond the scope of this guideline. The PCP should perform a careful evaluation of conditions with a known cause and initiate conservative therapy consistent with the PCP's skill and best judgment. Expert consultation should be considered in situations where the diagnosis is uncertain, the member has not responded to usual conservative therapy or specialty care is required based on the diagnosis.
3. After initial specialist consultation, or a significant change in the patient status or when the specialist terminates care of patient, the specialist is responsible to send all relevant information back to the PCP.
4. Patients with suspected substance use disorder (SUD) should be assessed by the PCP or be referred for

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Original Date: 06/16/2004		Next Review Date: ~~06/11/2027~~ <u>08/12/2027</u> Last Review Date: 06/11/ 2025 <u>08/2/2026</u>	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

assessment. In many instances, opioid use disorder (OUD) and other SUDs can be evaluated and treated by the PCP, using Medications for Addiction Assisted-Treatment (MAT). Treating opioid use disorder with buprenorphine/buprenorphine-naloxone, or naltrexone extended-release injection is within the scope of primary care practice. Another MAT for OUD, methadone, is available for outpatient treatment only through certified narcotic treatment programs (NTP) with some exceptions for acute care hospitals and emergency department settings. PCPs cannot prescribe methadone for the treatment of OUD under the guise-pretext of treating pain. However, sublingual buprenorphine products can be prescribed simultaneously for both pain and OUD. Naltrexone products should not be co-prescribed with any opioid medication, as naltrexone is an opioid receptor antagonist. If referral is warranted, providers and patients can call Partnership Behavioral Health Access Line~~Carelon Behavioral Health~~ at (855) 765-9703 for referral information and options if the patient resides in Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, ~~and-or~~ Solano counties. For residents of all other Partnership HealthPlan counties, contact the relevant county behavioral health access departments; a list of phone numbers may be found under "Benefits: Alcohol and Drug Treatment" at <https://www.partnershiphp.org/Members/Medi-Cal/Pages/Benefits.aspx>. In addition, regardless of county of residence, for buprenorphine providers, patients and providers may visit the Partnership Provider Directory or the Substance Abuse and Mental Health Services Administration (SAMHSA) treatment locator website (<https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator>). It can be helpful for PCPs or staff at the PCP office to assist patients in securing a referral connection with an assessing provider, or a substance use disorder treatment provider. ~~PCPs should also note that a specialized DEA waiver (known previously as the "X-Waiver") is no longer required for the prescribing of FDA-approved buprenorphine products for the treatment of opioid use disorder, and there are no longer any patient limits for prescribing under these circumstances. All PCPs, therefore, with DEA certification to prescribe Schedule II-V controlled substances may now prescribe FDA-approved buprenorphine products for the treatment of opioid use disorder.~~

5. For facts about buprenorphine and important points to review with the patient, see the SAMHSA Buprenorphine Quick Start Guide at <https://www.samhsa.gov/sites/default/files/quick-start-guide.pdf>.
6. Additional training materials and live mentoring can also be obtained through:
 - a. The Provider's Clinical Support System (PCSS): <https://pcssnow.org>
 - b. The University of California, San Francisco National Clinician Consultation Center warmline: <https://nccc.ucsf.edu/clinician-consultation/substance-use-management/>
 - c. CA Bridge program: <https://bridgetotreatment.org/addiction-treatment/ca-bridge/>

D. Opioid Prescribing Guidelines for Physicians

1. Initial treatment considerations should include non-pharmacological therapies, including physical therapy, acupuncture, chiropractic treatment, activity modifications (rest, splinting), and mobility assistance (canes.)
2. Based on provider skill level, the PCP should prescribe appropriate analgesics when indicated for the initial management of chronic pain.
 - a. Initial pharmacologic treatment should rely on non-opioid analgesics, including acetaminophen and nonsteroidal anti-inflammatory drugs (NSAIDs).
 - b. The use of opioids (tramadol, and opioids such as codeine, hydrocodone, methadone, oxycodone, morphine, and fentanyl) should be reserved for:
 - 1) Temporary use following trauma or surgery if non-opioid treatment is inadequate, with plan for discontinuation.
 - 2) For chronic use intermittently at the lowest doses in combination with other non-pharmacologic and non-opioid therapies.

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Original Date: 06/16/2004		Next Review Date: 06/11/202708/12/2027 Last Review Date: 06/11/ 2025 08/2/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

- 3) Severe functional disability, at the lowest doses in combination with other non-pharmacologic and non-opioid therapies (may involve ongoing regular doses).
- 4) Chronic pain associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.
- c. Before committing patients to long-term regular opioid treatment that may become lifelong, the patient's age should be taken into consideration, and the risks of physiologic dependence and misuse potential should be discussed with patients.
- d. Opioids in the frail elderly may be contraindicated due to safety concerns.
- e. Recommend, furnish, or prescribe naloxone to patients at risk of overdose, family and friends who may witness an overdose or are themselves at risk of overdose. As of 2026, naloxone is available over the counter (OTC) at pharmacies, online retailers and community organizations without a prescription. Medi-Cal Rx covers both prescription and OTC naloxone with no copayments. Medicare Part D may cover the cost of prescribed forms of naloxone. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose, including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set to, in regulations, to require employers to include naloxone in workplace first-aid kits by December 2028.
3. Pain modulating agents should be considered when appropriate, such as tricyclic antidepressants (amitriptyline and nortriptyline), and anticonvulsants, (gabapentin, pregabalin and carbamazepine.)
4. As a minimum standard, when starting opioid therapy for acute, subacute, or chronic pain – not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease – clinicians should prescribe immediate-release opioids instead of extended-release/long-acting opioids.
 - a. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs. Certain in-office toxicology screens are covered by Partnership (See Important Provider Notice on Partnership's website for details.)
 - b. Consider a confirmatory urine test if the results of an in-office screen are unexpected, because false positive and negative screening results are common.
 - c. If a patient is at higher risk for substance use disorder (SUD), diversion, or substance misuse, strongly consider more frequent toxicology screens.
 - a-d. Ensure that the toxicology screen used can detect the relevant medications or substances of interest.
 - 1) Validated screening tools for substance misuse or substance use disorder can be helpful. Please refer to Attachment A of policy MPBP8007 Screening and Treatment for Substance Use Disorders for a table of Recommended Tools and Training Resources for Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT), including validated tools for pregnant people, such as:
 - a) Drug Abuse Screening Test (DAST): <https://cde.drugabuse.gov/instrument/e9053390-ee9e-9140-e040-bb89ad433d69>
 - b) Tobacco, Alcohol, Prescription Medication and Other Substance Use Tool (TAPS-1)
 - i. A self or clinician administered tool available in online platform, TAPS-1 is a 4-item screen for tobacco, alcohol, illicit drugs, and non-medical use of prescription drugs. If an individual screens positive on TAPS-1 (i.e., reports other than "never"), the tool will automatically begin the second component, TAPS-2 as described below.
 - ii. After a positive screen on TAPS-1, TAPS-2 guides clinicians through brief substance-specific assessment questions to arrive at a risk level for that substance.
 - b. For pregnant individuals, consider using any of the validated tools recommended by the American College of Obstetricians and Gynecologists (ACOG): the 4Ps Plus (Parents, Partner, Past and Present), TAPS, or the CRAFFT (Driven in a Car while high or with someone who was, use drugs

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Original Date: 06/16/2004		Next Review Date: 06/11/202708/12/2027 Last Review Date: 06/11/ 2025 08/2/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

or alcohol to Relax, ever use when Alone, ever Forget what you did while using, ever have Friends tell you to cut down, ever gotten into Trouble on account of use).

e.e. Consider a signed medication use agreement with the prescriber or prescribing office.

f. Provider to check California Department of Justice Controlled Substance Utilization Review and Evaluation System (CURES) report at the time of writing each controlled substance prescription, or more frequently, as required by state law.

d.g. The CDC recommends, for most patients, a suggested interval of every Schedule at a minimum, three months or more frequently office visits yearly for chronic pain and monitoring opioid use.

e.h. Educate patients on proper safe storage of opioid medications to help prevent diversion (i.e., lock boxes).

f.i. Utilize CURES, pill counts, and urine drug screens to minimize the potential for diversion/resale or distribution of prescribed opioid medications.

4. Further Recommendations for PCPs and Specialists are found in Attachment A: Partnership Recommendations for Safe Use of Opioid Medications - Primary Care & Specialist Prescribing Guidelines.

E. Follow-up and monitoring during chronic opioid therapy

1. The benefits and harms for patients on chronic opioid therapy should be assessed at least every three months for patients on stable doses of opioids. UpToDate suggests patients should be seen more frequently after dosing changes, particularly if initiating or increasing extended-release long-acting (ER/LA) opioids. The risks for overdose increase in the first week after a dosing change.
2. Patients who are transitioned to or have dosing increases of methadone should be seen within three days, or within one week for other ER/LA opioids.

F. Community Pharmacy Guidelines

Community Pharmacies play a key role in helping prevent Opioid overdoses, Opioid induced hyperalgesia, Opioid diversion, and Opioid addiction, and have a legal responsibility to do so. Partnership recommends that all community pharmacies develop policies and standards to fulfill this responsibility. For detailed recommendations, see Attachment B, Partnership Recommendations for Safe Use of Opioid Medications: Community Pharmacy Guidelines.

G. Emergency ~~Department Room~~ (ED) Guidelines

The ED has two key roles in helping with community-wide efforts to control Opioid overuse: assuring acute pain is treated in a way that decreases the probability of future over-use of Opioids and working closely with primary care providers to ensure a coherent, safe approach to treating chronic pain. Partnership recommendations are found in Attachment C, Partnership Recommendations for Safe Use of Opioid Medications: Emergency Department Guidelines.

1. The ED can be a critical access point for members with SUD. ED personnel should consider screening for SUD and initiating Mmedication for Addiction Treatment ~~-assisted treatment~~ (MAT). See these articles:

- a. Consensus Recommendations on the Treatment of Opioid Use Disorder in the Emergency Department <https://www.annemergmed.com/action/showPdf?pii=S0196-0644%2821%2900306-1>
- b. Emergency Department Medication-Assisted Treatment of Opioid Addiction [-https://www.chcf.org/wp-content/uploads/2017/12/PDF-EDMATOpioidProtocols.pdf](https://www.chcf.org/wp-content/uploads/2017/12/PDF-EDMATOpioidProtocols.pdf)

H. Dentist Guidelines

Dentists play a key role in community-wide efforts to ensure safe prescribing of opioid medications. Partnership recommendations are found in Attachment D, Partnership Recommendations for Safe Use of Opioid Medications: Dentist Prescribing Guidelines.

I. Indicators Monitored by Partnership

As part of retrospective Drug Utilization Review (DUR), Partnership will monitor pharmacy claims and

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Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

CURES data for high Morphine Equivalent Dose (MED) and use of multiple prescribers and pharmacies.

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- C. Centers for Disease Control. [Overdose Prevention](#). Accessibility verified April 23, 202622, 2025
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- F. Hawk K, Hoppe J, Ketcham E, et al. Consensus recommendations on the treatment of opioid use disorder in the emergency department. *Ann Emerg Med*. 2021;78(3):434-442. doi:10.1016/j.annemergmed.2021.04.023
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- ~~K.J.~~ SAMHSA [Buprenorphine Quick Start Guide](#). Accessibility verified on June 22, 2026, 2025
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- ~~N.~~ American Society of Addiction Medicine (ASAM) National Practice Guideline for the Treatment of Opioid Use Disorder (2020) https://sitefinitystorage.blob.core.windows.net/sitefinity-production-blobs/docs/default-source/guidelines/npg-jam-supplement.pdf?sfvrsn=a00a52c2_2
- ~~O.~~ National Institute on Drug Abuse (NIDA) Opioid Risk Tool – OUD (ORT-OUD) <https://nida.nih.gov/nidamed-medical-health-professionals/screening-tools-resources/opioid-risk-tool-oud-ort-oud>

VIII. DISTRIBUTION:

- A. Partnership ~~P~~provider Manual
- B. Partnership Department Directors

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IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal

10/20/04; 03/15/06; 03/21/07; 06/18/08; 07/15/09; 01/16/13; 01/15/14; 01/20/15; 02/17/16; 04/19/17;
*03/14/18; 04/10/19; 03/11/20; 04/14/21; 06/08/22; 09/13/23; 08/14/24; 06/11/25; [08/12/26](#)

*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.

Partnership Advantage (effective Jan. 1, 2028~~6~~)
[06/11/25](#); [06/10/26](#); [08/12/26](#)

PREVIOUSLY APPLIED TO:

Healthy Kids MPXG5008 (Healthy Kids program ended 12/01/2016)

03/21/07; 06/18/08; 07/15/09; 01/16/13; 01/15/14; 01/20/15; 02/17/16 to 12/01/2016

Partnership Advantage:

MPXG5008 – 03/21/2007 to 01/01/2015

Healthy Families

MPXG5008 – 10/01/2010 to 03/01/2013



PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Primary Care & Specialist Prescribing Guidelines

Introduction

Partnership HealthPlan is a County Organized Health System (COHS) covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 24 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have community-wide guidelines to promote safer use of opioid medications.

Based on their skill level, the primary care provider (PCP) should prescribe appropriate analgesics when indicated for the initial management of pain. In starting analgesics for new onset acute pain, the possibility the acute process will evolve into a chronic pain syndrome should be kept in mind. Chronic pain is defined as pain lasting longer than normally expected for the healing of an acute injury or tissue inflammation, usually in the range of 3-6 months. In this guideline, we are not addressing chronic pain associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease, conditions in which treatment goals and needs are different.

Use of opioid pain medications for pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease related should be weighed carefully by any prescriber. Chronic use of opioids is associated with an increased risk of addiction, physiologic dependence, and tolerance. When combined with alcohol use or with other sedating medications such as benzodiazepines and muscle relaxants, opioid use is associated with an increased risk of accidental overdose and motor vehicle accidents. In addition, chronic use of opioids in high doses can cause opioid-induced hyperalgesia, which ultimately generates increased pain and debility. Unlike acute pain or pain related to metastatic cancer or end-of-life care, the goal of opioid therapy in chronic non-cancer, non-terminal pain is *improved functioning*, not necessarily *elimination of pain*.

The following standards for opioid use in patients' pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease are suggested as a starting point from which each community in our Partnership regions can develop their own standards, for the good of our members and the community. These guidelines are not a replacement for clinical judgment or individualized, person-centered care.

Effective Jan. 1, 202⁸⁷, Partnership 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. Therefore, federal guidelines are cited throughout this policy attachment.

Recommendations

For all opioid prescriptions, write as intended to be taken (i.e., 1 tablet q 6 hrs prn (this is a max of 4 per day); or 1-2 q 4-6 hrs but no more than 4 per day (also a max of 4 per day)

- A. Acute pain. The main goal is to treat pain without creating opioid physiologic dependency, tolerance, or hyperalgesia.
1. Preferentially use non-narcotics as first line therapy, especially acetaminophen or NSAIDs. Remember to be cautious with NSAIDs in seniors and persons with hypertension, gastrointestinal disorders, and azotemia.
 2. Restrict use of narcotic pain medications to situations with more severe pain, e.g., traumatic injuries, and if prescribed, limit their use to short periods.*
 3. Discuss the risk of opioid dependence, tolerance, and hyperalgesia with patients being initiated on opioid treatment.
 4. According to the Centers for Disease Control (CDC), the lowest effective dose of fast-acting opioid prescriptions should be prescribed for 3 days or less; more than 7 days will rarely be needed. Per these recommendations, prescriptions for acute treatment of pain should not go beyond a few days without reevaluation.
 5. Before initiating opioid therapy for acute pain, assess for risk of substance use disorder/diversion using a standardized tool (e.g., DIRE, see Appendix A). Refer to Attachment A of policy MPBP8007 Screening and Treatment for Substance Use Disorders for a table of Recommended Tools and Training Resources for Alcohol and Drug Screening, Assessment, Brief Interventions, and Referral to Treatment (SABIRT), including validated tools for pregnant people. If patient is at high risk, consider a baseline urine toxicology screen and focus on the use of non-opioid modalities to treat pain. Patients between 18 and 25 years of age are at increased risk of misusing prescription drugs, so patients in this age range should be screened carefully.
 6. Advise patients that short-term opioid use can lead to unintended long-term opioid use and the importance of working toward planned discontinuation of opioid use as soon as feasible, including a plan to appropriately taper opioids as pain resolves if opioids have been used around the clock for more than a few days. Review communication mechanisms and protocols patients can use to inform clinicians of severe or uncontrolled pain and to arrange for timely reassessment and management. Advise patients about serious adverse effects of opioids, including potentially fatal respiratory depression and development of a potentially serious lifelong opioid use disorder that can cause distress and inability to fulfill major role obligations at work, school, or home. Advise patients about common effects of opioids, such as constipation, dry mouth, nausea, vomiting, drowsiness, confusion, tolerance, physical dependence, and withdrawal symptoms when stopping opioids. To prevent constipation associated with opioid use, advise patients to increase hydration and fiber intake and to maintain or increase physical activity as they are able. A cathartic (e.g., senna) with or without a stool softener or a laxative might be needed if opioids are used for more than a few days. Prescribing medicines to treat opioid-induced constipation is also an option. To minimize withdrawal symptoms, clinicians should provide and discuss an opioid tapering plan when opioids will be used around the clock for more than a few days (see Recommendation 7). Limiting opioid use to the minimum needed to manage pain (e.g., taking the opioid only when needed if needed less frequently than every 4 hours and the prescription is written for every 4 hours as needed for pain) can help limit development of tolerance and therefore of withdrawal once opioids are discontinued.
 7. If formulations are prescribed that combine opioids with acetaminophen, advise patients of the risks of taking additional over-the-counter products containing acetaminophen. Acetaminophen can be hepatotoxic at dosages of >3–4 grams/day and at lower dosages in patients with chronic alcohol use or liver disease (American Geriatrics Society Panel on the Pharmacological Management of Persistent Pain in Older Persons, 2009). To help patients assess when a dose of opioids is needed, explain that the goal is to reduce pain to make it manageable rather than to eliminate pain. Discuss effects that opioids might have on ability to safely operate a vehicle or other machinery, particularly

when opioids are initiated or when other central nervous system depressants, such as benzodiazepines or alcohol, are used concurrently. Discuss increased risks for opioid use disorder, respiratory depression, and death at higher dosages, along with the importance of taking only the amount of opioids prescribed, i.e., not taking more opioids or taking them more often. Review increased risks for respiratory depression when opioids are taken with benzodiazepines, other sedatives, alcohol, non-prescribed or illicit drugs such as heroin, or other opioids. Discuss risks to household members and other individuals if opioids are intentionally or unintentionally shared with others for whom they are not prescribed, including the possibility that others might experience overdose at the same or at lower dosage than prescribed for the patient, and that young children and pets are susceptible to unintentional ingestion. Discuss storage of opioids in a secure, preferably locked location and options for safe disposal of unused opioids (U.S. Food and Drug Administration, 2020a).

8. Discuss planned use of precautions to reduce risks, including naloxone for overdose reversal and clinician use of prescription drug monitoring program information.

B. Chronic pain in patients with a remote history of malignancy, but currently in remission, should be treated the same as those with chronic non-cancer pain. (See next section.)

C. Chronic pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.

1. Chronic pain not associated with the cancer or related to its treatment, end-of-life care palliative care, or sickle cell disease and not responding to non-opioid treatment modalities may benefit from chronic use of low dose opioid medications. This should be weighed against the risk of misuse and diversion. Use of a standardized Opioid Risk Tool should be considered.
2. According to the CDC 2022 Guidelines, additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits relative to risks to patients as dosage increases further. Clinicians should carefully evaluate a decision to further increase dosage based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to risks with previous dosage increases, other treatments and effectiveness, and patient values and preferences.
3. These guidelines are not a replacement for clinical judgment or individualized, person-centered care.
4. Other treatment modalities should be considered (if not previously utilized), including acupuncture, physical therapy, massage, exercise, counseling, chiropractic, activity modification, podiatric (for appropriate diagnoses), etc.
5. In neuropathic chronic pain, consideration should be given to the use of agents such as tricyclic antidepressants (e.g., amitriptyline or nortriptyline) and anticonvulsants (e.g., gabapentin, pregabalin or carbamazepine).
6. Emphasis should be placed on functional status as opposed to complete elimination of pain.
7. For patient safety, intramuscular and intravenous opioids should not be administered for pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.
8. In order to reduce the incidence and severity of neonatal abstinence syndrome (NAS) in pregnant individuals with chronic pain, consider consultation with obstetric specialists as well as targeting the lowest effective opioid dose and the use of appropriate non-opioid analgesics. Buprenorphine or similar classes of opioids may be helpful in addressing chronic pain in the setting of opioid dependence, and may carry less risk of severe NAS. For members of reproductive age on chronic opioids, consider discussing the pregnancy-specific risks of opioids, as well as contraception options.
9. The co-prescription of opioids, benzodiazepines, other sedative-hypnotic medications and muscle relaxants should be avoided.

- D. Chronic pain not associated with cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease already on opioid doses greater than 90 mg MED/day.
1. According to the CDC Guidelines, for patients already receiving higher opioid dosages, clinicians should carefully weigh benefits and risks and exercise care when reducing or continuing opioid dosage. If risks outweigh benefits of continued opioid therapy, clinicians should optimize other therapies and work closely with patients to gradually taper to lower dosages or, if warranted based on the individual clinical circumstances of the patient, to appropriately taper and discontinue opioids. Unless there are indications of a life-threatening issue, such as warning signs of impending overdose, e.g., confusion, sedation, or slurred speech, opioid therapy should not be discontinued abruptly, and clinicians should not abruptly or rapidly reduce opioid dosages from higher dosages.
 - a. Substitution with buprenorphine or buprenorphine-naloxone products by a prescriber educated in the use of this medication. ~~(Note: no longer does a prescriber require a DEA “X-Waiver” in order to prescribe buprenorphine products for the treatment of opioid use disorder.)~~
 - b. Combination of the above with involvement of a multidisciplinary team, including behavioral health and physical therapy, and non-opioid medication options. The goal is to optimize functional status as opposed to complete alleviation of pain as the latter is often not possible.
 - c. Reducing the opioid dose to a safer range can be time-consuming, and it requires both a discussion with the patient about the reasons why this reduction is needed and a clear, well-communicated plan for how this will happen. It is not advisable to allow the patient to decide whether to remain on an unsafe opioid doses.
 - d. In larger practices or in communities, consider establishing a “chronic pain review committee” to review cases where greater than 90 mg MED/day are requested, if other exceptions to the institutional policy are considered, and to review clinical management of difficult cases. This helps support clinicians with responding to challenging patient circumstances and gives good support for peer review, if a patient has an adverse outcome.
 - e. ~~Prescribe naloxone to patients at risk of overdose. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. California law permits pharmacists to furnish naloxone without a physician’s prescription and be reimbursed under AB 1114. If naloxone is furnished by a pharmacist outside of AB 1114 to a Medi-Cal patient, a prescription is required for the pharmacy to be reimbursed. (Note: naloxone is also now available over the counter without need of a prescription, but a prescription is required for Medi-Cal or Medicare reimbursement.)~~ Recommend, furnish, or prescribe naloxone to patients at risk of overdose, family and friends who may witness an overdose or are themselves at risk of overdose. As of 2026, naloxone is available over the counter (OTC) at pharmacies, online retailers and community organizations without a prescription. Medi-Cal Rx covers both prescription and OTC naloxone with no copayments. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose, including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set to implement in regulations to require employers to include naloxone in workplace first-aid kits by December 2028.
- E. Routine monitoring of patients on chronic opioid therapy.
1. The benefits and harms for patients on chronic opioid therapy should be assessed at least every three months for patients on stable doses of opioids. UpToDate® suggests patients should be seen more frequently after dosing changes, particularly if initiating or increasing extended-release long-acting (ER/LA) opioids. The risks for overdose increase in the first week after a dosing change.
 2. Patients who are transitioned to or have dosing increases of methadone should be seen within three days, or within one week for other ER/LA opioids.
- F. The following monitoring standards for patients on opioid therapy should be used by all clinicians in Partnership’s regions.
1. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.

2. Consider utilizing a signed medication use agreement with the prescriber or prescribing office, renewed yearly.
 3. Partnership recommends clinicians use best clinical judgment and seek consultation (when appropriate) when considering the risks of prescribing opioids to individuals who are using illicit substances, alcohol, marijuana (or derivatives thereof), and/or prescription medications.
- G. For patients reporting current methadone maintenance for opioid use disorder, immediately contact their Narcotic Treatment Program (NTP) to verify dosing and standing with their program. Do not adjust or discontinue methadone dosing without consultation with the patient's NTP. Methadone maintenance dosing (e.g. daily) will not adequately provide analgesia for acute pain and these patients will often require additional analgesia (sometimes additional opioid medications) to obtain adequate analgesia.
- H. Treating opioid use disorder with buprenorphine/buprenorphine-naloxone, or naltrexone extended release injection is within the scope of primary care practice. For facts about buprenorphine and important points to review with the patient, see the [SAMSHA Buprenorphine Quick Start Guide](#). Further education and mentoring are also available through the [Provider Clinical Support System \(PCSS\)](#) and the [UCSF warmline](#).
- I. For patients presenting with acute pain who are on buprenorphine or naltrexone treatment for opioid use disorder, achieving analgesia may present unique challenges. Consider consulting available resources for analgesia strategies and protocols for these individuals (e.g., [CA Bridge Program](#)).
- J. For all patients with identified **opioid use disorder**, offer initiation of **medications for addiction treatment (MAT)**; (e.g., buprenorphine-naloxone, methadone, naltrexone). Example protocols and strategies can be found through the [CA Bridge](#) website.
1. Linkages to community MAT providers can be facilitated through consulting the Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment locator (<https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator>), or, for patients who reside in Humboldt, Mendocino, Shasta, Siskiyou, Solano, Lassen, Modoc, contact ~~Carelon~~ **Partnership's** Behavioral Health **department** for treatment options: (855) 765-9703.
 2. Patients with **opioid use disorder (OUD)** commonly use other substances. MAT for OUD should not be withheld solely because the patient is using other substances (i.e., cannabis). Of course, reasonable care should be taken when prescribing buprenorphine, for example, and the patient is also misusing alcohol or sedative-hypnotics, but the co-occurring use of these substances should not preclude the prescribing of buprenorphine for OUD treatment. The FDA has listed these as relative contraindications, not absolute contraindications. ([FDA Drug Safety Communication: FDA urges caution about withholding opioid addiction medications from patients taking benzodiazepines or CNS depressants: careful medication management can reduce risks | FDA](#))
- K. When opioids are prescribed for the treatment of pain, consider the following:
1. When prescribing opioids, review the patient's controlled-substance history. Review Controlled Substance Utilization Review and Evaluation System (CURES) no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III or Schedule IV controlled substance to the patient for the first time and at least once every 4 months thereafter if the substance remains part of the treatment of the patient. If a finding on the CURES report is not consistent with the patient's history, Partnership recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur. While not mandatory, consider checking CURES even when prescribing Schedule V medications.
 3. Schedule at least three office visits yearly for chronic pain patients using opioids.
 4. Limit each opioid prescription to 28 days (exactly four weeks), writing this on the prescription (e.g., "must last 28 days".) Writing for a 28-day quantity and making sure this is scheduled for a Tuesday, Wednesday, or Thursday every 4 weeks, reduces the problems of refills being sought on

- weekends or holidays, and requests for early refills because the patient will be running out on a weekend day (which will happen frequently if prescriptions are written for a 30-day supply.)
5. Develop an office policy on breaches in the medication use agreement. Consider a tiered approach, depending on the breach. Examples of different tiers include: warning, modification of prescription frequency, reduced dosage of medication, cessation of medication.
 6. Develop an office policy for offering ~~M~~medications for ~~A~~addiction ~~T~~treatment (MAT), and referral for substance use disorder treatment, if appropriate.
 7. Monitor for sedation that would make driving motor vehicles unsafe, particularly if opioids are combined with other sedating medications, alcohol, or other substances. If the patient is potentially unsafe to drive a motor vehicle, recommend to the patient they not drive if impaired and consider reporting the patient to the Department of Motor Vehicles (DMV) for evaluation. Note that a stable dose of opioid alone has not been shown to decrease reaction time, but if a patient is involved in a motor vehicle accident while taking an opioid, the use of the opioid may be used by law enforcement or attorneys to attribute blame. At times prescribers have come under fire in situations like this.
- ~~8.8. — Offer to prescribe naloxone to patients at risk of overdose, or to family members or friends (with consent of the patient) of those who may be at risk of overdose. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. Although, California law permits pharmacists to furnish naloxone without a physician's prescription, a prescription or standing order is required for dispensing to Medi-Cal patients in order for the pharmacy to be reimbursed by Medi-Cal. Recommend, furnish, or prescribe naloxone to patients at risk of overdose, family and friends who may witness an overdose or are themselves at risk of overdose. As of 2026, naloxone is available over the counter (OTC) at pharmacies, online retailers and community organizations without a prescription. Medi-Cal Rx covers both prescription and OTC naloxone with no copayments. Medicare Part D may cover the cost of prescribed forms of Naloxone. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set to, in regulations, to require employers to include naloxone in workplace first-aid kits by July, 2027. December, 2028.~~
- ~~See <http://prescribetoprevent.org/> for details. Intranasal naloxone is available at a pharmacy without a physician's prescription, although Medi-Cal and Medicare payment require a prescription.~~
9. The co-prescription of opioids, benzodiazepines, other sedative-hypnotic medications and muscle relaxants should be avoided.
 10. Medication lock boxes are available through Partnership's Medical Equipment Distribution Services (PMEDS) program. [Form and information can be found on the Partnership website at https://www.partnershiphp.org/Providers/Medi-Cal/Pages/PMEDS%20Program.aspx](https://www.partnershiphp.org/Providers/Medi-Cal/Pages/PMEDS%20Program.aspx)

Examples of a 90 Morphine Dose Equivalent (MED)
(Before use of any comparative dose data for patient use,
please refer to listed reference below for dosing calculator)

Drug (Generic Name)	Mg	Low Cost Generic Available?	Brand Name Examples
Morphine (PO) Chronic	90	Yes	MS Contin, Avinza (Long Acting)
Codeine (PO)	600	Yes	
Fentanyl (Transdermal)	37.5mcg/hr	Yes	Duragesic (continuous release patch)
Hydrocodone (PO)	90	Yes	Vicodin, Norco (short acting only)
Hydromorphone (PO)	22.5	Yes	Dilaudid (short acting)
Levorphanol (PO) Chronic	7.5*	Yes	LevoDromoran
Methadone	20	Yes	
Oxycodone (PO)	60	Short Acting: Yes Long Acting: ~~Yes~~ No-Yes	OxyContin (long acting)
Oxymorphone (PO)	30	No	Opana, Numorphan (short acting generic available but not low cost)
Tapentadol (PO)	225*	No	Nucynta

~~<http://www.globalrph.com/narcotic.cgi>~~ <https://globalrph.com/medcalcs/opioid-conversions-calc-original-single-agent/>

*~~<https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/Downloads/Opioid-Morphine-EQ-Conversion-Factors-March-2015.pdf>~~

Other Guidelines for Safe Opioid Prescribing

Dental Guidelines
Emergency Room Guidelines
Community Pharmacy Guidelines

Key Points from Other Guidelines

1. Emergency Departments should
 - a. Check a CURES report on every patient who will receive an opioid prescription.
 - b. Maximize the use of non-opioid analgesics, and limit the use of opioids in the treatment of acute pain. Exercise reasonable caution in the use of opioids in those individuals with evidence of substance misuse and in adults under the age of 25. Balance this caution, however, against the need to adequately treat pain.
 - c. Limit opiate prescriptions to 4 days duration.
 - d. Notify the PCP when an opioid is prescribed.
2. Dental Guidelines
 - a. Preferentially use NSAIDs instead of opioids for dental pain (opioids are no better than placebo).
3. Community Pharmacies should
 - a. Check a CURES report for all new opioid prescriptions.
 - b. Notify the PCP if there is a prescription pattern suggesting misuse.
 - c. Check the photo ID of any patient picking up an opioid prescription.
 - d. Counsel patients on the risk of tolerance, addiction, opiate-induced hyperalgesia, and drug overdose.

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May 1, 2026~~April 23, 2025~~

Appendix A

D.I.R.E. Score: Patient Selection for Chronic Opioid Analgesia

For each factor, rate the patient's score from 1-3 based on the explanations in the ~~right hand~~right-hand column.

Score	Factor	Explanation
	<u>D</u> agnosis	1 = Benign chronic condition with minimal objective findings or no definite medical diagnosis. Examples: fibromyalgia, migraine headaches, nonspecific back pain. 2 = Slowly progressive condition concordant with moderate pain, or fixed condition with moderate objective findings. Examples: failed back surgery syndrome, back pain with moderate degenerative changes, neuropathic pain. 3 = Advanced condition concordant with severe pain with objective findings. Examples: severe ischemic vascular disease, advanced neuropathy, severe spinal stenosis.
	<u>I</u> ntractability	1 = Few therapies have been tried and the patient takes a passive role in his/her pain management process. 2 = Most customary treatments have been tried but the patient is not fully engaged in the pain management process, or barriers prevent (insurance, transportation, medical illness). 3 = Patient fully engaged in a spectrum of appropriate treatments but with inadequate response.
	<u>R</u> isk	(R = Total of P + C + R + S below)
	<u>P</u> sychological:	1 = Serious personality dysfunction or mental illness interfering with care. Example: personality disorder, severe affective disorder, significant personality issues. 2 = Personality or mental health interferes moderately. Example: depression or anxiety disorder. 3 = Good communication with clinic. No significant personality dysfunction or mental illness.
	<u>C</u> hemical Health:	1 = Active or very recent use of illicit drugs, excessive alcohol, or prescription drug abuse. 2 = Chemical coper (uses medications to cope with stress) or history of CD in remission. 3 = No CD history. Not drug-focused or chemically reliant.
	<u>R</u> eliability:	1 = History of numerous problems: medication misuse, missed appointments, rarely follows through. 2 = Occasional difficulties with compliance, but generally reliable. 3 = Highly reliable patient with meds, appointments & treatment.
	<u>S</u> ocial Support:	1 = Life in chaos. Little family support and few close relationships. Loss of most normal life roles. 2 = Reduction in some relationships and life roles. 3 = Supportive family/close relationships. Involved in work or school and no social isolation.
	<u>E</u> fficacy score	1 = Poor function or minimal pain relief despite moderate to high doses. 2 = Moderate benefit with function improved in a number of ways (or insufficient info – hasn't tried opioid yet or very low doses or too short of a trial). 3 = Good improvement in pain and function and quality of life with stable doses over time.

_____ Total score = D + I + R + E

Score 7-13: Not a suitable candidate for long-term opioid analgesia

Score 14-21: May be a candidate for long-term opioid analgesia

Source: Miles Belgrade, Fairview Pain & Palliative Care Center © 2005.

Functional Pain Scale

(developed by Kaiser Health Plan)

PAIN SENSATION
*The actual feeling of the pain you are experiencing
(stabbing, throbbing, aching, burning, tightness)*

0		No Pain <i>Pain Free</i>
1	}	Functional <i>The pain is present It does not get in the way No effect on my daily activities and my life</i>
2		
3		
4		
5	}	Uncomfortable <i>Hard to move, cannot concentrate Impacting my abilities Affects my daily activities and my life</i>
6		
7		
8	}	Severe <i>Not able to leave my home Unable to do anything: I am in Bed High Effect on my daily activities and my life</i>
9		
10		Unbearable <i>Out of Control, Overwhelmed Cannot tolerate the excruciating sensation Seeking Immediate Attention (Urgent Care/Emergency Room)</i>



PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Community Pharmacy Guidelines

Introduction

Partnership HealthPlan is a County Organized Health System (COHS) covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 24 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have community wide guidelines to promote safer use of opioid medications.

Effective Jan. 1, 2028, Partnership 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. Therefore, federal guidelines are cited throughout this policy attachment.

A prescription for a controlled substance shall only be issued for a legitimate medical purpose by an individual practitioner acting in the usual course of his or her professional practice. Health & Safety Code Section 11153 (a) provides that the responsibility for the proper prescribing and dispensing of controlled substances is upon both the prescribing practitioner AND a corresponding responsibility rests with the pharmacist who fills the prescription.

Community pharmacies play a key role in helping prevent opioid overdoses, opioid-induced hyperalgesia, opioid diversion, and opioid dependence and addiction. They also have legal responsibility to do so. Partnership recommends that all community pharmacies develop policies and standards to fulfill this responsibility. Here are recommended components of this policy:

Recommendations

- A. Every pharmacist working at a community pharmacy should have an account to be able to check Controlled Substance Utilization Review and Evaluation System (CURES) reports.
- B. Each pharmacy should define the circumstances for checking the CURES report of a patient. Options include:
 - 1. All patients with a prescription for a controlled drug
 - 2. New prescriptions for a controlled drug
 - 3. Patients with behavior suspicious for substance use disorder or diversion.Examples include:
 - a. Patient is paying cash for a medication when they have active insurance coverage.
 - b. Patient has no active filling history at this pharmacy, but presents a prescription for a controlled medication.

- c. Patient has multiple prescriptions, but only wants to pick up the narcotic.
 - d. Patient has a prescription with an unusually high quantity of pain medications.
 - e. Patient's doctor's office is not within reasonable distance of the pharmacy.
 - f. Subject to professional judgment.
 - g. Patient's home address is not within a reasonable distance from the pharmacy or the doctor's office.
 - h. Patient looks nervous and tries to hurry the pharmacy staff.
 - i. Patient is unable to provide a valid ID.
 - j. Patient presents a story that sounds too suspicious to be true.
 - k. A significant number of customers appear with prescriptions from the same prescriber and for the same controlled medication.
 - l. Patient shows "unusual knowledge of controlled substances."
- C. If finding in CURES report indicates potential inappropriate use, contact prescriber for appropriate actions. In situations where the prescriber is not the primary care physician (PCP), contact the PCP as well.
- D. Pharmacists may have access to information that prescribers may not, and pharmacists should collaborate with prescribers when concerns arise. Consider notifying the patient's primary care clinician or primary prescriber when filling a controlled medication for a patient:
1. If the patient is picking up a prescription written by an Emergency Department clinician, a dental practice, or an out-of-area prescriber.
 2. If the patient calls to request early refills.
 3. If there are other concerns or questions.
- E. Pharmacists should counsel patients picking up opioid prescriptions of the risk of tolerance, addiction, opioid induced hyperalgesia, and overdose.
- F. Pharmacists should request photo ID for patients picking up controlled medications from the pharmacy.
- G. Pharmacists should not allow cash payments for controlled medications; submit a Prior Authorization Request when indicated.
- H. Pharmacy should establish and provide on-site medication disposal. Access to safe disposal of all medications at convenient locations help reduce the chance of accidental overdose or misuse in the community.
- I. Naloxone: Recommend, furnish, or prescribe naloxone to patients at risk of overdose, family and friends who may witness an overdose or are themselves at risk of overdose. As of 2026, naloxone is available over the counter (OTC) at pharmacies, online retailers and community organizations without a prescription. Medi-Cal Rx covers both prescription and OTC naloxone with no copayments. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose, including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set to implement in regulations to require employers to include naloxone in workplace first-aid kits by December 2028. California law permits pharmacists to furnish naloxone without a physician's prescription and be reimbursed under AB 1114. If naloxone is furnished by a pharmacist outside of AB 1114 to a Medi-Cal patient, a pre-prescription is required for the pharmacy to be reimbursed. Prescribe naloxone to patients at risk of overdose. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. Intranasal naloxone is available at a pharmacy without a prescription, although a prescription is required for Medi-Cal or Medicare reimbursement.

Other Guidelines for Safe Opioid Prescribing

Dental Guidelines
Emergency Room Guidelines
Primary Care & Specialist Prescribing Guidelines

Key Points from Other Guidelines

1. According to the Centers for Disease Control ([CDC](#)) [2022 Clinical Practice Guideline for Prescribing Opioids for Pains](#), additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits relative to risks to patients as dosage increases further. Clinicians should carefully evaluate a decision to further increase dosage based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to risks with previous dosage increases, other treatments and effectiveness, and patient values and preferences.
2. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.
3. Require a signed medication use agreement with the prescriber or prescribing office.
4. Regularly check the CURES database in all patients being prescribed opioids, preferably each time a prescription is being authorized. At a minimum, the CURES database should be checked annually. If a finding on the CURES report is not consistent with the patient's history, Partnership recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur.
5. Schedule at least three office visits yearly for chronic pain patients using opioids.
6. Limit each opioid prescription to 28 days, writing this on the prescription (e.g., "must last 28 days"). The 28-day refill, scheduled for a Tuesday, Wednesday, or Thursday every 4 weeks, is a best practice, to avoid weekends, holidays, and Friday refills.
7. [Naloxone](#). Recommend or furnish naloxone to patients at risk of overdose. CAs of 2026, naloxone is available over the counter at pharmacies, online retailers and community organizations without a prescription. Medi-cal Rx covers both prescription and OTC naloxone with no copayments. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set ~~to~~ in regulations, to require employers to include naloxone in workplace first-aid kits by December, 2028.

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PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Emergency Department Guidelines

Introduction

Partnership HealthPlan is a County Organized Health System ([COHS](#)) covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 24 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have community-wide guidelines to promote safer use of opioid medications.

Effective Jan. 1, 202~~8~~⁷, Partnership 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. Therefore, federal guidelines are cited throughout this policy attachment.

The Emergency Department has two key roles in helping with community-wide efforts to control opioid overuse: (1) insuring acute pain is treated in a way that decreases the probability of future over-use of opioids and (2) working closely with primary care clinicians to ensure a coherent, safe approach to treating chronic pain. The ~~Emergency Department~~ can be a critical access point for members with Substance Use Disorder (SUD). ED personnel should consider screening for SUD and initiating [medication-assisted treatment \(MAT\)](#). Partnership recommends the following to achieve these goals:

Recommendations

- A. Check a Controlled Substance Utilization Review and Evaluation System (CURES) report on all patients who will receive opioid medications, and also those patients who will receive other Schedule I-IV controlled medications. If there is a discrepancy, consider contacting the relevant pharmacies to confirm information, as occasionally the CURES data is not accurate.
- B. Limit opioid prescriptions for Acute Pain to no more than 4 days. Avoid opioids if pain is not severe, and consider non-opioid analgesic options preferentially. If there are risk factors for SUD (e.g., contextual or individual risk factors, such as history of abuse/trauma, personal history of SUD, family history of SUD, poverty, other mental health conditions, family rejection of sexual orientation or gender identity), carefully consider balancing the need for adequate analgesia against the risks of controlled substance misuse and/or SUD behavioral destabilization. If opioids are prescribed, use low doses for short courses with all patients. Refer also to the [CDC Reducing Health Risks Among Youth](#).

- C. Avoid prescribing opioids for chronic pain not associated with ~~the~~ active cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease.
- D. Avoid prescribing opioids for poorly defined pain (e.g., pain not fitting any clinical syndrome after appropriate medical work up).
- E. In patients with a suspected or documented history of substance misuse or SUD, take a careful history and after appropriate medical work up; if opioid analgesia is indicated, carefully balance the need for adequate analgesia against the risks of controlled substance misuse and/or SUD behavioral destabilization. Potential indicators of substance misuse behaviors include:
 - 1. Patient goes to an emergency room outside of the community they live in (or multiple) with suspected aim to secure opioid analgesic medications
 - 2. Patient paying cash for ED visit.
 - 3. Patient reports they are on a chronic opioid prescribed by an out-of-area prescriber, who cannot be reached.
 - 4. Patient reports that their medications were lost or stolen.
 - 5. CURES report reveals multiple controlled substance prescribers in multiple locations.
 - 6. Collateral sources indicate a history of maladaptive behaviors in relation to controlled substances.
- F. Refer patient to primary care provider (PCP) instead of prescribing refills of existing opioid medications.
- G. If the PCP cannot be contacted to do a refill, limit opioid refills to a 4-day supply maximum.
- H. Notify PCP if an opioid prescription is given, especially if it is a refill.
- I. Call pharmacy to verify medication history on intoxicated patients.
- J. Perform a urine toxicology screen on a patient before prescribing a controlled medication, to be sure the result is consistent with the patient's medication history. Consider a confirmatory test if the results of a tox screen are unexpected, because false positive and negative screening results are common. Ensure that the urine toxicology screen adequately captures the substances of interest (e.g., often urine toxicology screens for "opiates" will not detect fully synthetic opioids such as methadone or fentanyl).
- K. Prescribe high dose NSAIDs for acute dental pain. (Studies show opioids are inferior for dental pain, and no more effective than placebo.)
- L. If patients come to the emergency room for severe, breakthrough pain on any regular basis, develop an agreed-upon treatment plan with the Primary Care Physician or usual prescribing outpatient physician to avoid such visits.
- M. For patient safety, intramuscular and intravenous opioids should not be administered for chronic pain not associated with active cancer or related to its treatment, end-of-life care, palliative care, or sickle cell disease related pain.
- N. For patients reporting current methadone maintenance for opioid use disorder, immediately contact their Narcotic Treatment Program (NTP) to verify dosing and standing with their program. Do not adjust or discontinue methadone dosing without consultation with the

patient's NTP. Methadone maintenance dosing (e.g., daily) will not adequately provide analgesia for acute pain and these patients will often require additional analgesia (sometimes additional opioid medications) to obtain adequate analgesia.

- O. For patients presenting with acute pain who are on buprenorphine-containing products or naltrexone treatment for opioid use disorder or substance use disorder, achieving analgesia may present unique challenges. Consider consulting available resources for analgesia strategies and protocols for these individuals in an emergency situation (e.g., [CA Bridge Program](#).)
- P. Recommend, prescribe, or furnish naloxone to patients, family member of, friends or close contacts, at risk of overdose. CAs of 2026, naloxone is available over the counter at pharmacies, online retailers and community organizations without a prescription. Medi-cal Rx covers both prescription and OTC naloxone with no copayments. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set, in regulations, to require employers to include naloxone in workplace first-aid kits by December 2028.
- Q. For all patients with identified opioid use disorder, offer initiation of Medications for Addiction Treatment (MAT); (e.g., buprenorphine-naloxone/buprenorphine, methadone, naltrexone). Example protocols and strategies can be found through CA Bridge website: <https://bridgetotreatment.org/addiction-treatment/ca-bridge/>
- R. Linkages to community MAT providers can be facilitated through consulting (Substance Abuse and Mental Health Services Administration) SAMHSA Treatment locator (<https://www.samhsa.gov/medication-assisted-treatment/find-treatment/treatment-practitioner-locator>), or for patients who reside in Humboldt, Mendocino, Shasta, Siskiyou, Solano, Lassen, Modoc, contact ~~Carelon Partnership's~~ Behavioral Health department for treatment options: (855) 765-9703. Members who reside in counties **other than** Humboldt, Mendocino, Shasta, Siskiyou, Solano, Lassen, or Modoc should be referred to their home county's behavioral health access number.

Other Guidelines for Safe Opioid Prescribing

Dental Guidelines

Community Pharmacy Guidelines

Primary Care & Specialist Prescribing Guidelines

Key Points from these other guidelines

1. According to the Centers for Disease Control- (CDC) 2022 Clinical Practice Guideline for Prescribing Opioids for Pains(~~CDC) 2022 Guidelines~~, additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits relative to risks to patients as dosage increases further. Clinicians should carefully evaluate a decision to

further increase dosage based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to risks with previous dosage increases, other treatments and effectiveness, and patient values and preferences.

2. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.
3. Consider a signed medication use agreement with the prescriber or prescribing office, renewed yearly.
4. Regularly check the CURES database in all patients being prescribed opioids at each time a prescription for a controlled substance (Schedule I-IV) is being authorized. Consider checking a CURES report when prescribing Schedule V controlled substances, as well. If a finding on the CURES report is not consistent with patient history, Partnership recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur.
5. Schedule at least three office visits yearly for chronic pain patients using opioids.
6. Limit each opioid prescription to 28 days, writing this on the prescription (e.g., “must last 28 days”.) The 28-day refill, scheduled for a Tuesday, Wednesday or Thursday every 4 weeks, is a best practice, to avoid weekends, holidays, and Friday refills.
- ~~7. Offer to prescribe naloxone for all patients being offered opioid prescriptions, of any duration. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. See <http://prescribetoprevent.org/> for details. Intranasal naloxone is available at a pharmacy without a prescription, but a prescription is required to obtain Medi-Cal or Medicare coverage for naloxone.~~
7. Recommend, furnish, or prescribe naloxone to patients at risk of overdose, family and friends who may witness an overdose or are themselves at risk of overdose. As of 2026, naloxone is available over the counter at pharmacies, online retailers and community organizations without a prescription. Medi-cal Rx covers both prescription and OTC naloxone with no copayments. Medicare Part D may cover the cost of a prescribed form of naloxone. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set, in regulations, to require employers to include naloxone in workplace first-aid kits by December 2028. If present, consider offering prescribing naloxone for family members, friends, close contacts of those who are at high risk of opioid overdose (e.g., those with a history of opioid overdose.)

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PARTNERSHIP HEALTHPLAN RECOMMENDATIONS For Safe Use of Opioid Medications

Dental Prescribing Guidelines

Introduction

Partnership HealthPlan is the County Organized Health System ([COHS](#)) covering Medical and Mental Health Benefits for Medi-Cal beneficiaries in 24 counties in Northern California. Our mission is to help our members, and the communities we serve, be healthy. In this spirit, we have community-wide guidelines to promote safer use of opioid medications.

Effective Jan. 1, ~~2027~~[2028](#), Partnership 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. Therefore, federal guidelines are cited throughout this policy attachment.

Dentists play a key role in community-wide efforts to ensure safe prescribing of opioid medications and prevention of chronic opioid misuse and diversion. Partnership has reviewed the literature on this topic, and has the following recommendations for our dental colleagues:

Recommendations

Partnership recommends dentists prescribe high dose NSAIDs for acute dental pain. (Studies show opioids are inferior for dental pain, and no more effective than placebo.)

Dentists should not prescribe opioids for patients already on opioid pain meds prescribed by another physician.

Dentists should also adhere to the Primary Care Clinician Prescribing Guidelines below:

1. If narcotic pain medication is prescribed, limit use to short periods (i.e., no more than 4 days) and only for conditions that are typically associated with more severe pain.
2. Discuss the risk of opioid dependence, opioid addiction, tolerance, and hyperalgesia with patients initiated on opioid treatment.
3. Assess for risk of substance use disorder and diversion, using a standardized tool if needed (see appendix for example). If patient is at high risk, consider baseline urine toxicology screen, use of non-opioids modalities to treat pain and carefully balance need for adequate analgesia against risk of misuse/diversion/overdose and behavioral destabilization.

4. Patients between 18 to 25 years of age are at increased risk of misusing prescription drugs, so patients in this age range should be screened carefully.
5. Initiation and continuation of use of opioid pain medications for chronic, non-cancer and non-terminal pain should be weighed carefully by any prescriber. It is not appropriate for a dentist to prescribe chronic opioids. This should be done by the primary care provider.
NOTE: There are standards required by Partnership to PCPs and Specialists covering patients with chronic pain or chronic opioid use. These may be found in MPXG5008 itself.
6. Chronic use of opioid medication (particularly when combined with other sedating medications such as benzodiazepines and muscle relaxants) or alcohol use is associated with an increased risk of accidental overdose and motor vehicle accidents. In addition, chronic use of opioids in high doses can cause opioid induced hyperalgesia, which ultimately causes the patient increased pain and debility. Unlike acute pain or pain associated with metastatic cancer or end-of-life care, the goal of opioid therapy for chronic non-cancer, non-terminal pain is improved functioning, not necessarily elimination of pain.
7. When prescribing opioids, review the patient's controlled-substance history. Review Controlled Substance Utilization Review and Evaluation System (CURES) no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III or Schedule IV controlled substance to the patient for the first time and at least once every three months thereafter if the substance remains part of the treatment of the patient.
8. For patients reporting current methadone or buprenorphine maintenance for opioid use disorder, consider contacting either their Narcotic Treatment Program (NTP) to verify dosing and standing with their program (methadone) or their buprenorphine or naltrexone provider to verify dosing and obtain analgesia recommendations. Do not adjust or discontinue methadone dosing without consultation with the patient's NTP. Methadone and buprenorphine maintenance dosing (e.g., daily) will not adequately provide analgesia for acute pain and these patients will often require additional analgesia (sometimes additional opioid medications) to obtain adequate analgesia.
9. Recommend, furnish, or prescribe naloxone to patients at risk of overdose, family and friends who may witness an overdose or are themselves at risk of overdose. As of 2026, naloxone is available over the counter (OTC) at pharmacies, online retailers and community organizations without a prescription. Medi-Cal Rx covers both prescription and OTC naloxone with no copayments. Medicare Part D may cover the cost of prescribed forms of naloxone. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose, including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set to, in regulations, require employers to include naloxone in workplace first-aid kits by December 2028.

Other Guidelines for Safe Opioid Prescribing

Emergency Room Guidelines

Community Pharmacy Guidelines

Primary Care & Specialist Prescribing Guidelines

Key Points from these other guidelines

1. According to the Centers for Disease Control ([CDC](#)) [2022 Guidelines](#), additional dosage increases beyond 50 MME/day are progressively more likely to yield diminishing returns in benefits relative to risks to patients as dosage increases further. Clinicians should carefully evaluate a decision to further increase dosage based on individualized assessment of benefits and risks and weighing factors such as diagnosis, incremental benefits for pain and function relative to risks with previous dosage increases, other treatments and effectiveness, and patient values and preferences.
2. Request a random toxicology screen performed at least once a year to detect prescribed and non-prescribed opioids and other controlled or illicit drugs.
3. Require a signed medication use agreement with the prescriber or prescribing office, renewed yearly.
4. Regularly check the CURES database in all patients being prescribed opioids at each time a prescription for a controlled substance (Schedule I-IV) is being authorized. Consider checking a CURES report when prescribing Schedule V controlled substances, as well. If a finding on the CURES report is not consistent with patient history, Partnership recommends contacting the relevant pharmacies to confirm the accuracy of the CURES report, as reporting errors do occur.
5. Schedule at least three office visits yearly for chronic pain patients using opioids.
6. Limit each opioid prescription to 28 days, writing this on the prescription (e.g., “must last 28 days”). The 28-day refill, scheduled for a Tuesday, Wednesday or Thursday every 4 weeks, is a best practice, to avoid weekends, holidays, and Friday refills.
7. Recommend, prescribe, or furnish naloxone to patients, family, friends, and close contacts of those at risk of overdose. CAs of 2026, naloxone is available over the counter at pharmacies, online retailers and community organizations without a prescription. Medi-cal Rx covers both prescription and OTC naloxone with no copayments. Health care providers must offer a prescription for naloxone to patients who are at high risk for overdose including those prescribed high doses of opioids or concurrent benzodiazepines. Cal/OSHA is set to in regulations to require employers to include naloxone in workplace first-aid kits by December 2028. Offer to prescribe naloxone for all patients being offered opioid prescriptions, of any duration. California law permits prescribing naloxone to patients taking opioids (legal or illegal) for use in an emergency to prevent accidental death. See <http://prescribetoprevent.org/> for details. Intranasal naloxone is available at a pharmacy without a prescription, but a prescription is required for Medi-Cal or Medicare coverage.

- ~~8. If present, consider offering prescribing naloxone for family members, friends, close contacts of those who are at high risk of opioid overdose (e.g., those with a history of opioid overdose.)~~

References

Links verified June 22, 2026

- A. American Pain Society (jpain.org). [Guideline for The Use of Chronic Opioid Therapy in Chronic Noncancer Pain Evidence Review](#). (February 2009)
- B. Becker DE. Pain Management: Part 1: [Managing Acute and Postoperative Dental Pain](#). Anesthesia Progress: A Journal for Pain and Anxiety Control in Dentistry. 2010; 57 (2): 67-69. DOI: 10.2344/0003-3006-57.2.67,
- C. Centers for Disease Control. [Overdose Prevention](#).
- D. Kahan M, Mailis-Gagnon A, Wilson L, and Srivastava A. [Canadian Guideline for Safe and Effective Use of Opioids for Chronic Noncancer Pain](#): Clinical Summary for Family Physicians. The Official Journal of The College of Family Physicians of Canada. Vol 57, November 2011.
- E. Prescribe to Prevent: [Prescribe Naloxone, Save a Life. Instructions for Healthcare Professionals](#): Prescribing Naloxone.
- F. Silverman S, [Opioid Induced Hyperalgesia: Clinical Implications for the Pain Practitioner](#). Pain Physician 2009; 12:679-684.

Appendix A

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[]	1	3
	Illegal Drugs	[]	2	3
	Prescription Drugs	[]	4	4
2. Personal History of Substance Abuse	Alcohol	[]	3	3
	Illegal Drugs	[]	4	4
	Prescription Drugs	[]	5	5
3. Age (Mark box if 16 – 45)		[]	1	1
4. History of Preadolescent Sexual Abuse		[]	3	0
5. Psychological Disease	Attention Deficit Disorder, Obsessive Compulsive Disorder, Bipolar, Schizophrenia	[]	2	2
	Depression	[]	1	1
TOTAL			_____	_____
Total Score Risk Category				
Low Risk 0 – 3				
Moderate Risk 4 – 7				
High Risk ≥ 8				

Reference: Webster LR. Predicting aberrant behaviors in opioid-treated patients: Preliminary validation of the opioid risk tool. *Pain Medicine*. 2005;6(6):432-442. Used with permission.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPXG5009			Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Lactation Clinical Practice Guideline			☒ External Policy ☐ Internal Policy	
Original Date: 01/15/2014		Next Review Date: ~~08/13/2026~~ <u>08/18/2027</u> Last Review Date: ~~08/13/2025~~ <u>08/12/2026</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIALS	☒ PAC
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~08/13/2025~~ <u>08/12/2026</u>	

I. RELATED POLICIES:

- A. ~~MCCP2020 – Lactation Policy and Guidelines~~
- A. MPCR16 – Lactation Consultant Credentialing Policy
- ~~B.~~ MCUG3118 – Prenatal and Perinatal Care
- ~~C.~~ MPNP9006 – Doula Services Benefit
- ~~B.D.~~ MPNP9007 – Lactation Policy and Guidelines
- E. ~~MCCP2021~~ MPNP9008 - Women, Infant and Children (WIC) Supplemental Food Program
- ~~C.F.~~ MCUP3013 Durable Medical Equipment (DME) Authorization

II. IMPACTED DEPTS:

- A. N/A

III. DEFINITIONS:

- A. Baby Friendly Hospital Initiative – A global initiative sponsored by the World Health Organization (WHO) and the United Nations Children’s Fund (UNICEF) to encourage and recognize hospitals and birth centers that offer an optimal level of care for infant feeding.

IV. ATTACHMENTS:

- A. N/A

V. PURPOSE:

To support optimal nutrition in the healthy infant by appropriately supporting efforts to initiate and sustain breastmilk feeding exclusively for about six months and with complementary foods (not formula) for at least 12 months per American Academy of Pediatrics (AAP) recommendations. Per All Plan Letter (APL) 26-005, Maternity Services for Pregnant and Postpartum Medi-Cal Members, lactation services and supplies are covered preventive services and are provided without cost sharing to the member.

VI. POLICY / PROCEDURE:

Lactation Guideline/Procedure

- A. General Breastfeeding Guidelines

Introduction: Human breast milk is uniquely specific to the needs of the human infant. Partnership HealthPlan of California (Partnership) and the American Academy of Pediatrics (AAP) acknowledge breast milk feeding as the preferred method of infant nutrition. Research has demonstrated numerous health benefits of breast milk feeding. Additional to health benefits, breast milk feeding also provides social, economic, and environmental benefits for both parent and infant. Services shall be coordinated

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[across providers to support continuity of care consistent with 42 CFR § 438.208.](#)

B. Promotion and Support of Breast Milk **F**eeding

1. **Lactation Education and Support Services:** Each Partnership county has a local Women Infants and Children (WIC) Nutrition Program that includes lactation education, support, and provision of breast pumps for low-income ~~persons~~individuals, including ~~those with Medi-Cal~~Partnership members. All eligible pregnant and postpartum members should be referred to WIC. Lactation support for Partnership members is a shared goal and responsibility of WIC and the health delivery system provided through Partnership, by the following providers and support services:
 - a. Primary care providers (PCPs) are encouraged to provide opportunities for members to learn about the advantages of breastfeeding through educational materials. Referrals for pregnant and postpartum members to breastfeeding breast milk feeding classes during and after pregnancy will ensure they have current evidence-based information about breast milk feeding. Providers should document education and referrals provided.
 - b. Prenatal care providers should specifically assess a pregnant member's knowledge and interest in breastmilk feeding at the first prenatal visit. Obstetrical care includes documentation of a complete breast exam and anticipatory guidance for any condition that could affect breastfeeding. Education regarding the advantages of breast milk feeding should be ongoing. The pregnant members and their partners should be referred to a breast milk feeding class antenatally and have access to one on one breast milk feeding education prenatally and postnatally. This is especially important for members in their first pregnancy who have not breastfed in the past. All assessments and education shall be documented in the medical record.
 - c. Comprehensive Perinatal Service Programs (CPSP) and Partnership Health Perinatal Services Programs (PHPS): Partnership strongly supports having all pregnant members receive support services provided through Perinatal Services providers, which provide comprehensive assessments as part of their total prenatal care. CPSP/Perinatal Services Providers may provide their own lactation support services or refer to other community resources to provide breast milk feeding promotion, education, and counseling.
 - d. Doulas are recognized Medi-Cal providers who may offer various types of support, including lactation support, education, and care coordination. For more details, refer to Partnership policy MCNP9006 Doula Services Benefit.
 - e. Partnership Population Health: Through specific programs and general case management support, Partnership Population Health supports breastfeeding in accordance with current guidelines and evidence-based practices. Members who are planning to breastfeed and need specific resources are encouraged to call for assistance with breast milk feeding when wanted.
 - f. Postpartum follow-up calls are made to Partnership members within the first month after delivery when possible to encourage a timely postpartum visit. If needed, referrals are made for lactation or newborn feeding assistance, support, education, and information.
 - g. Hospitals providing obstetrical care play a key role in supporting successful breastfeeding. Standards of care for hospitals in this area are fully outlined in the UNICEF/WHO Baby Friendly Hospital Initiative (<https://www.unicef.org/documents/baby-friendly-hospital-initiative>) and will also include:
 - 1) The hospital should receive information on the member's prenatal record stating the infant feeding plan. That plan should be confirmed when a birthing person is admitted for delivery.
 - 2) Family centered childbirth practices allowing for early parent-infant contact and breastfeeding within one half-hour of birth as well as rooming in. Hospitals are encouraged to view initiation of breast milk feeding as a process accomplished over several days and offer support, assistance, and education accordingly.

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- 3) Newborns should be nursed whenever they show signs of hunger/interest, approximately 8-12 times every 24 hours after the first 24 hours. Lactating persons can be encouraged to hold their infants even when not feeding to better assist them as they begin the process of learning and understanding feeding cues.
 - 4) Members need access to qualified nursing staff to assist with initiation of breastfeeding, evaluation of breastfeeding progress, and providing ongoing information to manage common difficulties during the hospital stay.
 - 5) Supplements such as water, glucose water or formula should not be given to breast milk feeding newborns unless there is an order from the Health Care Provider. Parents should be counseled in the risks associated with bottles and pacifiers.
 - 6) Coordinate discharge to ensure parents and infants have access to ongoing breast milk feeding care and support.
 - a) Discharge planning includes consideration of arrangements that include follow-up with perinatal health educator, doula WIC, a peer counselor, the infant care provider -office, an International Board ~~of Lactation Consultant Examiner (IBCLC)~~ Certified Lactation Consultant (IBCLC), or a home health or public health nurse visit specifically to assist the parent with breast milk feeding. Whenever possible this should occur within 1-2 calendar days of discharge.
 - 7) The Birth Facility should provide lactating patients with a list of resources for support and assistance with breast milk feeding, including information on how to tell if the baby is getting enough milk and referral for breast milk feeding support resources.
 - h. Infant care providers should encourage exclusive breast milk feeding per AAP recommendations. Infant care providers should consider referral to a lactation counsellor / educator, certified lactation consultant, doula, licensed midwife, home health nurse or public health nurse for evaluation before suggesting supplementation with formula or cessation of breast milk feeding. Providers need to consider the birthing parent's health and well-being when giving recommendations. If a baby needs to stop feeding at the breast, the lactating parent may be provided with a breast pump and instructions on how to use it to maintain milk supply.
 - i. Home Health Nurse or Public Health Nurse Visit: All members who are eligible to receive home health nurse visits or public health nurse visits after discharge from the hospital for assistance with breastfeeding will be offer these services. It is strongly recommended that home visiting nurses have specific training in lactation/breastfeeding support. The first parent-baby home health visit by a home health nurse does not require prior authorization and subsequent visits are easily available through the authorization process. Public health nurse visits do not require authorization and can be ordered in a variety of ways including by notation on the postpartum discharge orders at time of discharge or by contacting the local county Public Health Department.
2. Timing of Lactation Support Services: Lactation Education and Support is different in the prenatal, immediate Postpartum (in the hospital), early postpartum (from hospital discharge to 84 calendar days after delivery), and late postpartum periods (from 84 calendar days to 365 calendar days post-delivery). Lactation visits independent of the standard postpartum visits are covered by Partnership. Services shall be provided based on medical need and without unnecessary delay.
 3. Providers of Lactation Ssupport Sservices:
 - a. Basic Lactation support services may be provided in a provider office by a medical professional as follows: Physician, a Registered Nurse (RN) or Registered Dietitian (RD) working under the supervision of a Physician, Nurse Practitioner (NP), Physician Assistant (PA), Certified Nurse Midwife (CNM), or Licensed Midwife (LM).

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- b. Licensed midwives may enroll in Medi-Cal as direct/billing providers and apply as a CPSP provider. See <https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx> for more information.
- c. Certified Lactation Consultants provide more specialized lactation support. Most International Board Certified Lactation Consultants (IBCLCs) have an underlying health professional licensure (RN, RD, MD, DO, CNM, LM, NP, PA) as well.
- d. Lactation Educators, lactation counselors, and other lactation support staff without additional health professional licensure may provide basic lactation support services under the supervision of a Partnership contracted licensed medical professional (Physician, NP, PA, CNM, LM) or Partnership credentialed IBCLC.
- e. Doulas may provide prenatal, peripartum and postpartum education and support
4. ~~Breast Pumps: When Medically necessary manual~~ Manual and electric breast pumps and breast pump supplies are covered when medically necessary and prescribed. ~~breastfeeding is interrupted or discontinued, the use of breast pumps and alternative feeding fluids may be necessary. If the lactating parent is unable to feed the baby at the breast due to a medically based separation or a physical problem of varying duration, and until resolution of any of these problems are achieved, providing a breast pump in a timely fashion is appropriate and a covered benefit. Breast pumps are a covered benefit when medically necessary.~~
 - a. DME Providers ensure the timely delivery of DME and related supplies necessary for breastfeeding
 - b. A Treatment Authorization Request is not required for non-hospital grade breast pumps.
- 4.5. Supplementation: When supplementation is necessary, consider AAP guidelines for breast milk supplementation.
- 5.6. Banked Human Milk: Banked human milk is currently not widely available but may be helpful for specific conditions in the hospital setting. According to WIC, in their landmark publication Ramping up for Reform, “Banked human milk is provided by Medi-Cal and health insurance plans in order to provide infants, especially high-risk infants, the healthiest start in life and reduce costly health complications.”
- 6.7. Active Management of Potentially Adverse Breastfeeding Situations
 - a. Active Management and Support of Breastfeeding should follow the guidelines set forth by the authorities listed in the reference section below.
 - 1) These guidelines change often as new research emerges, so providers are expected to stay informed of updated best practice guidelines.
- C. Contraindications
 1. AAP Guidelines should be utilized to identify additional conditions that are contraindicated
 - a. Medications that may require temporary interruption of breastfeeding may be found utilizing AAP Guidelines; or for additional information call the Infant Risk Center at 806-352-2519.
- D. Education Materials for Partnership Members
Educational materials may be helpful for parents. They are readily available through ~~your~~ local WIC office, perinatal services and clinical providers.
- E. Useful Resources
 1. Sources of simplified definitions:
ACA <http://www.investopedia.com/terms/a/affordable-care-act.asp> (updated Jan. 27, 2025)
 2. CPSP <https://www.cdph.ca.gov/Programs/CFH/DMCAH/CPSP/Pages/default.aspx>
 3. FQHC <https://www.cms.gov/mlnproducts/downloads/fqhcfactsheet.pdf> (updated October 2022)
 4. Bilitool www.bilitool.org
 5. Hale’s Medications & Mothers’ Milk 2025-2026, A Manual of Lactational Pharmacology, 21st Ed., Springer Publishing

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6. [Breastfeeding ANSWERS Made Simple – A Guide for Helping Mothers](#), Mohrbacher, N., 2020, Second Edition Hale Publishing, L.P. (PDF digital edition available)
7. [Red Book: 2024-2027 Report of the Committee on Infectious Disease](#), 33rd Edition, American Academy of Pediatrics, April 2024

VII.

~~VII.~~ REFERENCES:

A. [Department of Health Care Services \(DHCS\) APL 26-005 Maternity Services for Pregnant and Postpartum Medi-Cal Members \(March 25, 2026 supersedes 00-012 and 18-022\)](#)

~~VIII.~~ B. American Academy of Pediatrics, Clinical Practice Guideline. <https://pediatrics.aappublications.org/content/pediatrics/129/3/3827.full.pdf>

C. Affordable Care Act, Section 4106a, Women's Health Preventive Services, Infant Risk Center: Call 806-352-2519

D. [California Department of Public Health: Women, Infants & Children \(WIC\) 2023 Toolkit Breastfeeding FAQs, \(Jan. 24, 2025\)](#)

E. Department of Health and Human Services/Center for Medicaid and CHIP Services
Medicaid Coverage of Lactation Services. CMS Bulletin

F. U.S. Preventive Services Task Force (USPSTF) Final Recommendation Statement. [Breastfeeding: Primary Care Behavioral Counseling Interventions](#) (April 11, 2025)

G. [42 CFR § 438.206 – Availability of Services](#)

H. [42 CFR § 438.208 – Care Coordination](#)

~~F.I.~~ [Affordable Care Act Section 2713 – Preventive Services](#)

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

IX. PERSON RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal

02/17/16; 04/19/17; *03/14/18; 05/08/19; 06/10/20; 08/11/21; 08/10/22; 08/09/23; 08/14/24; 08/13/25;
08/12/26

Partnership Advantage (effective Jan. 1, 20287)

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:

HealthyKids MPXG5009 (Healthy Kids program ended 12/01/2016)

02/17/16 to 12/01/2016

Partnership Advantage

MPXG5009 – 01/15/2014 to 01/01/2015

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PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCQP1025 (previously MPQP1025, QP100125)			Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Substance Use Disorder (SUD) Facility Site Review and Medical Record Review (previously Behavioral Health/ Substance Abuse Facility Site Review)			☒ External Policy ☐ Internal Policy	
Original Date: 02/18/2004		Next Review Date: <u>08/13/2026</u> <u>08/12/2027</u> Last Review Date: <u>08/13/2025</u> <u>08/12/2026</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO ☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: <u>08/12/2026</u> <u>08/13/2025</u>	

I. RELATED POLICIES:

- A. MPQP1022 - Site Review (SR) Requirements and Guidelines
- B. MPQP1016 - Potential Quality Issue Investigation & Resolution
- C. MPQP1053 - Peer Review Committee
- D. CMP36 - Delegation Oversight and Monitoring
- E. MCUP3144 - Residential Substance Use Disorder Treatment Authorization
- F. MCUG3118 - Prenatal and Perinatal Care
- G. ~~MCUP3101~~ MPBP8007 - Screening and Treatment for Substance Use Disorders
- H. CMP41 - Wellness and Recovery Program Records
 - I. MPCR601 - Fair Hearings Process for Adverse Credentialing Decisions
 - J. MPCR300 – Physician Credentialing and Re-credentialing Requirements
- K. MPQP1052 Physical Accessibility Review Survey – SR Part C
- L. MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guideline

II. IMPACTED DEPTS:

- A. Health Services
- B. Network Services
- C. Regulatory Affairs and Compliance
- D. Claims
- E. Member Services
- F. Grievance & Appeals

III. DEFINITIONS:

- A. Substance Use Disorder Treatment Provider: Person or entity that provides direct alcohol and other drug treatment services and has been certified by the State as meeting the certification requirements for participation in the Drug Medi-Cal (DMC) program set forth in the DMC certification Standards for Substance Abuse Clinics and Standards for Drug Treatment Programs in California.
- B. Substance Use Disorders (SUD): According to the Substance Abuse and Mental Health Services Administration (SAMHSA), substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school, or home. The term is often used synonymously with “addiction.” According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-5), a diagnosis of substance use disorder is based on evidence of impaired control, social impairment, risky use, negative consequences of use, and substance-dependent pharmacological criteria (e.g., tolerance and/or withdrawal). Substance use disorders occur in a range of severity, including mild, moderate, or severe. Substances can be obtained illicitly, or prescription medications can be misused for purposes

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Original Date: 02/18/2004		Next Review Date: ~~08/13/2026~~ 08/12/2027 Last Review Date: 08/13/2025 ~~08/12/2026~~	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

other than the intended prescription (also known as “non-medical use” of prescription medications). The most common substance use disorders in the United States include the following:

1. Alcohol Use Disorder
 2. Tobacco Use Disorder
 3. Cannabis Use Disorder
 4. Stimulant Use Disorder (including cocaine, methamphetamine, and prescription stimulants)
 5. Opioid Use Disorder
- C. Drug Medi-Cal Organized Delivery System (DMC-ODS): an opt-in 1115 waiver program available in California since 2015 that provides for the opportunity for counties to expand substance use treatment options outside of traditional Medicaid substance use treatment offerings. In DMC-ODS, opted-in counties provide a continuum of care modeled after the American Society of Addiction Medicine Criteria for substance use disorder treatment services, enables more local control and accountability, provides greater administrative oversight, creates utilization controls to improve care and efficient use of resources, implements evidenced based practices in substance abuse treatment, and coordinates with other systems of care. Of Partnership’s 24 counties, seven participate in a Partnership-organized DMC-ODS program (“Wellness and Recovery Program”): Humboldt, Mendocino, Shasta, Siskiyou, Solano, Modoc, and Lassen counties. Five other counties have organized their own county-managed DMC-ODS programs (over which Partnership has no regulatory oversight responsibilities): Marin, Yolo, Napa, Nevada and Placer counties. The remaining counties have not opted into the DMC-ODS program and therefore abide by the county-managed “state plan” DMC program.
- D. Non- Physician Medical Practitioners (NPMP) are defined as nurse practitioners (NPs), physician assistants (PAs), certified nurse midwives (CNM) and licensed midwives (LM). See MPQG1011 – Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines.
- E. Licensed Practitioner of the Healing Arts (LPHA) includes physicians, NPs, PAs, registered nurses (RNs), registered pharmacists, licensed clinical psychologist, licensed clinical social worker (LCSW), licensed professional clinical counselor, licensed marriage and family therapist (LMFT), and licensed-eligible practitioners working under the supervision of licensed clinicians. See MCUP3144 - Residential Substance Use Disorder Treatment Authorization.

IV. ATTACHMENTS:

- A. [SUD Facility Site Review \(FSR\) Standards](#)
- B. [SUD Medical Record Review \(MRR\) Standards](#)
- C. [Community Based Adult Services \(CBAS\) Physical Accessibility Review Survey](#)

V. PURPOSE:

- A. To provide Substance Use Disorder (SUD) Service providers with guidelines for Substance Use Disorder Facility Site Review (SUD FSR) and Substance Use Disorder Medical Record Review (SUD MRR) requirements and processes. This policy will apply to DMC certified providers contracted with Partnership HealthPlan of California (Partnership).
- B. The purpose of the SUD FSR and SUD MRR is to ensure that practice sites have sufficient capacity to:
 1. Provide appropriate SUD services
 2. Carry out processes that support continuity and coordination of care, [consistent with 42 CFR § 438.208](#).
 3. Operate in compliance with industry documentation standards of format and legal protocols
 4. Maintain patient safety standards and practices, and

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Original Date: 02/18/2004		Next Review Date: ~~08/13/2026~~ <u>08/12/2027</u> Last Review Date: ~~08/13/2025~~ <u>08/12/2026</u>	
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5. Operate in compliance with applicable federal, state, and local laws and regulations.
Findings of the Site Review are used to:
 - a. Provide information for credentialing/re-credentialing decisions
 - b. Identify areas where education and technical assistance is needed
 - c. Identify and share best practices in patient safety, medical error prevention, and provision of quality care.

VI. POLICY / PROCEDURE:

A. Requirements

Partnership will perform annual monitoring reviews of services and subcontracted services, aligned with the fiscal year (July 1 – June 30). A secure copy of the resulting monitoring and audit reports must be submitted to the Department of Health Care Services (DHCS) within two weeks of the report's issuance.

B. Site Review Personnel

1. The Partnership HealthPlan of California (Partnership) Chief Medical Officer (CMO) is ultimately responsible for Site Review activities completed by Partnership personnel. At a minimum, Partnership's Site Review team will consist of one of the following staff: a physician, a registered nurse (RN), or other Non-Physician Medical Practitioner (NPMP).
2. Licensed physicians, RNs, NPMPs, and Certified Counselors, are eligible to act as Site Reviewers and may perform a site review (SR) independently and sign off on the FSR and MRR tools. Partnership will assure that reviewers collect data that is appropriate to their level of education, expertise, training and professional licensing scope of practice as determined by California statute.
3. Site reviewer personnel can independently make determinations regarding implementation of appropriate reporting or referral of abnormal review findings to initiate peer review procedures.
- 2-4. Findings shall be documented and maintained per applicable recordkeeping requirements.

C. **Site Review (SUD SR)** – A Substance Use Disorder Site Review consists of two basic components: the Substance Use Disorder Facility Site Review (SUD FSR) and the Substance Use Disorder Medical Record Review (SUD MRR). (See Attachments A, B, and C.) Provider Relations' Credentials staff assesses the accreditation status of Substance Use Disorder Treatment Providers as part of the credentialing process. Site review activities support Partnership's ongoing quality assessment and performance improvement programs per CFR § 438.330.

1. A SUD FSR is required to be completed prior to final credentialing of the site. The SUD FSR consists of the following sections. (See Attachments A and B.)
 - a. Access/Safety
 - b. Office Management
 - c. Policy/Procedures
 - d. Program Policy Booklet
 - e. Intake Packet
 - f. Interpreter Services
 - g. Staff Requirements
 - h. Detox Facility
 - i. Perinatal Services
 - j. Pharmaceutical/Laboratory
 - k. Telehealth
 - l. Peer support services
 - m. Adolescent services

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2. A SUD MRR consists of 10 randomly selected member medical records and consists of the following sections. (See Attachment B.)
 - a. Format Criteria
 - b. Intake Services
 - c. Care Planning Guidelines-treatment plans- NTP Only
 - d. Care Planning Guidelines- Problem Lists- All LOC (except NTP)
 - e. Treatment Services Discharge Services
 - f. Care Coordination Services
 - g. Residential Services
 - h. Perinatal/Family Services
 - i. Telehealth
 - j. Peer support services
 - k. Adolescent services
 3. Community Based Adult Services (CBAS) Physical Accessibility Review Survey (PARS) (See Attachment C.)
 - a. During the Initial SUD SSR and subsequent annual SUD SRs, a CBAS/PARS will be addressed every year at all substance use disorder program sites within the Partnership DMC-ODS network.
- D. Initial SUD SR
1. An initial SUD SR includes a SUD FSR.
 - a. The SUD FSR is conducted first to ensure the site operates in compliance with all applicable local, state, and federal laws and regulations. Credentialing is not completed until the site has received a passing score and Corrective Action Plan (CAP) items are signed off. An initial SUD FSR is not required when a new provider joins a site that has a current passing SUD FSR score.
 2. An initial SUD MRR must be completed within 11 months of the SUD FSR assuming services have been rendered. This may be deferred based on claims.
 3. Additional scenarios that require an Initial SUD SR, but are not limited to instances when:
 - a. A new site is added to the Partnership network.
 - b. The site relocates.
- E. Subsequent SUD SRs
1. Subsequent SUD SRs consist of a SUD FSR and SUD MRR conducted annually during Partnership's fiscal calendar year. The SUD FSR and SUD MRR are scored separately by the Site Reviewer.
 2. Site reviews may be conducted more frequently based on monitoring, evaluation, or follow up related to an applied CAP.
 3. The SUD MRR score is based on a review of randomly selected records from the previous fiscal year. ten medical records will be reviewed unless there are not enough member claims to support this. If Partnership is unable to generate a list of 10 medical records, due to a lack of claims, Partnership will conduct the medical records review with the records available. A reduced number of records may be reviewed at the discretion of the Plan based on actual services rendered
- F. Corrective Action Plan (CAP) Requirements and Timelines
- If Partnership determines that a provider is out of compliance following a site review, Partnership will issue a CAP identifying found deficiencies. The provider must submit a CAP response to Partnership within 60 calendar days of receipt of the CAP. [Failure to complete CAP requirements may result in additional monitoring or corrective action.](#)

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The CAP must include the following information:

- Description of corrective actions that will be taken by the provider to address deficiencies
- Date of completion of corrective action(s);
- Supporting evidence of correction;
- Site Provider, Program Director or designee (e.g., compliance administrator) name, and the date of their approval of the CAP.

The provider shall submit the CAP and supporting documentation as applicable electronically email to W&RQuality@partnershiphp.org or as specified by Partnership. Upon receipt of the CAP, Partnership will provide an Acknowledgement email within five business days.

Partnership may approve an extended resolution timeline only if necessary and appropriate.

Compliance level categories for SUD FSR include:

Compliance Category	FSR Score	MRR Score
Exempted Pass (No CAP required)	No Deficiencies noted. Score of 100%	No Deficiencies noted. Score of 100%
Conditional Pass (CAP required)	Deficiencies noted. Score of 99%-80%	Deficiencies noted. Score of 99%-80%
Not Pass (CAP required)	79% and below	79% and below

G. Non-Compliance with Corrective Action Process

1. Providers who do not correct survey deficiencies, or do not cooperate with the CAP process within the established CAP timelines may result in referral to the Partnership CMO; Provider Relations staff and/or the Credentials Committee. Actions taken by the Credentials Committee may include termination of the site from the provider network. If Partnership chooses to remove the site from the network, per IGA, Exhibit A: Partnership shall make a good faith effort to give written notice of termination of a network provider, within 15 calendar days after receipt or issuance of the termination notice, to each beneficiary who received his or her care from, or was seen on a regular basis by, the terminated provider [in accordance with applicable DHCS and federal requirements](#).

H. Organizational Provider Appeals

1. See Partnership Policy MPCR601 “Fair Hearings Process for Adverse Credentialing Decisions” for appeal procedures.
2. If the decision is not reversed, and the provider is terminated from the network, the practice may reapply to become a network provider and Partnership will complete a new site review upon approval.

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- I. Systematic Monitoring
 - 1. Monitoring following the SUD SR will include, but is not limited to, data gathered through the following sources to coincide with ODS monitoring requirement 4.2.2:
 - a. Potential Quality Issue information (reviewed when identified)
 - b. Focused review or other on-site visit
- J. Outside Entity Reviews
 - 1. Outside reviews will be accepted on a case by case basis upon review by Partnership Site Review and Behavioral Health team.
 - 2. If Partnership accepts these reviews, Partnership will still do a complete on site SUD Site Review at a minimum of every three years. Partnership will submit a copy of outside entity reviews to DHCS as proof of annual monitoring.
- K. Focused Review
 - 1. A focused review is a targeted review of one or more specific areas of the SUD FSR or SUD MRR. Partnership must not substitute a focused review for the SUD SR. Focused reviews may be used to monitor providers between SUD SRs to investigate problems identified through monitoring activities or to follow up on corrective actions.
 - 2. Site Reviewers utilize the appropriate sections of the SUD FSR and SUD MRR tools for the focused review, or other methods to investigate identified deficiencies or situations.
 - 3. All deficiencies identified in a focused review must require the completion and verification of the corrective action plan (CAP) according to the CAP timelines.
- L. Potential Quality of Care Issues
 - 1. Potential quality of care issues identified during the Site Review will be conducted in accordance with the Partnership policy for Potential Quality Issue Investigation and Resolution. The clinical reviewer will complete a PQI Report Form and submit it Partnership's Quality Improvement department for follow up review.

VII. REFERENCES:

- A. California Department of Health Care Services (DHCS) All Plan Letter ([APL 22-017 Primary Care Provider Site Reviews: Facility Site Review and Medical Record Review](#) (Sept. 22, 2022) supersedes APL 20-006
- B. [MMCD Policy Letter \(PL\) 12-006](#) Revised Facility Site Review Tool (Aug. 9, 2012)
- C. [DHCS All Plan Letter \(APL\) 15-023](#) Facility Site Review Tools for Ancillary Services and Community- Based Adult Services Providers (Oct. 8, 2015)
- D.3 CCR §504; 24 CCR (CA Building Standards Code); 28 CFR §35 (American Disabilities Act of 1990, Title II, Title III)
- E. DHCS Intergovernmental Agreement for Drug Medi-Cal Organized Delivery System (DMC-ODS) Services
- F. DHCS Behavioral Health Information Notice ([BHIN 21-056 Ongoing-Compliance-Monitoring-FY-2021-22](#) (Sept. 14, 2021)
- G. [BHIN 24-001 Drug Medi-Cal Organized Delivery System \(DMC-ODS\) Requirements for the Period of 2022 – 2026](#) (Dec. 21, 2023) supersedes BHIN 23-001
- H. [BHIN 23-068 Updates to Documentation Requirements for all Specialty Mental Health \(SMH\), Drug Medi-Cal \(DMC\), and Drug Medi-Cal Organized Delivery System \(DMC-ODS Services](#) (Nov. 20, 2023) supersedes BHIN 22-019
- I. [42 CFR § 438.208: Care Coordination](#)
- H.J. [42 CFR § 438.330: Quality Assessment and Performance Improvement Program](#)

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VIII. DISTRIBUTION:

- ~~B.~~ A. Partnership Provider Manual
 C. B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Medi-Cal

05/18/05; 04/19/06; 06/20/07; 06/18/08; 07/15/09; 09/15/10; 02/20/13; 05/15/13; 05/21/14; 09/20/17;
 *10/10/18; 11/13/19; 04/08/20; 04/14/21; 05/11/22; 01/11/23; 05/10/23; 06/12/24; 08/13/25; 08/12/26

*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:

MPQP1025 - 06/20/2007 to 02/20/2013

Healthy Families:

MPQP1025 - 10/01/2010 to 02/20/2013

Healthy Kids

MPQP1025 - 06/20/2007 to 02/20/2013

SUD Facility Site Review Standards

Criteria	I. Site Access/Safety Survey Guidelines
A. Site is accessible and useable by individuals with physical disabilities.	A. Site is accessible and useable by individuals with physical disabilities.
1) Site is accessible and useable by individual with physical disabilities	A1. ADA Regulations: Site must meet city, county and state building structure and access ordinances for persons with physical disabilities. A site/facility includes the building structure, walkways, parking lots, and equipment. All facilities designed, constructed; or altered by, on behalf of, or for the use of a public entity must be readily accessible and usable by individuals with disabilities, if the construction or alteration was begun after January 26, 1992 (28 CFR 35.151). Any alteration to a place of public accommodation or a commercial facility, after January 26, 1992, must be made to ensure that, to the maximum extent feasible, the altered portions of the facility are readily accessible to and useable by individuals with disabilities, including individuals who use wheelchairs (28 CFR 36.402). Parking: Parking spaces for persons with physical disabilities are located in close proximity to handicap-accessible building entrances. Each parking space reserved for the disabled is identified by a permanently affixed reflectorized sign posted in a conspicuous place. If provider has no control over availability of disabled parking lot or nearby street spaces, provider must have a plan in place for making program services available to persons with physical disabilities. Ramps: A clear and level landing is at the top and bottom of all ramps and on each side of an exit door. Any path of travel is considered a ramp if its slope is greater than a 1-foot rise in 20 feet of horizontal run. Exit doors: The width of exit doorways (at least 32-in.) allows for passage clearance of a wheelchair. Exit doors include all doors required for access, circulation, and use of the building and facilities, such as primary entrances and passageway doors. Furniture and other items do not obstruct exit doorways or interfere with door swing pathway. Elevators: If there is no passenger elevator, a freight elevator may be used to achieve program accessibility if it is upgraded for general passenger use and if passageways leading to and from the elevator are well-lit, neat, and clean.

SUD Facility Site Review Standards

	Clear Floor Space: Clear space in waiting/exam areas is sufficient (at least 30-in. x 48-in.) to accommodate a single, stationary adult wheelchair and occupant. A minimum clear space of 60-in. diameter or square area is needed to turn a wheelchair. Sanitary Facilities: Restroom and hand washing facilities are accessible to able-bodied and physically disabled persons. A wheel-chair accessible restroom stall allows sufficient space for a wheelchair to enter and permits the door to close. If wheelchair accessible restrooms are not available within the office site, reasonable alternative accommodations are provided. Alternatives may include: grab bars located behind and/or along the sides of toilet with assistance provided as needed by site personnel; provision of urinal, bedpan, or bedside commode placed in a private area; wheelchair accessible restroom located in a nearby office or shared within a building. Sufficient knee clearance space underneath the sink allows wheelchair users to safely use a lavatory sink for hand washing. A reasonable alternative may include, but is not limited to, hand washing items provided as needed by site personnel. Additionally: communication shall be at a maximum 6th grade level. Reading materials available in large print.
2) If the site is NOT accessible, are reasonable alternatives available?	A2. Note: A public entity may not deny the benefits of its program, activities, and services to individuals with disabilities because its facilities are inaccessible (28 CFR 35.149-35.150). Every feature need not be accessible, if a reasonable portion of the facilities and accommodations provided is accessible (Title 24, Section 2-419, California Administrative Code, the State Building Code). Reasonable Portion and/or Reasonable Alternatives are acceptable to achieve program accessibility. Reasonable Portion applies to multi-storied structures and provides exceptions to the regulations requiring accessibility to all portions of a facility/site. Reasonable Alternatives are methods other than site structural changes to achieve program accessibility, such as acquisition or redesign of equipment, assignment of assistants/aides to beneficiaries, provision of services at alternate accessible sites, and/or other site specific alternatives to provide services (ADA, Title II, 5.2000). Points shall not be deducted if Reasonable Portion or Reasonable Alternative is made available on site. Specific measurements are provided strictly for “reference only” for the reviewer. Site reviewers are NOT expected to measure parking areas, pedestrian path of travel walkways and/or building structures on site.
B. Site environment is maintained in a clean and sanitary condition.	B. Site environment is maintained in a clean and sanitary condition.
1) All patient areas including floor/carpet, walls, and furniture are neat, clean, and well maintained.	B1. The physical appearance of floors/carpets, walls, furniture, patient areas and restrooms are clean and well maintained.

SUD Facility Site Review Standards

2) Restrooms are clean and contain appropriate sanitary supplies	B2. Appropriate sanitary supplies, such as toilet tissue, hand washing soap, cloth/paper towels, or antiseptic towelettes are made available for restroom use. Environmental safety includes the “housekeeping” or hygienic condition of the site. Clean means unsoiled, neat, tidy, and uncluttered. Well maintained means being in good repair or condition.
3) The program is maintained in a clean, safe, sanitary, and alcohol/drug-free environment.	B3. AOD 12000, “Each program shall comply with all applicable local, state, and federal laws and regulations. The program shall develop written procedures to ensure that the program is maintained in a clean, safe, sanitary, and alcohol and drug-free environment.”
4) The Program is free from all of the following (AOD 20000) a. Broken glass, filth, litter, or debris b. Flies, insects, or other vermin c. Toxic chemicals or noxious	B4. The Program is free from all of the following (AOD 20000) a. Broken glass, filth, litter, or debris b. Flies, insects, or other vermin c. Toxic chemicals or noxious fumes and odors d. Exposed electrical wiring e. Other health or safety hazards
5) Program equipment and supplies shall be stored in an appropriate space and shall not be stored in a space designated for other activities	B5. Program equipment and supplies shall be stored in an appropriate space and shall not be stored in a space designated for other activities
6) The program shall safely dispose of contaminated water and chemicals used for cleaning purposes	B6. The program shall safely dispose of contaminated water and chemicals used for cleaning purposes
C. Site environment is safe for all patients, visitors, and personnel.	C. Site environment is safe for all patients, visitors, and personnel.
There is evidence that staff has received safety training and/or has safety information available in the following:	There is evidence that staff has received safety training and/or has safety information available in the following:
1) Fire safety and prevention	C1. Fire safety and prevention: There is evidence staff has received safety training and/or has safety information
2) Emergency non-medical procedures (e.g. site evacuation, workplace violence)	C2. Non-medical emergency procedures: Non-medical emergencies include incidents of natural disaster (e.g. earthquakes), workplace violence, etc. Specific information for evacuation procedures is available on site to staff. Personnel know where to locate information on site, and how to use information. Evidence of training must be verifiable, and may include informal in-services, new staff orientation, external training courses, educational curriculum and participant lists, etc.
3) Lighting is adequate in all areas to ensure safety.	C3. Illumination: Lighting is adequate in patient flow working and walking areas such as corridors, walkways, waiting and exam rooms, and restrooms to allow for a safe path of travel.

SUD Facility Site Review Standards

4) Exit doors and aisles are unobstructed and egress (escape) accessible.	C4. Access Aisle: Accessible pedestrian paths of travel (ramps, corridors, walkways, lobbies, elevators, etc.) between elements (seats, tables, displays, equipment, parking spaces, etc.) provide a clear circulation path. Means of egress (escape routes) are maintained free of obstructions or impediments to full instant use of the path of travel in case of fire or other emergency. Building escape routes provide an accessible, unobstructed path of travel for pedestrians and/or wheelchair users at all times when the site is occupied. Cords (including taped cords) or other items are not placed on or across walkway areas.
5) Exit doors are clearly marked with “Exit” signs.	C5. Exits: Exit doorways are unobstructed and clearly marked by a readily visible “Exit” sign.
6) Clearly diagramed “Evacuation Routes” for emergencies are posted in a visible location.	C6. Evacuation Routes: Clearly marked, easy-to-follow escape routes are posted in visible areas, such as hallways, exam rooms and patient waiting areas. The minimum clear passage needed for a single wheelchair is 36 inches along an accessible route, but may be reduced to a minimum of 32 inches at a doorway.
7) Electrical cords and outlets are in good working condition.	C7. Electrical Safety: Electrical cords are in good working condition with no exposed wires, or frayed or cracked areas. Cords are not affixed to structures, placed in, or across walkways, extended through walls, floors, and ceiling or under doors or floor coverings. Extension cords are not used as a substitute for permanent wiring. All electrical outlets have an intact wall faceplate. Sufficient clearance is maintained around lights and heating units to prevent combustible ignition.
8) At least one type of firefighting/protection equipment is accessible at all times.	C8. Fire Fighting/Protection Equipment: There is firefighting/protection equipment in an accessible location on site at all times. An accessible location is reachable by personnel standing on the floor, or other permanent working area, without the need to locate/retrieve step stool, ladder, or other assistive devices. At least one of the following types of fire safety equipment is on site: 1) Smoke Detector with intact, working batteries 2) Fire Alarm Device with code and reporting instructions posted conspicuously at phones and employee entrances 3) Automatic Sprinkler System with sufficient clearance (10-in.) between sprinkler heads and stored materials. 4) Fire Extinguisher in an accessible location that displays readiness indicators or has an attached current dated inspection tag. Specific information for handling fire emergency procedures is available on site to staff.

SUD Medical Record Review Standards

Criteria	I. Format Reviewer Guidelines
A. An individual medical record is established for each member.	A. AOD 12020, “A separate, complete, and current record shall be maintained at the program for each client. Programs shall develop any necessary forms. All client files shall contain demographic information sufficient to identify the client and to satisfy data collection needs of the program and funding agencies.”
B. Chart contents are securely fastened and consistently organized.	B. Printed chart contents are securely fastened, attached or bound to prevent record loss. Electronic record information is readily available. Charts are consistently organized. This is per PHC requirements.

SUD Medical Record Review Standards

Criteria	II. Intake Services Reviewer Guidelines
A. Medical record contains a signed Consent to Release Information document.	A. There is evidence of a Consent to Release Information document signed and in the client file for review. This is per 42 CFR. A signed release of information (ROI) is present and includes Partnership HealthPlan, the County, and entities that assist in the coordination of care indicated in the treatment plan.
B. Medical record contains signed HIPAA notification.	B. There is evidence of a HIPAA (Health Information Portability and Accountability Act) notification signed and in the client file for review.
C. Medical record contains signed Client Rights document.	C. There is evidence of a Client's Rights document available in the client file for review.
D. Medical record contains signed Consent to Treatment document.	D. The beneficiary shall sign a consent for treatment form.
E. Medical record contains signed Program Rules document.	E. There is evidence of a Program Rules document signed and in the client file for review.
F. Medical record contains signed Admission Agreement.	F. There is evidence of an Admission Agreement and in the client file for review.
G. Medical record contains evidence of Medi-Cal/Partnership eligibility verification.	G. There is evidence of Partnership or Medi-Cal eligibility in the client file for review.
H. Medical record contains a documented physical exam within 30 days of admission.	H. A physical exam must be in documented in the patient's chart within 30 days of admission into program. The SUDS Clinician Must either: a. Obtain a copy of the most recent physical exam (if one was completed in the last 12 months). The exam can only be reviewed by a Physician, PA, or Nurse Practitioner (N.P.). b. OR c. Perform a new exam. The exam must be performed by a Physician, PA, or Nurse Practitioner (N.P.). d. Contact Partnerships Care Coordination (CC) team to assist the member with establishing a PCP provider that will be able to perform the necessary physical exam. • Perinatal Patients - o Physician shall review the most recent physical examination within 30 days of admission to treatment. The physical examination should be within a 12 month period prior to the admission date. • Alternatively, a physician or non-physician medical practitioner may perform a physical examination within 30 calendar days of admission. 22 CCR § 51303, 42 CFR § 438.210(a)(4) PHC contract states if client has not been seen in longer than 6 months, client will be referred to Partnership Care Coordination department to aid in receiving medical care.

SUD Medical Record Review Standards

I. Medical Record indicates MAT services were offered or member was referred	I. Medical Record indicates MAT services were offered or member was referred
J. If a member is non-or Limited-English proficient (LEP) there is evidence of interpreting services.	J. If a member is non-or Limited-English proficient (LEP) there is evidence of interpreting services.
K. Appropriate documentation of admission and readmission criteria.	K. Each provider shall include in its policies, procedures and practice, written admission and readmission criteria for determining beneficiary's eligibility and the medical necessity for treatment. These criteria shall include, at minimum: • DSM diagnosis • Use of alcohol/drugs abuse • Physical health status • Documentation of social and psychological problems
L. Medical Necessity is determined appropriately.	L. Medical necessity must be performed in a face-to-face or telehealth (video-conference) review by either a medical director or a LPHA. Reference: Intergovernmental Agreement Exhibit A, Attachment I, III, B. 2. i. *This is part of a DHCS decision to make this a mandatory step in Medical Necessity Determination for waiver beneficiaries (see waiver). The intake information is compared to the DSM-IV criteria. A diagnosis is made if enough criteria are met to support the diagnosis. The ASAM criteria is compared to the DSM diagnosing criteria, and the level of care is then determined. For beneficiaries 21 and older, a service is medically necessary when it is reasonable and necessary to protect life, to prevent significant illness or disability, or to alleviate severe pain. For beneficiaries under 21 years of age, a service is deemed medically necessary if the service can improve or correct a screened health condition, such as SUD. The service does not have to correct the issue. It can sustain, support, improve or make the condition more tolerable to be necessary. These services are covered under Early Periodic Screening, Diagnostic and Treatment (EPSDT) mandate. The diagnosis and medical necessity determination shall be completed within 30 calendar days of the first face-to-face interaction. Medical necessity determination for homeless patients shall be completed within 60 days.
M. Missed appointments and outreach efforts are consistently documented in the client's chart.	M. There must be documentation from the facility to the client for engagement in treatment. Medical record contains documentation of missed/excused group sessions and/or individual counseling sessions.

SUD Medical Record Review Standards

N. Medical record contains evidence the provider accepts proof of eligibility as payment.	N. Per Title 22, providers must accept proof of Medi-Cal/Partnership eligibility as payment in full for treatment services rendered upon intake and monthly. NOTE: This is except when there is a share of cost (SOC).
O. Medical record contains evidence of ASAM criteria used to determine medical necessity.	O. • American Society of Addiction Medicine (ASAM) Criteria shall be documented by the diagnosing individual (Medical Director or LPHA) and used to determine placement and level of services needed. Adults must meet the ASAM criteria definition of medical necessity for services. • Providers shall use their clinical expertise to complete initial assessments and subsequent assessments as expeditiously as possible, in accordance with each member's clinical needs and generally accepted standards of practice. • The assessment shall include a typed or legibly printed name of the service provider, provider signature , provider title (or credentials), and date of signature • Assessments shall be updated as clinically appropriate, or as needed if the member's condition changes • For adolescent clients, a developmentally appropriate ASAM tool shall be used • RESIDENTIAL ASAM Criteria Assessment is required before a DMC-ODS plan authorizes a residential treatment level of care. **AUTOMATIC CAP IF ASAM IS NOT COMPLETED
P. Medical record contains evidence of appropriate documentation during intake.	P. The provider shall assure a counselor or LPHA completes a personal, medical, and substance use history for each beneficiary upon admission to treatment. The history shall be completed during the first face-to-face interaction. Assessment for all beneficiaries shall include at a minimum: Drug/alcohol use history; Medical history; Family history; Psychiatric/psychological history; Social/recreational history; Financial status/history; Educational history; Employment history; Criminal history, legal status, and previous SUD treatment history.

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Criteria	III. Care Planning Criteria – Treatment Plans – NTP ONLY Guidelines
A. Medical record contains the most recent Treatment Plan.	A. The most recent treatment plan must be in the file.
B. Medical record contains a legibly signed treatment plan during appropriate timeframe.	B. Signature: If the MD or LPHA deem the services in the initial treatment plan medically necessary, they must print their name, sign, and date the treatment plan within 15 calendar days of being signed by the counselor. Withdrawal Management within one business day of admission. • It must be signed by the beneficiary (client) and the counselor within 30 days of admission to treatment. • If the beneficiary refuses to sign the treatment plan, the provider shall document the reason for refusal and the provider's strategy to engage the beneficiary to participate in treatment. Note: If ALL signatures are not within the total 30 day timeframe, Services rendered in that time will be ineligible for payment. Legibility: means the record entry is readable by a person other than the writer. Handwritten documentation, signatures and initials are entered in ink that can be readily/clearly copied.
C. Treatment plan is client specific and AOD 7110 compliant.	C. Per Title 22, the statement of problems should match the assessment. Goals to be reached need to address each problem the patient presents with. Action steps refer to activities and interventions which will be taken to accomplish the goal(s). Target dates are dates set in place for when the action steps are scheduled to be accomplished. • Statement of problems • Goals including goal of obtaining a physical exam if needed, and goal of obtaining treatment for an identified significant medical illness if needed • Action steps should include: Target dates • Type and frequency of counseling/services • Diagnosis as documented by the Medical Director or LPHA • Assignment of primary therapist or counselor • Documentation of physical exam requirements • Documentation demonstrates the client played an active role in creating the treatment plan. • Recovery/discharge plan is part of ongoing treatment plan goals. • Timeframe: Within 30 calendar days from beneficiary's admission to treatment

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D. Medical record contains evidence that the ongoing treatment plan meets Title 22 requirements.	D. The Ongoing Treatment Plan must be: • Completed with 90 days after the signing of the initial Treatment Plan. • Signed by the counselor within 90 days after the initial Treatment plan. • Signed by the client within 30 days of being signed by the counselor. The ongoing Treatment plan must have a signature from the LPHA/MD within 15 days of being signed by the client. Per Title 22, It is mandatory for the ongoing treatment plan to be completed no later than 90 days after the initial treatment plan and must be signed by the counselor within 90 days after the initial treatment plan, signed by the client within 30 days of the counselor's or LPHA's signature, and signed by the MD/LPHA within 15 days of being signed by the client. • If beneficiary refuses to sign updated treatment plan, then document reason for refusal and document strategies to engage beneficiary to participate in treatment. Note: All Signatures must be present and within the appropriate timeframe in order to get the point for this criteria.
Criteria	III. Care Planning Guidelines – Problem Lists – All LOC (except NTP)
A. A problem list is established for each client	A. The problem list supports the medical necessity of each service provided.
B. Problem list includes all the required elements	B. The problem list includes a list of symptoms, conditions, diagnoses, social drivers, and/or risk factors identified through the assessment, psychiatric diagnostic evaluation, crisis encounters, or other types of service encounters. The problem list shall include all of the following, but is not limited to: A diagnosis given by a LPHA. Should include specifiers from the DSM, if applicable. Problems identified by provider acting within their scope of practice, if any. Problems or illness provided by client or significant support person, if any. Name and title of provider who identified, added, or resolved the problem, and the date the problem was identified, added, or resolved.
C. Problem list is updated in a reasonable time frame	C. Any problems identified during a subsequent intervention may be added to the problem list. Problems should be updated on an ongoing basis when there is a relevant change. Provider is required to update when problems change and in a reasonable time.

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Criteria	IV. Treatment Services Reviewer Guidelines
A. Counseling session attendance is appropriately documented in the chart.	A. According to AOD 8000 c. 1-4, “The following documentation of attendance at each individual counseling session and group counseling session shall be placed in the client's file: 1. Date of each session attended; 2. Type of session (i.e., individual or group); 3. Signature of counselor who conducted the session; and 4. Notes describing progress toward achieving the client’s treatment plan or recovery plan goals”. This is also illustrated in § 51341.1. Drug Medi-Cal Substance Use Disorder Services.22 CA ADC § 51341.1
B. Progress notes contain the minimum required documentation according to Title 22 and AOD 7100b.BHIN 23-068	B.For Outpatient, Intensive Outpatient, Naltrexone Treatment, and Recovery Services, the Progress Note consists of all of the minimum components spelled out in the AOD 7100 b. Per Title 22 and AOD 7100 b, LPHA or Counselor must have these elements in their progress notes for all patients enrolled in outpatient services:
1) Topic of the session	1) Topic of the session
2) Description of beneficiary’s progress toward treatment plan goals.	2) Description of beneficiary’s progress toward treatment plan goals.
3) Date of each treatment service.	3) Date of each treatment service.
4) Start and end time of each treatment service.	4) Start and end time of each treatment service.
5) Typed or legibly printed name of LPHA or counselor, signature and date progress note was documented (printed and signed name adjacent to one another) within 3 days of the session	5) Typed or legibly printed name of LPHA or counselor, signature and date progress note was documented (printed and signed name adjacent to one another) within 3 days of the session
6) Identifies if the service was in-person, telephone or telehealth	6) Identifies if the service was in-person, telephone or telehealth
7) Location of the service and how confidentiality was maintained (if provided in the community) is clearly documented	7) Location of the service and how confidentiality was maintained (if provided in the community) is clearly documented
8) If care coordination services are provided, additional criteria of: a description of how the services relates to the beneficiary’s treatment plan problems, goals, action steps, objectives, and/or referral.	8) If care coordination services are provided, additional criteria of: a description of how the services relates to the beneficiary’s treatment plan problems, goals, action steps, objectives, and/or referral.

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9) For Crisis services, documentation must be completed within 24-hours of incidence.	9) For Crisis services, documentation must be completed within 24-hours of incidence.
C. There is evidence of at least two Evidence Based Practices (EBPs) being used.	C. Intergovernmental Agreement Exhibit A, Attachment I Providers will implement and deliver to fidelity at least two of the following Evidence Based Practices (EBPs) in patient's treatment. They are as follows: • Motivational Interviewing: this approach frequently includes other problem solving or solution-focused strategies that build on clients' past successes. • Cognitive- Behavioral Therapy: Based on the theory that most emotional and behavioral reactions are learned and that new ways of reacting and behaving can be learned. • Trauma-Informed Treatment: Services must take into account an understanding of trauma, and place priority on trauma survivor's safety, choice, and control. • Psycho-Education: Psycho-educational groups are designed to educate beneficiaries about substance abuse, and related behaviors and consequences. Psycho-educational groups provide information designed to have a direct application to beneficiaries' lives, to instill self- awareness, suggest options for growth and change, identify community resources that can assist beneficiaries in recovery, develop an understanding of the process of recovery, and prompt people using substances to take action on their own behalf. • Relapse Prevention: A behavioral self-control program that teaches individuals with substance addiction how to anticipate and cope with the potential for relapse. Relapse prevention can be used as a stand-alone substance use treatment program or as an aftercare program to sustain gains achieved during initial substance use disorder treatment.
D. Medical record contains evidence of the required number of monthly counseling sessions.	D. Per Title 22 and AOD standards: Outpatient - two individual or group counseling sessions each month Intensive Outpatient – progress note for each session Residential –daily When applicable, the progress notes must contain dates and duration of group counseling sessions and have to be signed within 3 days There is evidence of the required number of counseling hours for each LOC. (OP 9 hours or less a week, IOP more than 9 hours a week, Residential: WM: NTP
E. Progress notes contain an individual narrative summary describing client's progress on the treatment plan/problem list goals and action steps.	E. Progress notes contain an individual narrative summary describing client's progress on the treatment plan goals and action steps. The progress note must contain this documentation in order to receive points on this criteria. This is crucial to insuring that the care and action steps taken are individualized to the client identified needs and consistent with the treatment plan goals.

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F. The program provides individual and group counseling directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources.	F. According to AOD 8000 a., “The program shall provide individual and group counseling sessions for clients. Family members and other persons who are significant in the client’s treatment and recovery may also be included in sessions. Individual and group counseling sessions shall be directed toward concepts of withdrawal, recovery, an alcohol and drug-free lifestyle, relapse prevention and familiarization with related community recovery resources. Emphasis shall be placed on the recovery continuum appropriate to clients’ needs.”
G. Medical record contains evidence of provider coordination of care to ensure smooth transitions between LOCs	G. Both the discharging and admitting PROVIDER agencies shall ensure the transition to appropriate LOC. This may include a step-up or step-down in DMC-ODS services. Care coordinators shall provide warm hand-offs and transportation to the new LOC when medically necessary. Provider Agencies shall ensure transitions to other LOCs occur no later than 10 days from the time of assessment or reassessment with no interruption of current treatment services A warm hand off is an interaction that happens in person between members of the transferring and receiving provider in front of the client and family (if present).

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Criteria	V. Discharge Services Reviewer Guidelines
A. Discharge plan or Discharge Summary is documented in the chart	A. Per Title 22: “A therapist or counselor shall complete a discharge plan for each beneficiary, except for a beneficiary with whom the provider loses contact.” If the medical director or LPHA determines that continuing treatment services for the beneficiary is not medically necessary, the provider shall discharge the beneficiary from treatment and arrange for the beneficiary to go to an appropriate level of treatment services. Discharge plan should include the following: • A description of each of the beneficiary’s relapse triggers. • A plan to assist the beneficiary to avoid relapse when confronted with a trigger • A support plan The discharge plan shall be prepared within 30 calendar days prior to the scheduled date of the last face-to-face treatment with the beneficiary. The discharge plan shall be completed by the time of transfer if moving to a different level of care.
B. The discharge plan is signed by both the patient and the counselor	B. During the LPHA’s or counselor’s last face-to-face treatment with the beneficiary, the LPHA or counselor and the beneficiary shall type or legibly print their names, sign and date the discharge plan. A copy of the discharge plan shall be provided to the patient and shall be documented in the patient’s record. This is N/A if the provider loses contact with the client.
C. Discharge plan or summary shall include the following elements:	C. A discharge summary shall include the following elements: (This must be signed and dated by the counselor, and completed within 30 days from the last face-to-face with the client. 3 documented attempts of outreach to client within 30 days of last visit. According to AOD 7120 b)
1) Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program;	1) Reason for discharge, including whether the discharge was voluntary or involuntary and whether the client successfully completed the program;
2) Description of treatment episodes;	2) Description of treatment episodes;
3) Description of recovery services completed	3) Description of recovery services completed
4) Current alcohol and/or other drug usage	4) Current alcohol and/or other drug usage
5) Vocational and educational achievement	5) Vocational and educational achievement
6) Client’s discharge summary signed by counselor and client	6) Client’s discharge summary signed by counselor and client

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7) Transfers and referrals	7) Transfers and referrals
8) Client's comments	8) Client's comments
9) Beneficiary's prognosis	9) Beneficiary's prognosis
10) Duration of Beneficiary's treatment as determined by the dates of admission and discharge from the treatment episode.	10) Duration of Beneficiary's treatment as determined by the dates of admission and discharge from the treatment episode.
11) Medication needs were addressed in the discharge planning	11) Medication needs were addressed in the discharge planning
12) Housing needs and/or a safe discharge plan were addressed in the discharge planning	12) Addressing where the beneficiary will be residing after discharge. Are they unhoused? They should be referred to Community Supports. Returning to a home where substances are used? Alternative housing such as a sober living environment should be addressed. Reference ASAM Dimension 6
D. If client was unavailable to complete a Discharge Plan, the Discharge Summary was completed within 30 days of the last face-to-face contact with the client.	D. This must be signed and dated by the counselor, and completed within 30 days from the last face-to-face with the client. 3 documented attempts of outreach to client within 30 days of last visit.
1) 3 documented attempts of outreach to client within 30 days of last visit	1) 3 documented attempts of outreach to client within 30 days of last visit

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Criteria	VI. Care Coordination Reviewer Guidelines
A. Care coordination shall be provided in conjunction with all levels of treatment deemed necessary	A. Care coordination consists of activities to provide coordination of SUD care, mental health care, and medical care, and to support the beneficiary with linkages to services and supports designed to restore the beneficiary to their best possible functional level. Care Coordination can be provided in clinical or non-clinical settings and can be provided in person, by telehealth, or by telephone.
B. Care coordination services shall include one or more of the component listed (Medical, Mental Health, Ancillary services, Housing, Children's Services, Social Services)	B. Coordinating with medical and mental health care providers to monitor and support comorbid health conditions. Discharge planning, including coordinating with SUD treatment providers to support transitions between levels of care and to recovery resources, referrals to mental health providers, and referrals to primary or specialty medical providers. Coordinating with ancillary services, including individualized connection, referral, and linkages to community-based services and supports including but not limited to educational, social, prevocational, vocational, housing, nutritional, criminal justice, transportation, childcare, child development, family/marriage education, cultural sources, and mutual aid support groups. Case managers (e.g., care coordinators) provide continuous support for the adolescents, ensuring there are linkages to services including those provided by other systems (CSAT, TIP 27, 2008). a) Each adolescent and his or her family should receive case management and/or care coordination services from the SUD treatment provider. b) Case managers and/or care coordinators should be familiar with adolescentserving agencies/systems and other community resources, both formal and informal, to effectively facilitate access to other systems. Providers should help ensure the adolescent and his or her family are educated on health care options in the community. This may include assisting with the coordination of transportation and scheduling medical appointments.
C. Clinical Peer to Peer Consultation must be documented with a progress note	C. Clinician Consultation Services consist of LPHAs, such as addiction medicine physicians, licensed clinicians, addiction Psychiatrists, or clinical pharmacists, to support the provision of care. Clinician Consultation is not a direct service provided to beneficiaries. It includes consultations between clinicians designed to assist DMC clinicians with seeking expert advice on treatment needs for specific DMC-ODS beneficiaries.

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Criteria	VII. Residential Reviewer Guidelines-Only if Applicable
A. Medical record contains evidence of prior authorization for services.	A. Residential Treatment requires a Prior Authorization for services.
B. Evidence of multidimensional LOC assessment within 72 hours of admission is present	B. Evidence of multidimensional LOC assessment is completed within 72 hours of admission is present
C. There is oversight of self-administered medications.	C. There is documentation present in the chart that illustrates oversight of patient's taking their medication.
D. Medical record contains documentation of a TB test performed, results, and services offered with a diagnosis of TB	D. A positive test and/or chest x-ray confirming Tuberculosis will be used to confirm the level of care that must be provided to the client. There has been Tuberculosis (TB) testing done and care received based on results. It is mandatory for Tuberculosis services to be offered with a diagnosis of Tuberculosis (TB).
E. Adult beneficiaries in Residential treatment shall be re-assessed every 30 days, Youth every 15 days	E. Adult beneficiaries in Residential treatment shall be re-assessed at a minimum every 30 days (since they will be assessed on day one). Youth beneficiaries in residential treatment shall be re-assessed at a minimum of every 15 days, unless there are significant changes warranting more frequent reassessments.

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Criteria	VIII. Perinatal/Family Guidelines – Only if Applicable
A. Relevant services offered to perinatal patients or clients with families.	A. 1) Mother/child/ family rehabilitative services. 2) Education provided on the harmful effects of drug and alcohol on the mother and fetus or infant. 3) Educational/vocational training and life skills resources 4) TB and HIV education and counseling 5) Education and information on the effects of alcohol and drug use during pregnancy and breastfeeding 6) Parenting skills-building and child development information 7) Child care is offered for women to receive primary medical care services and any gender-specific treatment services.
B. Daycare facilities are available to Outpatient Perinatal Patients.	B. In a perinatal program, daycare is a service that needs to be available for clients while receiving treatment Program provides/arranges for therapeutic interventions for the children of the women receiving SUD treatment services to address the child's: i. Developmental needs; ii. Sexual abuse; iii. Physical abuse; and Neglect
C. Perinatal/Pediatric Patient Care	C. Immunizations, pediatric care, transportation to appointments, monitored and documented while mother is in treatment if baby is with her.
D. Interim services have been offered	D. If client waited more than 48 hours for treatment, indication of the offering of interim services and the outcome of that offering is included in the patients chart
E. IVDU Interim services have been offered	E. If the patient uses needles, documentation that the patient received expedited admission within 14 days after the request or within 120 days if interim services were provided.
F. Transportation have been offered/provided	F. Evidence of transportation provided to perinatal, postnatal, or well child appointments indicated within chart
G. Medical record contains proof of pregnancy and/or delivery for perinatal patients.	G. Positive pregnancy test or proof of delivery is documented in the medical records.

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	Telehealth Services Guidelines
Criteria	DHCS requires that every provider offering covered services to a beneficiary via telehealth must also meet the requirements of Business and Professions Code Section 2290.5(a)(3), or otherwise be designated by DHCS as able to render Medi-Cal services via telehealth. All providers that are listed in the California Medicaid State Plan as qualified providers of SMHS, DMC, or DMC-ODS services are designated by DHCS as able to render covered services, within their scopes of practice, via telehealth. The California Medicaid State Plan includes qualified provider lists in Supplement 3 to Attachment 3.1-B, Limitation on Services 13.d.5, Substance Use Disorder Services, Provider Qualifications (Drug MediCal); Supplement 3 to Attachment 3.1-B, Limitation on Services 13.d.6, Expanded Substance Use Disorder Treatment Services, Practitioner Qualifications (Drug Medi-Cal Organized Delivery System); and Supplement 1 to Attachment 3.1-A, Qualification of Providers; Supplement 2 to Attachment 3.1-B, Provider Qualifications; and Supplement 3 to Attachment 3.1-A, Provider Qualifications (Specialty Mental Health).
Member consent was received and documented prior to providing telehealth services.	Providers must document the beneficiary's verbal or written consent to receive covered services via telehealth prior to the initial delivery of the services. The beneficiary's consent must be documented in their medical record and made available to DHCS upon request. A provider may utilize a general consent agreement to meet this documentation requirement if that general consent agreement: 1) specifically mentions the use of telehealth delivery of covered services; 2) includes the information described above; 3) is completed prior to initial delivery of services; and 4) is included in the beneficiary record. DHCS has created model verbal and written consent language, which can be found on the DHCS website. The Model Telehealth Patient Consent Language is available at: https://www.dhcs.ca.gov/provgovpart/Pages/Patient-Consent.aspx.

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Telehealth services are documented and clearly notes the mode of use; telephone or video.	Prior to initial delivery of covered services via telehealth, providers are required to obtain verbal or written consent for the use of telehealth as an acceptable mode of delivering services, and must explain the following to beneficiaries: •The beneficiary has a right to access covered services in person. •Use of telehealth is voluntary and consent for the use of telehealth can be withdrawn at any time without affecting the beneficiary’s ability to access MediCal covered services in the future, •Non-medical transportation benefits are available for in-person visits. •Any potential limitations or risks related to receiving covered services through telehealth as compared to an in-person visit, if applicable
If the assessment was completed via telehealth services, it was performed via synchronous video interaction unless documented that the member does not have video capability.	Services provided by telehealth may be provided and reimbursed by each of the following programs as described below: Drug Medi-Cal Organized Delivery System: •The initial clinical assessment and establishment of a new patient relationship, including any determination of diagnosis, medical necessity, and/or level of care may be delivered through synchronous video interaction. •The initial clinical assessment and establishment of a new patient relationship, including any determination of diagnosis, medical necessity, and/or level of care shall only be delivered through synchronous audio-only interaction in the situations identified above in this BHIN. •Licensed providers and non-licensed staff may deliver services through telehealth, as long as the service is within their scope of practice. •Covered DMC-ODS services may be delivered through telehealth when those services meet the standard of care. The group size limit still applies for group counseling provided via telehealth. •Certain services, such as residential services, require a clearly established site for services and in-person contact with a beneficiary in order to be claimed. However, California’s State Plan does not require that all components of these services be provided in-person. (For example, services can be provided via telehealth for a patient quarantined in their room in a residential facility due to illness.) Drug Medi-Cal: •DMC services, as defined in W&I section 14124.24, provided by a licensed practitioner of the healing arts, or a registered or certified alcohol or other drug counselor or another individual authorized by DHCS to provide DMC

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Criteria	Peer Support Services Guidelines
Where services are rendered by Peer Support Specialists they are limited to Education Skill Building Groups, Engagement, or Therapeutic Activity	Medi-Cal Peer Support Services may be delivered as a standalone service or provided in conjunction with other Specialty Mental Health Services (SMHS), DMC, or DMC-ODS services, including inpatient and residential services. Medi-Cal Peer Support Specialist Services are not subject to prior authorization by Medi-Cal behavioral health delivery systems. In accordance with the SMHS, DMC, and DMC-ODS billing manuals, there are no lockouts for Medi-Cal Peer Support Services. Medi-Cal Peer Support Services may be delivered by any Medi-Cal Peer Support Specialist affiliated with an organizational provider that is contracted with a Medi-Cal behavioral health delivery system to provide Medi-Cal Peer Support Services. Medi-Cal Peer Support Services must be coordinated to avoid duplicative services. Medi-Cal Peer Support Services must be based on an approved plan of care. Please refer to BHIN 23-068, or superseding guidance, for documentation requirements for SMH, DMC, and DMC-ODS services. Medi-Cal Peer Support Services are limited to the following three service components as outlined in California's Medicaid State Plan. Services provided shall fit within at least one of those service components: (1) Educational Skill Building Groups means providing a supportive environment in which members and their families learn coping mechanisms and problem-solving skills in order to help the members achieve desired outcomes. These groups promote skill building for the members in the areas of socialization, recovery, selfsufficiency, self-advocacy, development of natural supports, and maintenance of skills learned in other support services.

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Documentation indicates supervision was rendered and who the supervising staff was.	Medi-Cal Peer Support Specialists shall provide services under the direction of a Behavioral Health Professional. Behavioral Health Professionals must be licensed, waived, or registered in accordance with applicable State of California licensure requirements and be listed in the California Medicaid State Plan as a qualified provider of SMHS, DMC, or DMC-ODS. All SUD and Expanded SUD services, including MediCal Peer Support Services, must be medically necessary and recommended by physicians or other Licensed Practitioner of the Healing Arts (LPHAs) acting within their scope of practice. All SMHS, including Medi-Cal Peer Support Services, must be medically necessary and recommended by physicians or other Licensed Mental Health Professionals (LMHPs) acting within their scope of practice. (1) For Medi-Cal Peer Support Services provided as SMHS, the following Behavioral Health Professionals listed in the state plan as LMHPs may direct services: Licensed Physicians; Licensed or Waivered Psychologists, Licensed, Waivered, or Registered Clinical Social Workers; Licensed, Waivered, or Registered Professional Clinical Counselors; Licensed, Waivered, or Registered Marriage and Family Therapists; 16 Registered Nurses (including Certified Nurse Specialists or Nurse Practitioners); and Licensed Occupational Therapists. (2) For Medi-Cal Peer Support Services provided as a DMC/DMC-ODS service, the following Behavioral Health Professionals listed in the state plan as LPHAs may direct services: Physicians; Nurse Practitioners; Registered Nurses; Licensed Clinical Psychologists; Licensed or Registered Clinical Social Workers; Licensed or Registered Professional Clinical Counselors; Licensed or Registered Marriage and Family Therapists; and Licensed Occupational Therapists.

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Criteria	Adolescent Services Guidelines
Provider addresses co-occurring mental health disorders through direct services or documents outcome of referrals and connections to treatment. The provider documents services provided to individuals with cooccurring mental and/or physical health conditions (e.g., medication noncompliance or abuse, interactions of drug use and other medications).	SUDs often co-occur with physical health conditions which is why it is important to provide access to appropriate medical care for adolescents entering treatment. . It is recommended part of the adolescent's assessment include identification of physical health issues and subsequent referral to relevant providers, services, and supports. Physical interventions may lessen the likelihood of depression and support abstinence and recovery. Additionally, adolescents being treated for SUDs have a significantly higher prevalence of several medical conditions (e.g., asthma, pain conditions, and sleep disorders) that could be ameliorated by physical interventions (SAMHSA, 2013). With this in mind, all SUD treatment providers should screen for health conditions, be familiar with the process for making health care referrals and make appropriate referrals to health care providers as needed (SAMHSA, 2013). a) Comprehensive assessments should include a screening of the adolescent's medical status, including medical history. b) Appropriately trained and educated providers should screen or refer adolescents for screening of existing physical health conditions and assess for behaviors that may place the adolescent's physical health at risk. The screening should pay particular attention to the identification of conditions that co-occur more commonly in individuals with SUDs (e.g., fetal alcohol spectrum disorders, HIV, hepatitis, liver/kidney disease, chronic pain, sexually transmitted infections [STIs], and tuberculosis). c) Providers should establish partnerships with medical organizations or practitioners equipped to address the physical health needs of adolescents (e.g., primary care physicians, dentists, optometrists, gynecologists, obstetricians) to facilitate any necessary referrals. d) Providers should ensure that health education will be used to provide

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The adolescent's developmental and cognitive levels; social, emotional, and communication abilities and strengths; and independent living skills are assessed and documented in the member's chart.	Effective assessments identify the adolescent's strengths and resilience factors (Massachusetts Department of Public Health, Bureau of Substance Abuse Services, 2011). a) Providers should use a comprehensive and multidimensional assessment to determine the adolescent's level of care, needs, and treatment approach. The adolescent's geographic location, school, cultural identity, family, developmental level, priorities, and gender and sexual identity may also be taken into account as they relate to engagement, retention, and recovery supports. b) Assessment is an ongoing process that should be trauma informed, comprehensive, multifaceted, and culturally and developmentally appropriate for each adolescent admitted to treatment. c) The assessment should include questions that identify the strengths, resiliencies, natural supports, and interests of the adolescent to accurately assess the adolescent's unique abilities that will assist in his or her recovery. d) The adolescent's developmental and cognitive levels; social, emotional, and communication abilities and strengths; and independent living skills should be assessed. e) The goals of assessment should include the identification of natural supports, strengths, and resilience along with motivation and readiness for treatment, cultural/linguistic barriers to treatment and recovery, and areas of functional impairment or skills deficit. f) The provider should assess for substance use (including tobacco/nicotine use); co-occurring mental health disorders; physical health; cognitive, social, and affective development; family, peer, and romantic relationships; trauma; current or past emotional, physical, or sexual abuse; suicidality;

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Provider documents use of EBPs that are age, gender, developmentally, and culturally appropriate.	EBPs include screening tools, assessment tools, counseling, family counseling, group counseling practices, and use of medications in treatment. In acknowledgement of the ever-evolving field of SUD treatment, specific EBPs are not listed in this document, but providers are encouraged to seek out and use developmentally appropriate EBPs. a) Providers should have an understanding of models and theories of SUDs and behavioral, psychological, physical, and social effects of psychoactive substances. They should also remain up to date on current research and evidence-based and best practices for adolescent treatment and recovery. b) To use EBPs effectively, providers should ensure staff members are adequately trained and qualified to implement the practices with fidelity and have the appropriate supervision. c) Provider personnel files should document training(s) and/or certification(s) in the evidence-based model(s) the staff member is using in the provision of adolescent services. d) Providers should be able to demonstrate which EBP is implemented, how trainings and supervision are conducted, and how fidelity is assured. e) Providers should use EBPs that are age, gender, developmentally, and culturally appropriate as identified by national or state-level EBP clearinghouses (e.g., EBPs listed in SAMHSA's National Registry of Evidence-Based Programs and Practices).

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Treatment and recovery plans reflect the adolescent's educational goals and objectives. Providers work with adolescents to help them discover their interests (e.g., hobbies, games, sports, creative ventures) and strengths through the treatment and recovery plan.	The treatment and recovery plans are assessed and modified continuously and reflects changes in needs and preferences of the adolescent. a) The treatment and recovery plan should be developed in collaboration with the adolescent and his or her family or other supportive adults based on his or her unique strengths, assets, and needs. b) The plan should reflect the adolescent's developmental stage; gender identity; culture; sexuality; and chronological, emotional, and psychological age. c) During the treatment and recovery planning process, the adolescent and his or her family should identify recovery goals (desired outcomes) that reflect how they define progress and support needs (e.g., the adolescent developing positive relationships, reduced substance use and abuse symptoms, school retention, and improvement of family relationships). d) The adolescent's individual treatment and recovery plan should be assessed and reviewed by the adolescent and provider on a scheduled basis, and, additionally, as requested by the adolescent or family. The plan should be open to changes by either the provider or adolescent based on the adolescent's preference, or if the desired outcomes are not being achieved. e) Treatment and recovery plans should include goals for family functioning, or the program should develop a family services plan that identifies the ongoing family support and improvement goals. f) Family members should be involved and/or updated about changes in the treatment and recovery plan as appropriate, including being provided information on recovery support services and continuing care options. g) The strategies and services specified in the plan should include identification of the individuals providing treatment, an expected timetable
For adolescents in residential treatment, a transition plan is developed prior to their return to the community that includes linkages to community-based agencies.	Recovery support services are ideally incorporated at the inception of services (e.g., during engagement, assessment, treatment, and recovery planning) and continue after the adolescent's discharge from or completion of a primary treatment episode. Recovery support services should be developmentally appropriate and tailored to each adolescent and his or her family. Support services should also be provided in a variety of settings and formats, using new technologies to communicate and engage with adolescents in innovative ways (SAMHSA, 2013).

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Group counseling sessions are provided when deemed clinically appropriate and in accordance with the adolescent's treatment and recovery plan	Adolescent identity formation is influenced by interactions with peers. Positive interaction with peers in facilitated, supportive group sessions can help the adolescent build meaningful interactions and/or relationships with his or her peers. Group therapies can be psychoeducational, cognitivebehavioral, therapeutic, or focused on relapse prevention. All group therapies should reflect the adolescent's treatment and recovery goals and objectives (CSAT, TIP 41, 2009). a) Group counseling sessions should be provided when deemed clinically appropriate and in accordance with the adolescent's treatment and recovery plan. b) Group counseling sessions should meet the client-to-staff ratio as designated by State regulation or requirement and the recommendations of the developer or purveyor of the group counseling type (e.g., group size). c) When possible and appropriate, providers should offer separate groups for girls, boys, and LGBTQI adolescents. All groups should be trauma-informed and sensitive to issues of gender, cultural norms, and sexual orientation. d) Providers should ensure proper training and supervision of staff members leading group therapy sessions. Training will include practicing group therapy techniques under the supervision of an experienced clinician and obtaining proper licensure or certification as required by the state. e) Prior to placing adolescents in specific group therapy sessions (e.g., prevention based or educational), the provider (e.g., case manager or counselor) should properly screen participants for SUDs and match the participants to appropriate group(s) (CSAT, TIP 41, 2009). f) Group therapists/facilitators should have an understanding of group

Community Based Adult Services (CBAS) Physical Accessibility Review Survey

California Department of Health Care Services
Managed Care Quality and Monitoring Division

Provider Name: ☒ CBAS ☐ Other		Date of Review:
Address:		Name of Reviewer:
City:		Health Plan Name: Partnership HealthPlan of CA
Phone:	FAX:	Contact Person Name:
(		
		<i>Level of Access:</i>
<u>Basic Access:</u> Demonstrates facility site access for the members with disabilities to parking, building, elevator, Participant Areas, and restroom. To meet Basic Access requirements, all (24) Critical Elements (CE) must be met.		☐ Basic Access
<u>Limited Access:</u> Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, participant areas, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.		☐ Limited Access

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at a provider office/site. These should also be used in online directories. In order for a provider office to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first six symbols (P, EB, IB, R, PA,). And a provider who has Medical Equipment Access will meet the medical equipment elements for the last symbol (T).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 6,7,8				
EB = EXTERIOR BUILDING	(CE): 9,15,16,17,20				
IB = INTERIOR BUILDING	(CE): 23,26,36,37,38,39,40,41				
R=RESTROOM	(CE): 47,49,50,53,56,58				
PA= PARTICIPANT AREAS	(CE): 60,61				

2nd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

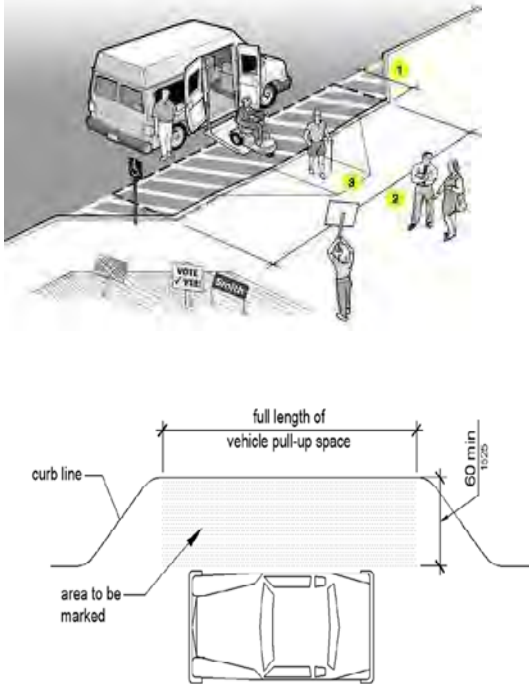
3rd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

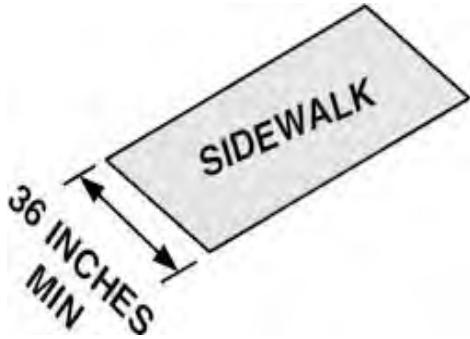
PARKING						
1	Are accessible parking spaces provided in the designated parking area?	Self explanatory.				
2	Are the correct number of accessible parking spaces provided? 1 to 25 total spaces – 1 required 26 to 50 – 2 required 51 to 75 – 3 required 76 to 100 – 4 required 101 to 150 – 5 required 151 to 200 – 6 required 201 to 300 – 7 required 301 to 400 – 8 required	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				
3	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				

4	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
5	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				

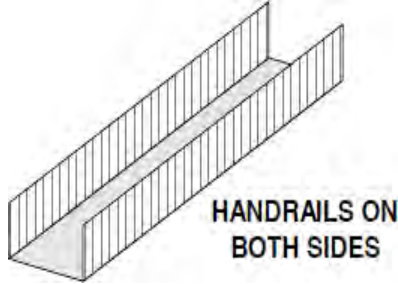
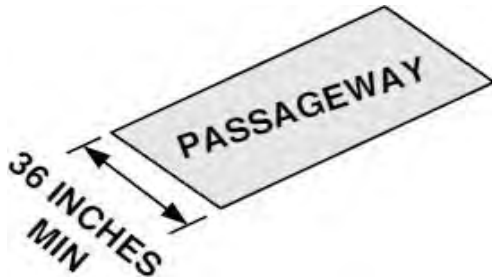
6 (CE)	Is a passenger loading zone provided with a vehicular pull-up space.	The vehicular pull-up space dimension is a minimum of 96 inches wide and 20 feet long				

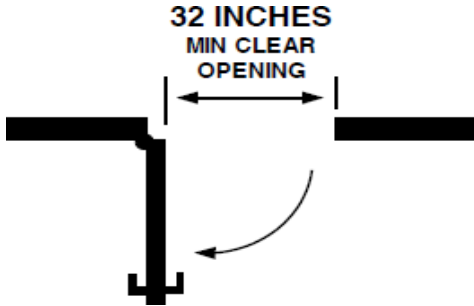
7 (CE)	Is there an access aisle that adjoins an accessible route and does not overlap the Vehicular way /driveway?	Access aisles serving vehicle pull-up spaces shall be a minimum of 60 inches wide. 				
8 (CE)	Do curbs on the route have curb ramps at the drop off locations?	Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.				

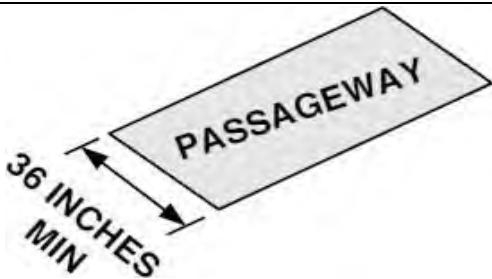
EXTERIOR ROUTE (FROM DROP OFF AND PICK UP LOCATIONS TO THE ENTRANCE)

9 (CE)	For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)	Self explanatory.			
	a. Public Transportation				
	b. Public sidewalk?				
	c. Drop off?				
10	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)	 A diagram showing a rectangular area labeled "SIDEWALK". A double-headed arrow indicates the width, with the text "36 INCHES MIN" written next to it.			
	a. Public Transportation				
	b. Public sidewalk?				
	c. Drop off?				
11	Is the accessible route to the	An example of a stable surface is a floor or			

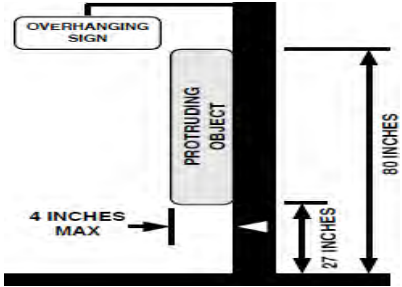
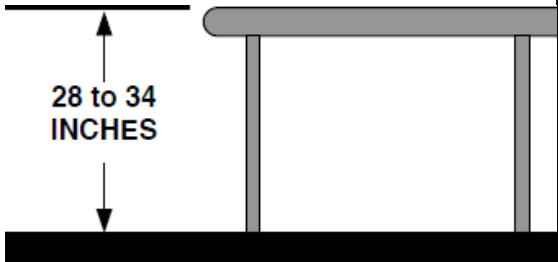
11	building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.						
	a. Public Transportation							
	b. Public sidewalk?							
	c. Drop off?							
12	Is there an accessible route that does not include stairs or steps?	Self explanatory.						
13	Is the route to the entrance from drop off, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.						

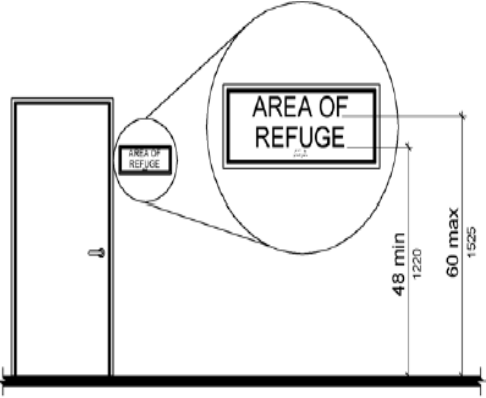
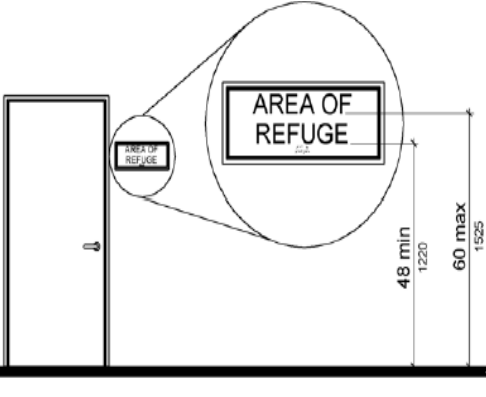
RAMPS:						
14	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				
15 (CE)	Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?	If the ramp is not longer than 6 feet, check N/A. 				
16 (CE)	Are all ramps at least 36 inches wide?					

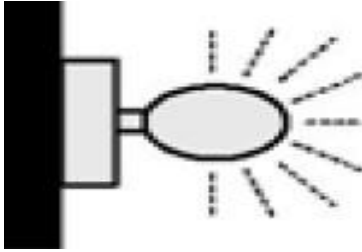
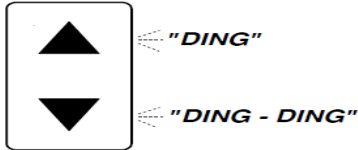
BUILDING ENTRANCE						
17 (CE)	Is the main entrance accessible?	Self explanatory.				
18	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
19	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					
20 (CE)	Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?	When measuring double doors, measure the opening with one door open to 90°. 				

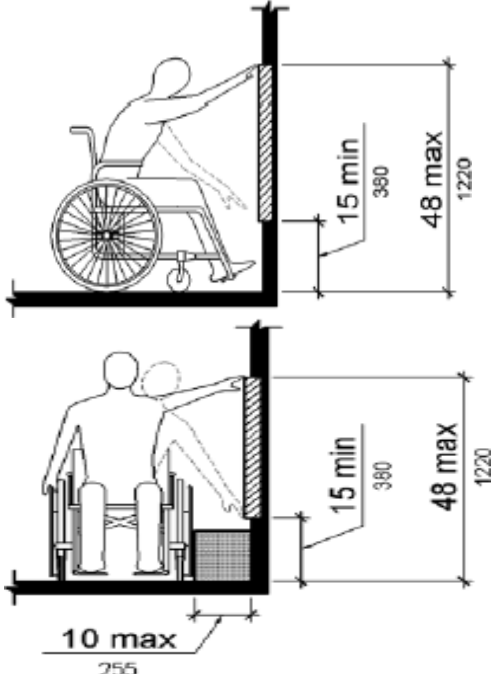
21	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
22	Is there an interior route to the participant area?	Some participant areas are accessed directly from the street or drop off rather than being located within a larger building or complex, therefore they do not have interior routes.				
23 (CE)	Are <u>ALL</u> interior paths of travel at least 36 inches wide?					
24	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				

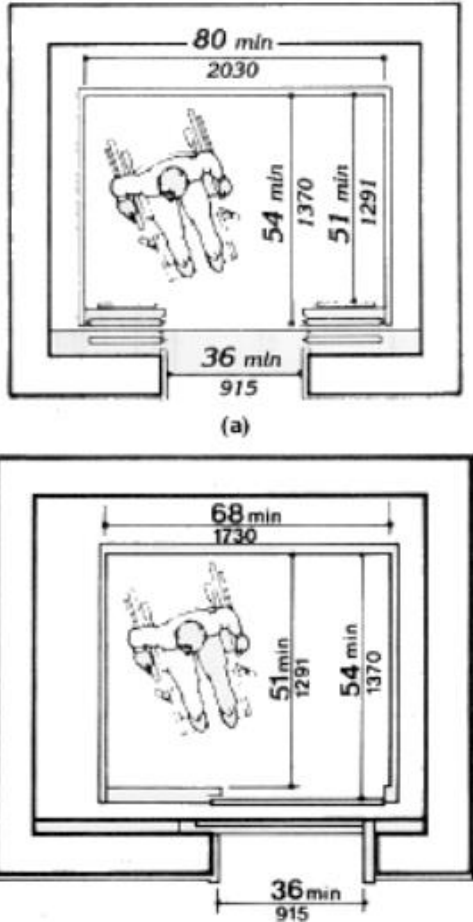
25	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
26 (CE)	If there are stairs on the accessible route, are there handrails on each side?	If there are no stairs, check N/A.				
27	If there are stairs, are all stair risers closed that are on the accessible route?					
28	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				

29	Is the path through the facility free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it. 				
30	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
31	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.					

32	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
33	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

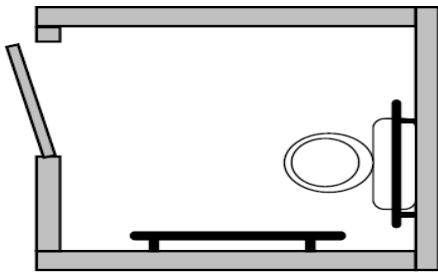
34	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and Participant Areas?	If the building does not have a fire alarm system, check NA. 				
ELEVATORS						
35	Is there an elevator?					
36 (CE)	If needed, is the elevator available for public/patient use during business hours?	Self explanatory.				
37 (CE)	Is the elevator equipped with both visible and audible door opening/closing and floor indicators?	A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement. 				

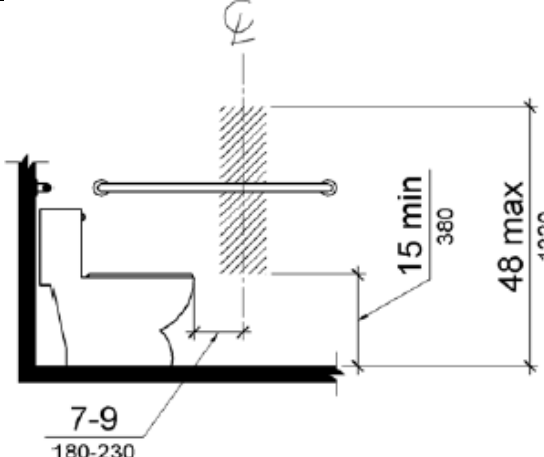
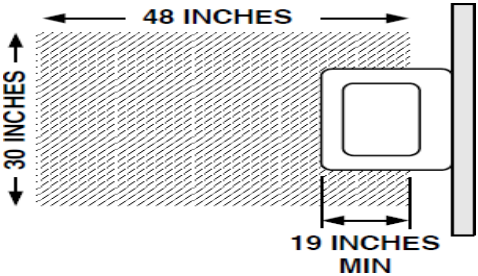
38 (CE)	Are there raised letter and Braille sign on each side of each elevator jamb?	These signs allow everyone to know which floor they are on before entering or exiting the elevator.				
39 (CE)	Are the hall call buttons for the elevator no higher than 48 inches from the floor?	 The diagrams illustrate the required height and width for elevator hall call buttons. The top diagram shows a person in a wheelchair reaching for a button, with dimensions: 15 min (380), 48 max (1220). The bottom diagram shows two people reaching for a button, with dimensions: 15 min (380), 48 max (1220), and 10 max (255) for the button width.				

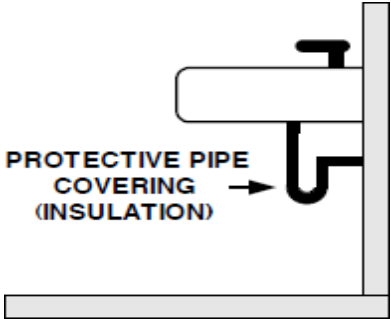
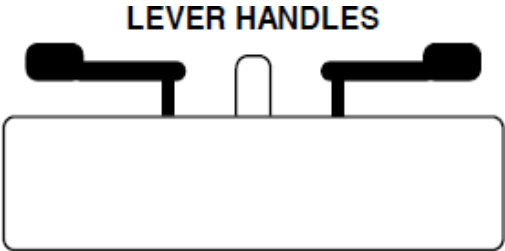
40 (CE)	Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?	The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.  (a)			
41 (CE)	Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?	Self explanatory.			

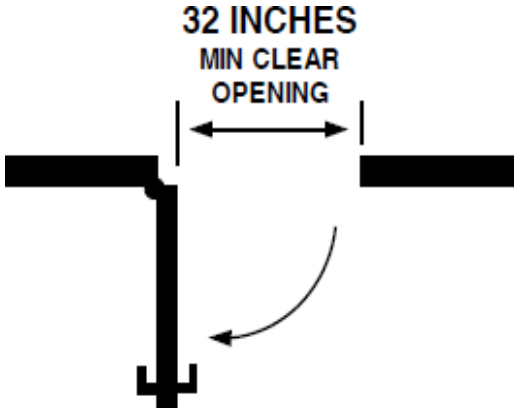
42	Is there an emergency communication system in the elevator?	Self explanatory.				
43	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				
44	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				

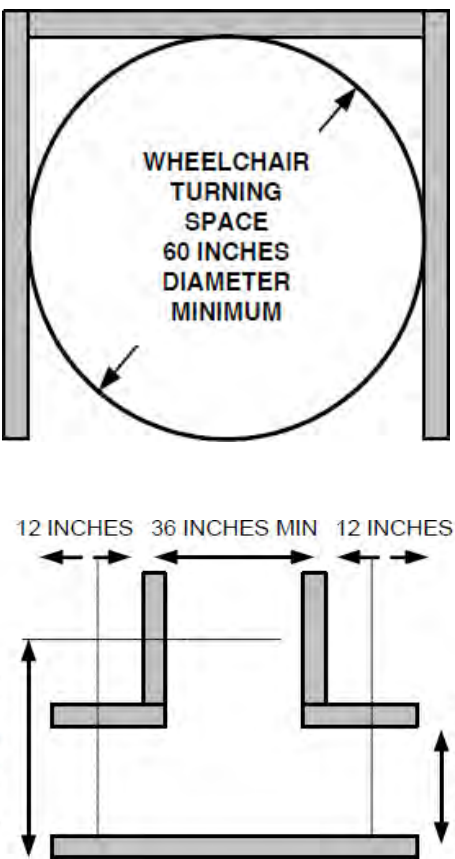
ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):

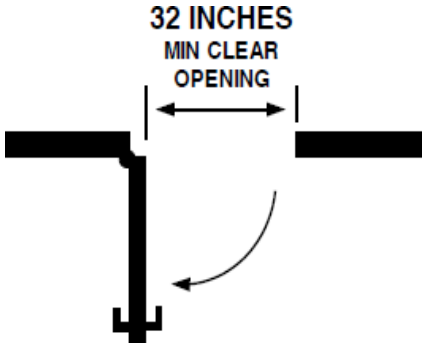
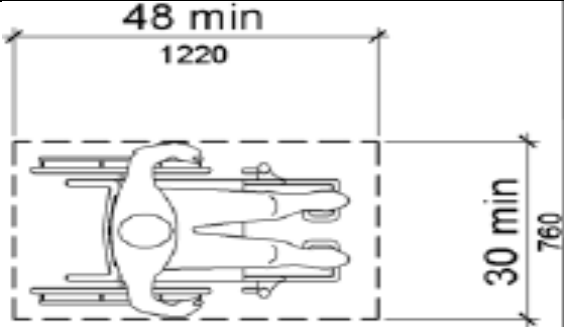
45	Is there an accessible restroom/toilet room?	Self explanatory.				
46	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
47 (CE)	Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?	Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface. 				
48	Are all objects mounted at least 12 inches above and/or 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				

49 (CE)	Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?					
50 (CE)	Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?	This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath. 				
51	Is the space in front of the sink free of trashcans and other movable items?	Self explanatory.				

52	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
53 (CE)	Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)	A knob handle would not be accessible. 				
54	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
55	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				

56 (CE)	Do restroom doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?					
57	Is the space inside the restroom clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

58 (CE)	Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the restroom to allow a turn around for wheelchair and scooter users?	 The diagram consists of two parts. The top part shows a circle with the text 'WHEELCHAIR TURNING SPACE 60 INCHES DIAMETER MINIMUM' inside it, with arrows indicating the circular path. The bottom part shows a T-shaped space. The horizontal bar at the bottom is labeled '36 INCHES MIN' on both sides. The vertical bars are labeled '12 INCHES' on the outside and '36 INCHES MIN' in the middle. The vertical bars are also labeled '60 INCHES MIN' on the left and '36 INCHES MIN' on the right.				
59	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
PARTICIPANT AREAS (QUIET ROOM/THERAPY ROOM S-PT/OT, ACTIVITY AREA)						

60 (CE)	Do doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?	 32 INCHES MIN CLEAR OPENING				
61 (CE)	There is space in the following areas for a wheelchair or scooter user to approach and park for participation in activities or use of exercise equipment:	 48 min 1220 30 min 760				
	a. Quiet room?					
	b. Physical Therapy Room {PT}?					
	c. Occupational Therapy {OT}?					
	d. Activity Area					

62	Is there a bed that is between 17 inches and 19 inches from the floor to the top of the cushion?	Self explanatory				

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MCQP1052			Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Physical Accessibility Review Survey – SR Part C			☒ External Policy ☐ Internal Policy	
Original Date: 02/20/2013		Next Review Date: ~~06/11/2026~~ 08/12/2027 Last Review Date: ~~06/11/2025~~ 08/12/2026		
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIALS	☒ PAC
Approval Signature: Robert Moore, MD MPH, MBA			Approval Date: ~~06/11/2025~~ 08/12/2026	

I. RELATED POLICIES:

- A. MPQP1022 - Site Review Requirements and Guidelines
- B. CMP36 - Delegation Oversight and Monitoring

II. IMPACTED DEPTS:

- A. Provider Relations
- B. ~~Quality Improvement~~Network Services (Credentialing)

III. DEFINITIONS:

- A. The Physical Accessibility Review Survey (PARS) is an on-site review of a provider office site's structural amenities vis-a-vis the potential for an adverse effect on seniors or persons with disabilities.
- B. Primary Care Provider (PCP): the PCP is a general practitioner, internist, pediatrician, family physician, obstetrician/gynecologist (OB/GYN), nurse practitioner or physician assistant.
- C. High Volume Specialist: a provider in Any Partnership HealthPlan of California's (Partnership's) that has billed at least 500 visits during the prior calendar year and who saw a minimum of 200 unique members during the prior calendar year-. Specialist types are those recommended by the American Board of Medical Specialties (ABMS). A specialist is defined as: A physician specialist, Board Certified by an ABMS Member Board is a licensed physician who focuses their practice in a particular area of medicine or patient care and may concentrate on certain body systems, specific age groups or complex scientific techniques to diagnose or treat particular medical conditions.
- D. High Volume Ancillary Provider: a provider in Partnership's Regions that has billed at least 500 visits during the prior calendar year and who saw a minimum of 200 unique members during the prior calendar year. Ancillary providers may provide audiology, community based adult services (CBAS), dialysis, occupational/speech/physical therapy, nutritional education, and home infusion or other such services.
- E. Excluded Providers: Certain provider types are excluded from the Partnership assessment of accessibility for Seniors and Persons with Disabilities (SPDs). They include licensed and certified facilities, [hospitals](#), dental and vision providers, Long Term Care (LTC) facilities, imaging centers, pharmacies and labs, medical transportation, medical supplies, and Durable Medical Equipment (DME) sites. Non-contracted providers are excluded from Partnership assessment of accessibility for SPDs.

IV. ATTACHMENTS:

- A. [Physical Accessibility Review Survey Guidelines/Tool](#)
- B. [Ancillary Services Physical Accessibility Review Survey](#)
- A-C. [Community Based Adult Services \(CBAS\) Physical Accessibility Review Survey](#)
- B-D. [PARS Close Letter Template](#)

Policy/Procedure Number: MCQP1052		Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Physical Accessibility Review Survey – SR Part C		☒ External Policy ☐ Internal Policy	
Original Date: 02/20/2013		Next Review Date: ~~06/11/2020~~ 08/12/20276 Last Review Date: ~~06/11/2025~~ 08/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

V. PURPOSE:

To define the scope and frequency of performing the Physical Accessibility Review Survey (PARS) for PCPs and ~~High Volume~~High-Volume Ancillary and Specialist Providers (HVASP). The PARS tool was developed by a collaborative coalition made up of staff from the California Department of Health Care Services (DHCS) and Medi-Cal Managed Care Health Plans and meets DHCS standards. The purpose of the PARS is to assess the physical accessibility of provider sites using a set of standards mindful of the needs of seniors or persons with disabilities. Results of the PARS will be made available through the Partnership website and provider directories.

VI. POLICY / PROCEDURE:

Partnership will conduct a PARS at the time of the initial site review for newly credentialed PCPs and at least once every three years thereafter. ~~Providers determined to be HVASPs will be reviewed every three years following their initial PARS assessment.~~ Partnership will notify DHCS of any changes made to the HVASP methodology by January 31st of each year in accordance with MMCD Policy Letter 12-006 (see references below.) Annually, no later than April ~~30~~45th, Partnership will apply the methodology approved by DHCS to identify any new HVASP that meet the criteria described in Section III. Providers that no longer meet the HVASP definition, will be deleted from the list to survey. Newly identified HVASP providers will receive a PARS assessment within six (6) months of such identification.

A. Requirements

1. PARS is an on-site review of the office site and covers critical elements across:
 - a. Parking
 - b. Exterior Building
 - c. Interior Building
 - d. Restroom
 - e. Exam Room
 - f. Exam Table/Scale

B. Scheduling - A member of the Quality Improvement department's Quality Inspections team or designee (aka the PARS Reviewer) conducts the PARS. (Refer to Section VI.E. for delegation criteria.)

1. The Quality Inspections team schedules the physical accessibility reviews and provides information to the provider on preparing for the review in the following situations:
 - a. ~~Providers who change site locations subsequent to receiving a PARS assessment must receive a new review. A Provider Relations' Credentialing Specialist Network Services will notify the~~ Inspections team ~~through the Provider Change Agenda of relocating/relocated providers, so that~~ the ~~Inspection~~ team ~~can will schedule complete the a~~ review within sixty (60) days of the notification date ~~or the date the site opened.~~
 - a-b. ~~PCPs will be assessed at a minimum of every three years.~~
 - b-c. Newly identified providers based on the annual HVASP methodology will be assessed within six months of being identified.
 - e-d. ~~PCPs and E~~existing HVASPs that continue to meet the ~~High Volume~~High-Volume methodology will be assessed every three years.

C. Review

1. The PARS Reviewer will conduct the review, using the most recent DHCS PARS tool.
 - a. Review Criteria
 - 1) Criteria are scored as Yes, No, or Not Applicable
 - 2) Access is identified as Basic or Limited, as well as Medical Equipment Access (if applicable)
 - 3) There is no Corrective Action Plan (CAP) required when elements of the review do not

Policy/Procedure Number: MCQP1052		Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Physical Accessibility Review Survey – SR Part C		☒ External Policy ☐ Internal Policy	
Original Date: 02/20/2013		Next Review Date: ~~06/11/2020~~ 08/12/2027 Last Review Date: ~~06/11/2025~~ 08/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

meet the standards

2. Results Notification:
 - a. Partnership Contracted Provider
 - 1) The Partnership contracted provider will receive a final close letter within sixty (60) days of the review, which will indicate the level of access and the appropriate accessibility indicator. – See Attachment [DC](#).
 - b. Provider Relations
 - 1) The results of the PARS will be forwarded to the Partnership Provider Relations department on a ~~quarterly~~ monthly basis. Provider Relations staff will make the information available on the Partnership website and in the provider directories in accordance with MMCD Policy Letter 12-006.
- D. Physical Access Designation
 1. Access designations are documented in the Partnership HealthPlan Provider Directory as required by MMCD 12-006.
 - a. Basic Access:- Demonstrates access for SPDs meet the Basic Access requirements, for all Critical Elements (CE) in the following areas: parking, building, elevator, doctor's office, exam room and restroom.
 - b. Limited Access: -Demonstrates access for SPDs where one or more of the Critical Elements (CE) are missing or incomplete in the following areas: parking, building, elevator, doctor's office, exam room, and restroom.
 - c. Medical Equipment Access: Demonstrates the PCP site has a height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to the level of basic or limited access as appropriate.
 - d. Provider Directory Indicators noted:
In addition to identifying the locations' accessibility level, the following should be identified (where applicable) such;
 P = Parking EB = Exterior Building IB = Interior Building
 R = Restroom E = Exam Room T = Exam Table/Scale
- E. Delegation of PARS functions
- F. Organizations or groups who have one or more DHCS Certified Site Reviewers or appropriately trained personnel may be determined eligible, at Partnership discretion, to perform PARS functions. An organization or group will perform these functions under a formal delegation agreement.
- G. A formal delegation agreement is inclusive of a detailed grid outlining key functions and responsibilities of both Partnership and the delegated entity.
- H. Delegated entities will perform PARS functions for all PCP sites no less than once every three years.
- I. Delegated organizations and/or groups will provide timely copies of all PARS reviews conducted at the site level, within Partnership's service area, when requested.
- J. Partnership's Quality Inspections team will track all PARS conducted by the delegated entities.
- K. For organizations and groups that are more than one year past due for PARS at the site level or otherwise missing a PARS, the Inspections team will refer to Partnership's Delegation Oversight Reporting Sub-Committee (DORS), which is managed by Partnership's Compliance unit within the Administration department, for action.
- L. As part of the oversight process, Partnership may perform one or more repeat PARS on sites that have had the PARS performed by a delegated entity.

VII. REFERENCES:

- A. [MMCD Policy Letter 12-006 Revised Facility Site Review Tool \(Aug. 12, 2012\)](#)
- B. [Department of Health Care Services \(DHCS\) All Plan Letter \(APL\) 22-017 Primary Care Provider Site Review: Facility Site Review and Medical Record Review \(Sept. 22, 2022 supersedes APL 20-006\)](#)

Policy/Procedure Number: MCQP1052		Lead Department: Health Services Business Unit: Quality Improvement	
Policy/Procedure Title: Physical Accessibility Review Survey – SR Part C		☒ External Policy ☐ Internal Policy	
Original Date: 02/20/2013		Next Review Date: ~~06/11/2020~~ 08/12/2027 Last Review Date: ~~06/11/2025~~ 08/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

- C. [DHCS APL 15-023 Facility Site Review Tools for Ancillary Services and Community-based Adult Service Providers \(Oct. 28, 2015\)](#)

VIII. DISTRIBUTION:

- A. Partnership Provider Manual
- B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES: Medi-Cal: 02/19/14; 02/18/15; 02/17/16, 02/15/17; *03/14/18; 03/11/20; 3/10/21; 05/12/21; 06/08/22; 06/14/23; 06/12/24; 06/11/25; 08/12/26

*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:

Physical Accessibility Review Survey

California Department of Health Care Services
Medi-Cal Managed Care Division

Provider Name: ☐ PCP ☐ Specialist ☐ Ancillary		Date of Review:
Address:		Name of Reviewer:
City:		Health Plan Name:
Phone:	FAX:	Contact Person Name:
		<i>Level of Access:</i>
<u>Basic Access:</u> Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.		☐ Basic Access
<u>Limited Access:</u> Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.		☐ Limited Access
<u>Medical Equipment Access:</u> PCP site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to level of Basic or Limited Access as appropriate.		☐ Medical Equipment is available

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at a provider office/site. These should also be used in online directories. In order for a provider office to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first six symbols (P, EB, IB, R, and E). And a provider who has Medical Equipment Access will meet the medical equipment elements for the last symbol (T).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 3, 7, 8, 11				
EB - EXTERIOR BUILDING	(CE): 14, 20, 22, 23 25, 27, 28, 31				
IB = INTERIOR BUILDING	(CE): 31, 34, 37 If lift include: 40 If elevators include: 53, 54, 55, 56, 57, 58				
R=RESTROOM	(CE): 65, 67, 68, 71, 75, 77				
E=EXAM ROOM	(CE): 80, 85				
T = EXAM TABLE/SCALE	Medical Equipment Elements (ME): 81, 82, 86				

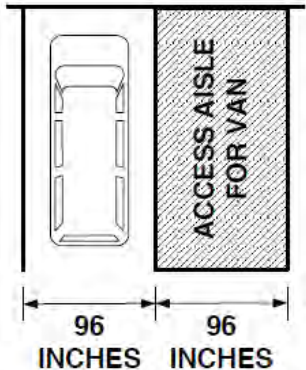
I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

I certify that there have been no changes since the last physical accessibility review:

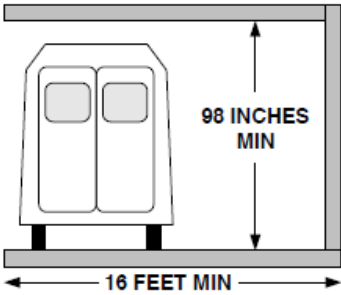
Name: _____ Signature: _____ Date: _____

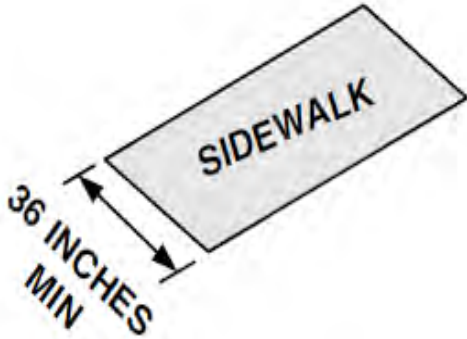
PARKING						
1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	Are the correct number of accessible parking spaces provided? 1 to 25 total spaces – 1 required 26 to 50 – 2 required 51 to 75 – 3 required 76 to 100 – 4 required 101 to 150 – 5 required 151 to 200 – 6 required 201 to 300 – 7 required 301 to 400 – 8 required	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				

4	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				
5	Is there an access aisle next to the accessible space(s)?	The access aisle is the space next to the accessible parking space where a person using the accessible space can load and unload from the vehicle.  The diagram shows a top-down view of a parking space. On the left is a car icon within a rectangular space. Below this space is a dimension line labeled '96 INCHES'. To the right of the car space is a shaded rectangular area labeled 'ACCESS AISLE FOR VAN'. Below this shaded area is another dimension line labeled '96 INCHES'.				
6	Is the parking space(s) and access aisle(s) free of curb ramps that extend into the space and other obstructions?	If a curb ramp extends into the parking space(s) or access aisle, a person using that space and aisle would not have adequate level space to unload and load from the vehicle.				

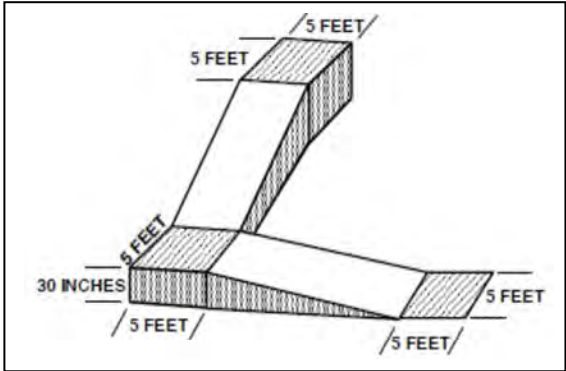
7 (CE)	Do curbs on the route from off-street public parking have curb ramps at the parking locations?	Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.				
8 (CE)	Do curbs on the route from off-street public parking have curb ramps at the drop off locations?	See above Question # 7.				
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility.  6				

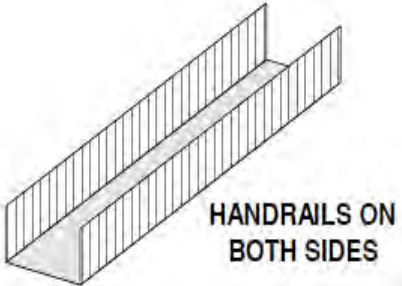
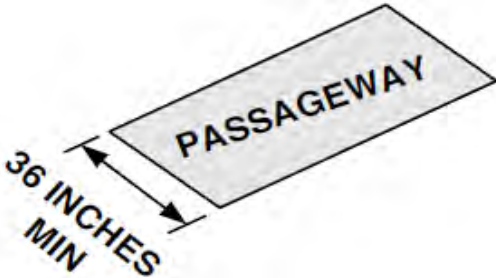
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				
11 (CE)	Is VAN accessible parking provided?	1 van space for every 6 standard accessible spaces must be provided, but never less than one. For example, if there are 23 total spaces, at least one accessible space is required and it must be large enough (See Question # 5 for dimensions) to accommodate a van. If there are 201 total parking spaces, at least seven accessible spaces would be required and two of those would have to accommodate vans.				
12	Is VAN accessible parking signage provided?	Signs must be mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle.				

13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should be at a minimum 8 feet 2 inches (98 inches). Vertical clearance should be posted. 				
EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)						
14 (CE)	For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)	Self explanatory.				
	a. Parking?					
	b. Public transportation?					

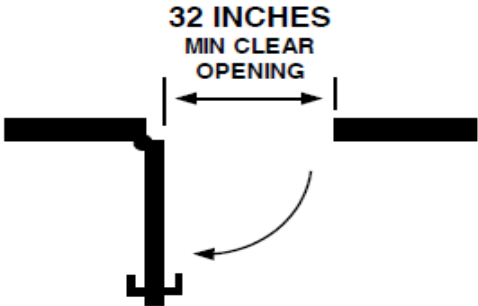
	c. Public sidewalk?							
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)							
	a. Parking?							
	b. Public transportation?							
	c. Public sidewalk?							
16	Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.						
	a. Parking?							

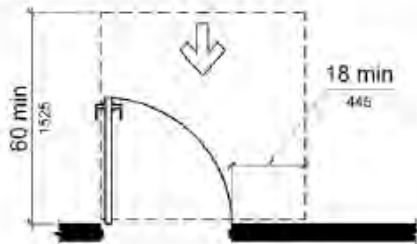
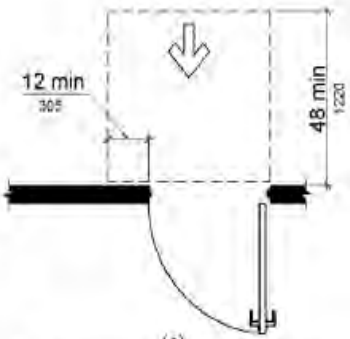
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				
18	Is the route to the entrance from the accessible parking spaces, including transitions at curb ramps, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				
RAMPS:						
19	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				

20 (CE)	Is each run (leg) of the ramp no longer than 30 feet between landings?	Each “run,” shown in the white sections in the diagram below, must be no longer than 30 feet. 				
21	Are 60 inches (5 feet) long, level landings provided at the top and bottom of each ramp run?	See Question 20 diagram above.				

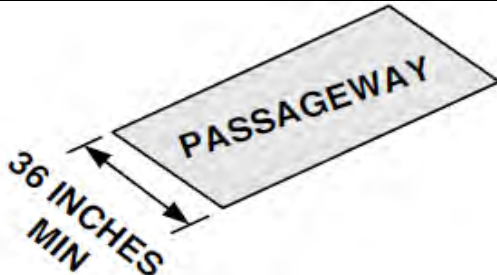
22 (CE)	Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?	If the ramp is not longer than 6 feet, check NA. 				
23 (CE)	Are all ramps at least 36 inches wide?					

BUILDING ENTRANCE						
24	Is the main entrance accessible?	Self explanatory.				
25 (CE)	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
26	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					

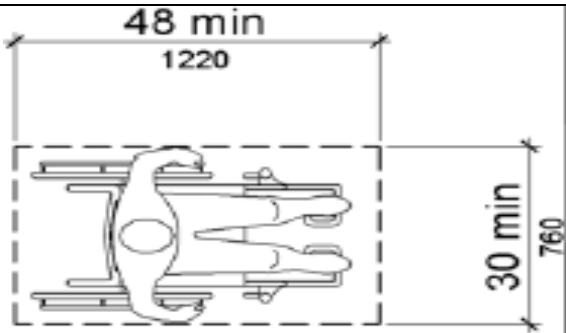
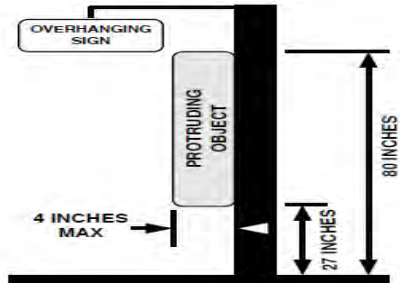
27 (CE)	Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?	When measuring double doors, measure the opening with one door open to 90°.  32 INCHES MIN CLEAR OPENING				
28 (CE)	Is space available for a wheelchair user to approach, maneuver, and open the door?	Appropriate space perpendicular and parallel to a doorway permits a wheelchair user, people using walkers and other mobility devices to open the door safely and independently. Following are two common examples of required minimum maneuvering clearances: 1. Approaching the door and pulling it toward you to open requires 60 inches of clear space perpendicular to the doorway and 18 inches parallel to the doorway. 2. Approaching the door and pushing it away from you to open requires 48 inches of clear space perpendicular to the doorway.				

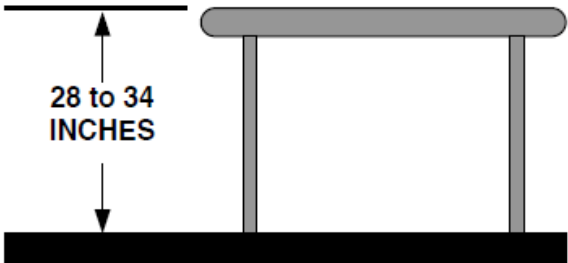
		 (a) front approach, pull side  (c) front approach, push side, door provided with both closer and latch				
29	Is the space required to open the door level and clear of movable objects (chairs, trash cans, etc.)?	If there are nonpermanent items such as trash cans, merchandise, etc., located in these areas, they must be removed or relocated.				

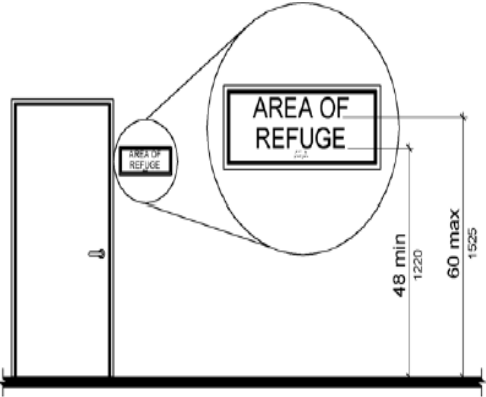
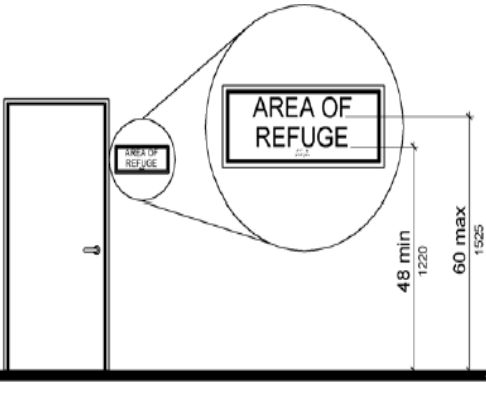
30	Are there automatic doors?	Self explanatory.				
31 (CE)	Do entrance doors have handles that can be opened without grasping, pinching, or twisting of the wrist?	Can the door be opened by someone with a closed fist or fully open hand? Door knobs, for example, cannot be used in this manner.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE TO THE CLINIC/OFFICE ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH THE CLINIC/OFFICE TO AREAS THAT PATIENTS COULD GO)						
32	Is there an interior route to the medical office?	Some medical offices are accessed directly from the street or parking lot rather than being located within a larger office building or complex, therefore they do not have interior routes.				

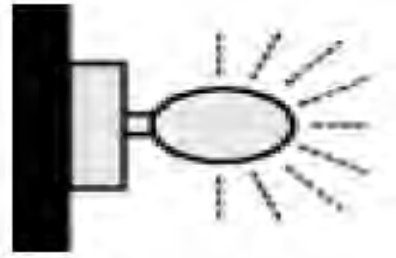
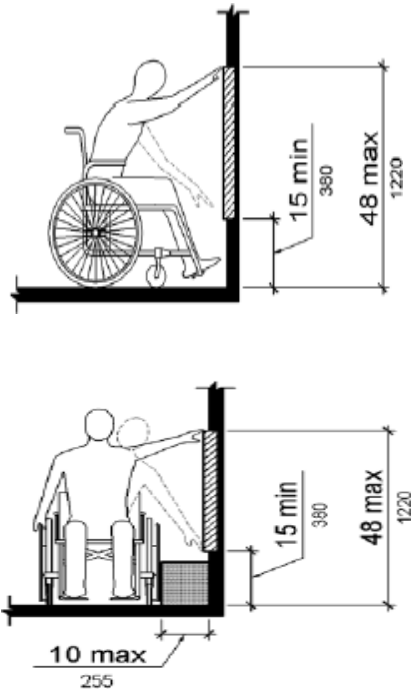
33	Is there an interior accessible route to the medical office that does not include stairs or steps?	Floors of a given story are level throughout the building, or connected by ramps, passenger elevators or access lifts.				
34 (CE)	Are <u>ALL</u> interior paths of travel at least 36 inches wide?					
35	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				
36	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				

37 (CE)	If there are stairs on the accessible route, are there handrails on each side?	If there are no stairs, check NA.				
38	If there are stairs, are all stairs risers closed that are on the accessible route?					
39	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				
40 (CE)	If a platform lift is used, can it be used without assistance?	If there is no platform lift, check NA. Lifts sometimes require a key for operation, thus preventing independent use.				

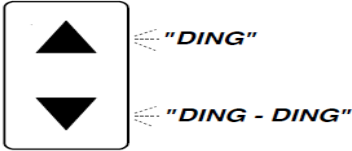
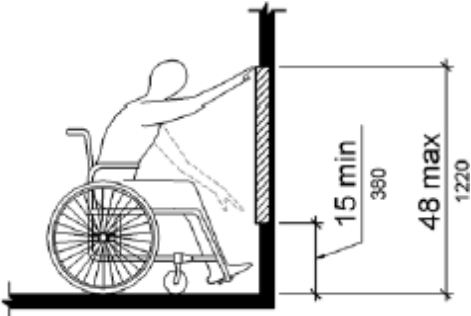
41	Does the interior door to the medical office require less than 5 pounds of pressure to open?	If interior door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
42	Is there a clear space 30 inches wide by 48 inches long in the waiting area(s) for a wheelchair or scooter user to park that is not in the path of travel?					
43	Is the path through the medical office free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it. 				

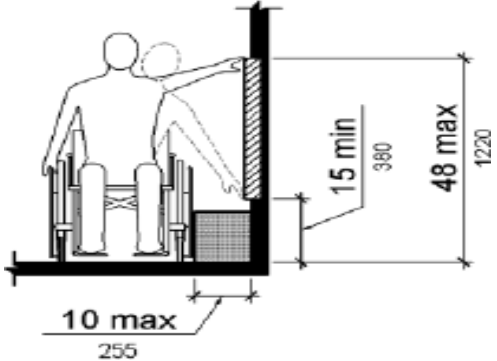
44	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
45	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.	 The diagram shows a cross-section of a counter. A horizontal line at the top represents the counter surface. Below it, two vertical lines represent the counter's legs. A double-headed vertical arrow is positioned to the left of the counter, indicating the height from the floor to the top surface. The text '28 to 34 INCHES' is written next to the arrow.				
46	Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.)	A medical office may use reasonable alternative methods to meet this need such as a clip board.				

47	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
48	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

49	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and each room where patients are seen?	If the building does not have a fire alarm system, check NA. 				
50	Are all patient-operated controls (call buttons, self-service literature, brochures, hand sanitizers, etc.) mounted or presented between 15 inches and 48 inches from the floor?					

51	Are all patient operated controls (e.g., call buttons, hand sanitizers) operable with one hand without grasping, pinching, or twisting to operate?	For example, a pump hand sanitizer that must be operated using two hands is inaccessible.				
ELEVATORS						
52	Is there an elevator?					
53 (CE)	If needed, is the elevator available for public/patient use during business hours?	Self explanatory.				

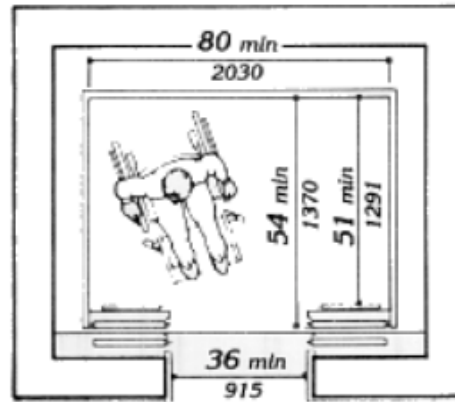
54 (CE)	Is the elevator equipped with both visible and audible door opening/closing and floor indicators?	A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement. 				
55 (CE)	Is there a raised letter and Braille sign on each side of each elevator jamb?	These signs allow everyone to know which floor they are on before entering or exiting the elevator.				
56 (CE)	Are the hall call buttons for the elevator no higher than 48 inches from the floor?					

		 Technical diagram showing a person in a wheelchair and a person standing next to a wall. Dimensions are indicated: 10 max (width of the wheelchair) 255 (width of the wheelchair) 15 min (clearance from the wall to the wheelchair) 380 (width of the wheelchair) 48 max (height of the wall) 1220 (height of the wall)				

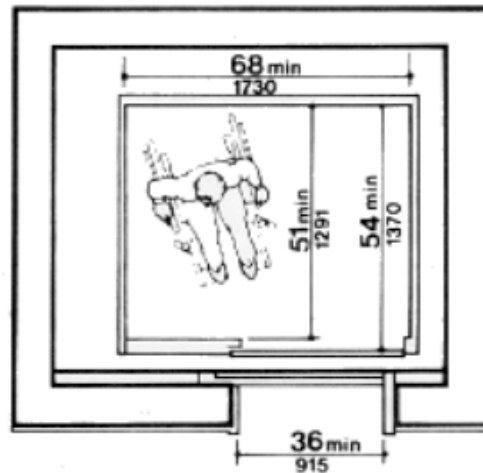
57
(CE)

Is the elevator car large enough
for a wheelchair or scooter user
to enter, turn to reach the
controls, and exit?

The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.

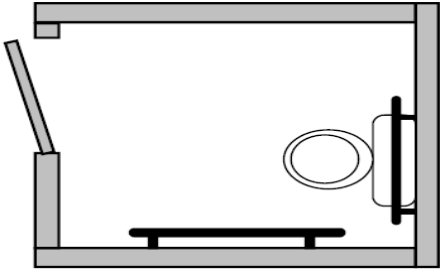
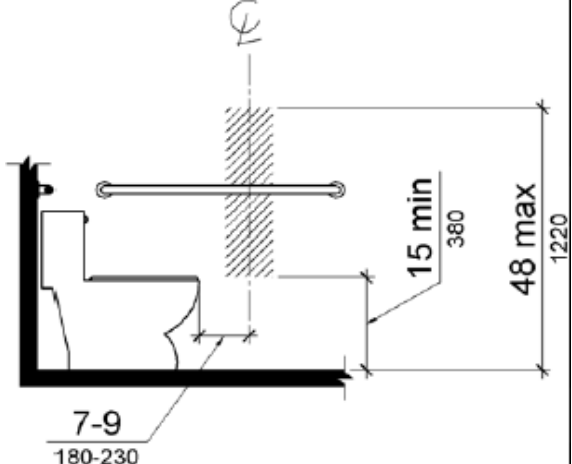


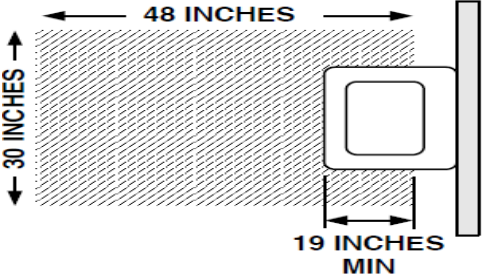
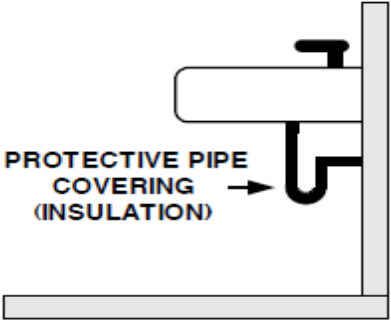
(a)

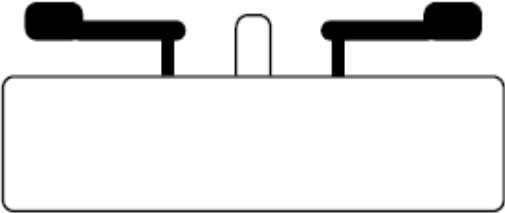


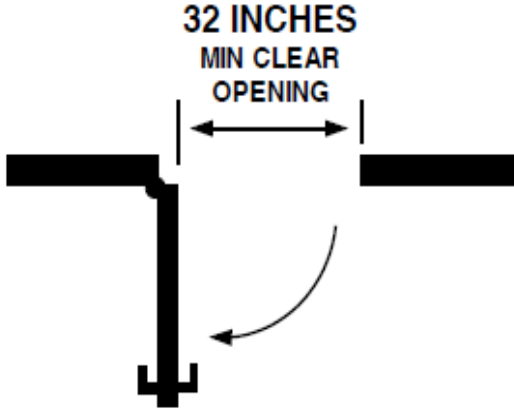
58 (CE)	Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?	Self explanatory.				
59	Is there an emergency communication system in the elevator?	Self explanatory.				
60	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				

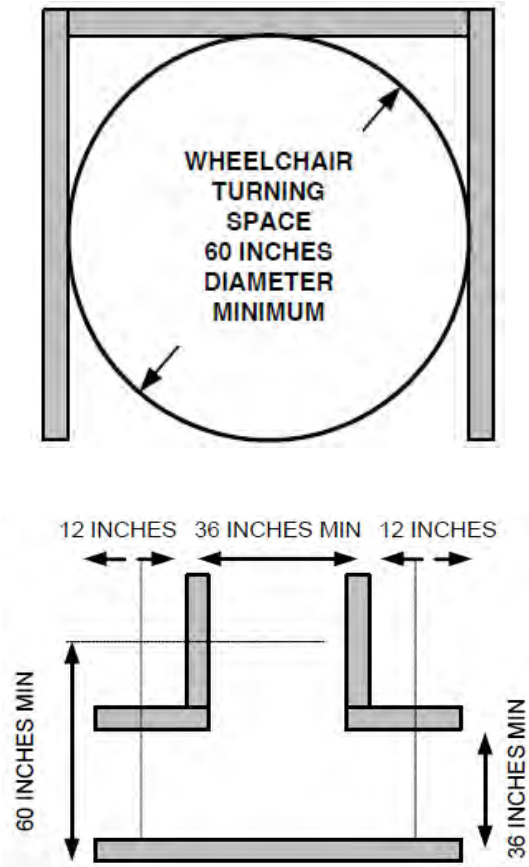
61	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				
TOILET ROOMS (INCLUDING THOSE USED FOR SPECIMEN COLLECTION)						
ALL TOILET ROOMS:						
62	Is there an accessible toilet room?	Self explanatory.				
63	If there is an inaccessible toilet room, is there directional signage to an accessible toilet room?	Mark NA if there are no inaccessible toilet rooms. Self explanatory.				
64	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the				

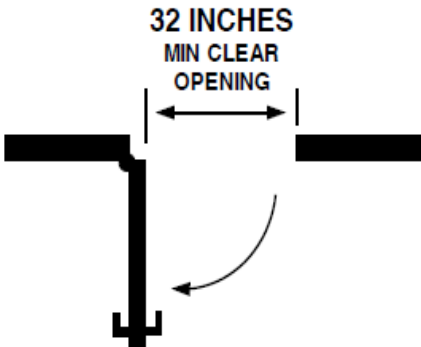
		weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
65 (CE)	For all toilet rooms with and without stalls: Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?	Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface. 				
66	Are all objects mounted at least 12 inches above and 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				
67 (CE)	Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?					

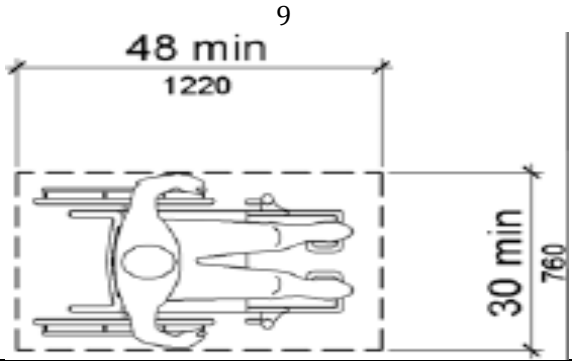
68 (CE)	Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?	This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath. 				
69	Is the space in front of the sink free of trash cans and other movable items?	Self explanatory.				
70	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
71 (CE)	Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)	A knob handle would not be accessible.				

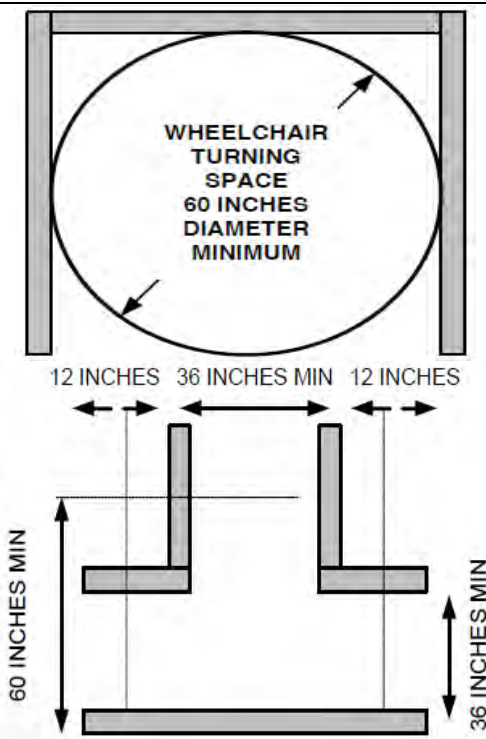
		LEVER HANDLES 				
72	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
73	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				
74	If there is a pass-through door for specimen collection, is there a 30 inches by 48 inches space for a wheelchair or scooter user to park in front of it?	If there is no such door, check NA.				

TOILET ROOM WITHOUT STALLS						
75 (CE)	<i>Toilet room without stalls:</i> Do toilet room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?	If there is no toilet room without stalls, check NA. 				
76	Is the space inside the toilet room without stalls clear, without trash cans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

TOILET ROOM WITH STALLS					
77 (CE)	<i>Toilet Room with stalls:</i> Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the toilet room with stalls to allow a turn around for wheelchair and scooter users?	If there is no toilet room with stalls, check NA.			
		 The diagram consists of two parts. The top part shows a circular area with a diameter of 60 inches, labeled 'WHEELCHAIR TURNING SPACE 60 INCHES DIAMETER MINIMUM'. The bottom part shows a 'T'-shaped space with a width of 36 inches minimum and a depth of 60 inches minimum. The horizontal bars of the 'T' are 12 inches wide on each side of the central 36-inch section. The vertical bar of the 'T' is 36 inches wide and 60 inches deep. The overall width of the 'T' shape is 60 inches (12 + 36 + 12).			

78	Is the space inside the accessible stall clear, without trash cans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				
79	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
EXAM/TREATMENT ROOMS/MEDICAL EQUIPMENT						
80 (CE)	Do exam room doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?					

81 (ME)	Is there a height adjustable exam table that lowers to between 17 inches and 19 inches from the floor to the top of the cushion?	Self explanatory				
82 (ME)	Is there space next to the height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table?					
83	Does the exam table provide elements to assist during a transfer (such as rails) and support a person while on the table? (If yes, please list in comments.)	Items that could help support a patient while on the table would be armrests, side rails, padded straps, cushions, wedges, etc.				

84	Is a lift available to assist staff with transfers (portable, overhead, or ceiling mounted)?	Self explanatory.				
85 (CE)	Is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space so that a wheelchair or scooter user can make a 180° turn?	 The diagram illustrates the required clearances for wheelchair maneuverability. At the top, a circular area is labeled 'WHEELCHAIR TURNING SPACE 60 INCHES DIAMETER MINIMUM'. Below this, a 'T'-shaped space is shown with specific dimensions: the horizontal base is '36 INCHES MIN' wide, and the vertical stem is '60 INCHES MIN' high. The clearances on either side of the stem are each '12 INCHES'. The width of the base is also indicated as '36 INCHES MIN'.				

86 (ME)	Is a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient?	Accessible scales are usable by all people including: wheelchair users, people with activity limitations, and larger people who may exceed a standard weight scale limit. This includes people with conditions that interfere with mobility, walking, climbing, using steps (joint pain, short stature, pregnancy, fatigue, respiratory and cardiac conditions, post surgical conditions, orthopedic injuries); and/or who use mobility devices (e.g. canes, crutches, walkers).				

References

2010 ADA Standards for Accessible Design

U.S Department of Justice

http://www.ada.gov/2010ADASTandards_index.htm

The revised regulations for Titles II and III of the Americans with Disabilities Act of 1990 (ADA) were published in the Federal Register on September 15, 2010. They provide the scoping and technical requirements for new construction and alterations resulting from the adoption of revised 2010 Standards in the final rules for Title II (28 CFR part 35) and Title III (28 CFR part 36). The 2010 ADA Standards go into effect March 15, 2012, but can be used now instead of the 1991 standards. The FSR Attachment C draws upon access requirements found in both the 1991 Americans with Disabilities Act Accessibility Guidelines and the 2010 ADA Standards. Some diagrams that appear in the FSR Attachment C are reproduced from these sources.

Two questions in the FSR Attachment C were drawn from Title 24, Part 2 of the California Building Standards Code. These are

1133B.4.4 – Striping for the visually impaired (Rev.1-1-2009), and 1115B-1 – Bathing and Toilet Facilities, placement of toilet paper dispensers. These standards can be found in:

2009 California Building Standards Code with California Errata and Amendments

State of California

Department of General Services

Division of the State Architect

Updated April 27, 2010

http://www.documents.dgs.ca.gov/dsa/pubs/access_manual_rev_04-27-10.pdf

Some diagrams are reprinted with permission from the Kentucky Department of Vocational Rehabilitation. These illustrations can also be found in:

“Health Care Usability Profile V3”

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Oregon Health & Science University RRTC: Health & Wellness

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healthwellness.org

Ancillary Services Physical Accessibility Review Survey

California Department of Health Care Services
Managed Care Quality and Monitoring Division

For purposes of this tool, Ancillary Services refers to Diagnostic and Therapeutic services such as, but not limited to: Radiology, Imaging, Cardiac Testing, Kidney dialysis, Physical Therapy, Occupational therapy, Speech therapy, Cardiac rehabilitation, Pulmonary testing.

Provider Name: _____		Date of Review:
☐ Radiology ☐ Infusion ☐ Physical Therapy ☐ Other _____		Name of Reviewer:
Address:		Health Plan Name:
City:		
Phone:	FAX:	Contact Person Name:
		<i>Level of Access:</i>
<u>Basic Access:</u> Demonstrates ancillary facility site access for the members with disabilities to parking, building, elevator, restroom, diagnostic and treatment use. To meet Basic Access requirements, all (34) Critical Elements (CE) must be met.		☐ Basic Access
<u>Limited Access:</u> Demonstrates ancillary facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, restroom, diagnostic and treatment use. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.		☐ Limited Access
<u>Medical Equipment:</u> Diagnostic and treatment equipment meet accessibility features for use as indicated the “accessibility indicators”. (assistance is available for the equipment used).		☐ Medical Equipment is available ☐ List of Equipment

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at the ancillary site. These should also be used in online directories. In order for an ancillary site to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first 5 symbols (P, EB, IB, R, PD).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 3,7,8,11				
EB = EXTERIOR BUILDING	(CE): 14,20,21,22,25				
IB = INTERIOR BUILDING	(CE): 28,31,42,43,44,45,46,47				
R =RESTROOM	(CE): 53, 55,56,59,62,64				
PD = PATIENT DIAGNOSTIC AND TREATMENT USE	(CE): 66,67,70,76,78				
T = MEDICAL EQUIPMENT	(T): 72,73,74,77,80,81				

2nd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

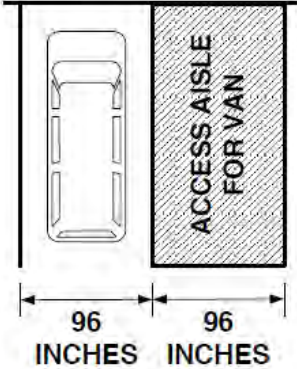
Name: _____ Signature: _____ Date: _____

3rd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

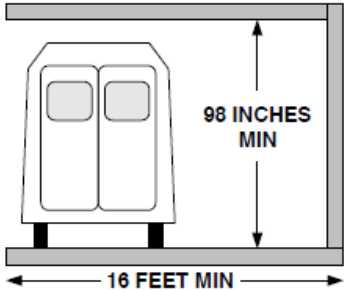
PARKING

1	Is off-street public parking available?	Self explanatory.				
2	Are accessible parking spaces provided in off-street parking?	Self explanatory.				
3 (CE)	Are the correct number of accessible parking spaces provided? 1 to 25 total spaces – 1 required 26 to 50 – 2 required 51 to 75 – 3 required 76 to 100 – 4 required 101 to 150 – 5 required 151 to 200 – 6 required 201 to 300 – 7 required 301 to 400 – 8 required	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				
4	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				

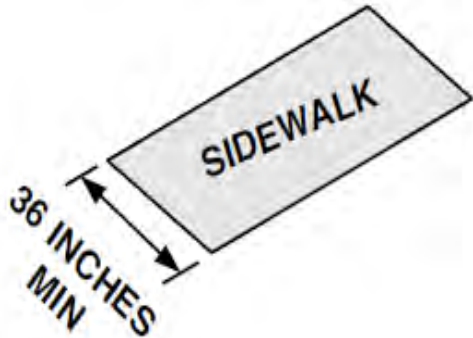
5	Is there an access aisle next to the accessible space(s)?	The access aisle is the space next to the accessible parking space where a person using the accessible space can load and unload from the vehicle.  The diagram shows a top-down view of a van and an adjacent access aisle. The van is represented by a rectangle with an interior outline. Below the van, a dimension line indicates a width of 96 INCHES. To the right of the van is a shaded rectangular area labeled 'ACCESS AISLE FOR VAN' in vertical text. Below this shaded area, another dimension line indicates a width of 96 INCHES.				
6	Is the parking space(s) and access aisle(s) free of curb ramps that extend into the space and other obstructions?	If a curb ramp extends into the parking space(s) or access aisle, a person using that space and aisle would not have adequate level space to unload and load from the vehicle.				

7 (CE)	Do curbs on the route from off-street public parking have curb ramps at the parking locations?	Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.				
8 (CE)	Do curbs on the route from off-street public parking have curb ramps at the drop off locations?	See above Question # 7.				

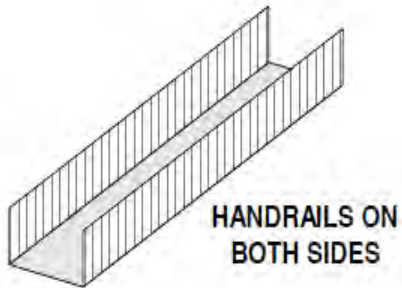
9	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
10	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				
	Is VAN accessible parking provided?	1 van space for every 6 standard accessible spaces must be provided, but never less than one. For example, if there are 23 total spaces, at least one accessible space is required and it must be large enough (See Question # 5 for dimensions) to accommodate a van. If there are 201 total parking spaces, at least seven accessible spaces would be required and two of those would have to accommodate vans.				
12	Is VAN accessible parking signage provided?	Signs must be mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle.				

13	If van accessible parking is provided in a parking garage, is there at least 8 feet 2 inches (98 inches total) vertical clearance available for full-sized, lift equipped vans?	If there is no parking garage, check NA. If designated accessible parking is located in a garage, the vertical clearance should be at a minimum 8 feet 2 inches (98 inches). Vertical clearance should be posted.  The diagram shows a top-down view of a van with two doors parked in a rectangular space. A horizontal double-headed arrow below the van indicates a width of '16 FEET MIN'. A vertical double-headed arrow to the right of the van indicates a height of '98 INCHES MIN' from the ground to the ceiling.				

EXTERIOR ROUTE (FROM ACCESSIBLE PARKING, PUBLIC TRANSPORTATION, AND PUBLIC SIDEWALK TO THE ENTRANCE)

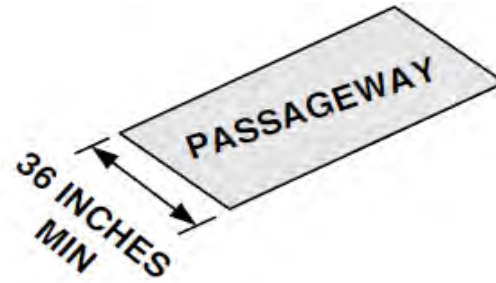
14 (CE)	For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)	Self explanatory.				
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
15	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)	 The diagram shows a rectangular area labeled "SIDEWALK". To the left of the rectangle, there is a double-headed arrow indicating a width, with the text "36 INCHES MIN" written vertically next to it.				

	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
16	Is the accessible route to the building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	An example of a stable surface is a floor or ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.				
	a. Parking?					
	b. Public transportation?					
	c. Public sidewalk?					
17	Is there an accessible route that does not include stairs or steps?	Self explanatory.				

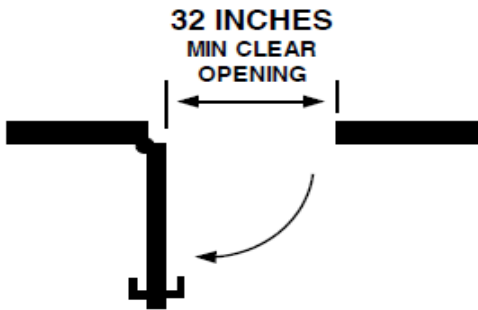
18	Is the route to the entrance from the accessible parking spaces, including transitions at curb ramps, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.				
RAMPS:						
19	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				
20 (CE)	Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?	If the ramp is not longer than 6 feet, check NA.  HANDRAILS ON BOTH SIDES				

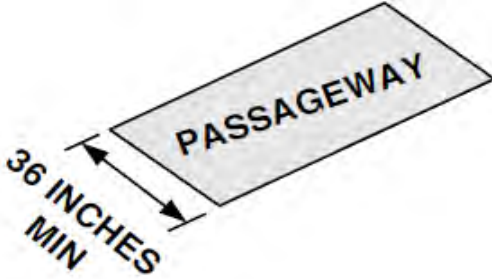
21
(CE)

Are all ramps at least 36 inches wide?

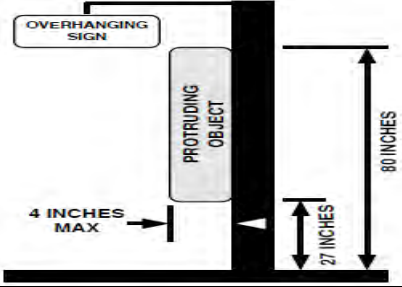
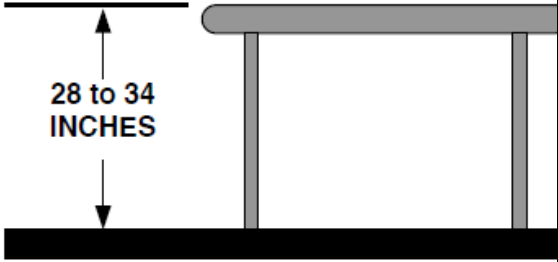


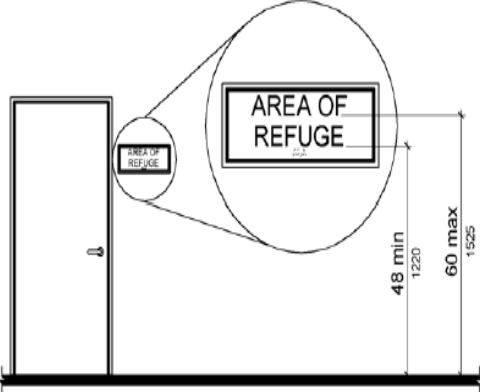
BUILDING ENTRANCE

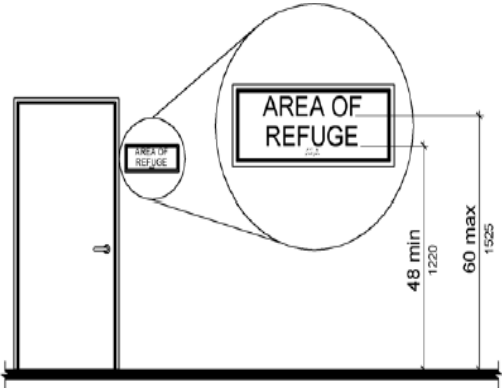
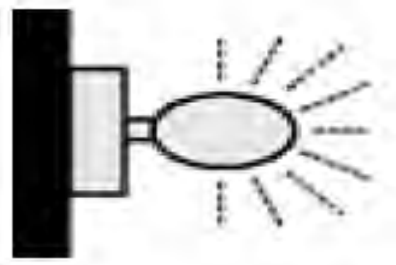
22 CE	Is the main entrance accessible?	Self explanatory.				
23	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
24	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					
25 (CE)	Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?	When measuring double doors, measure the opening with one door open to 90°. 				

26	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
27	Is there an interior route to the patient area?	Some patient areas are accessed directly from the street or drop off rather than being located within a larger building or complex, therefore they do not have interior routes.				
	Are <u>ALL</u> interior paths of travel at least 36 inches wide?					
29	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				

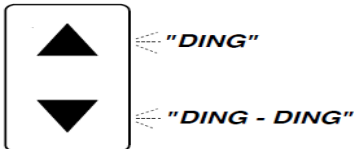
30	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
31 (CE)	If there are stairs on the accessible route, are there handrails on each side?	If there are no stairs, check NA.				
32	If there are stairs, are all stair risers closed that are on the accessible route?					
33	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				

34	Is the path through the facility free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it. 				
35	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
36	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items?					

37	Does the office have a method, other than a lowered counter, by which people can sign in/register? (If yes, please note this method in comments.)	A medical office may use reasonable alternative methods to meet this need such as a clip board.				
38	Do signs identifying permanent rooms and spaces include raised letters and Braille?					

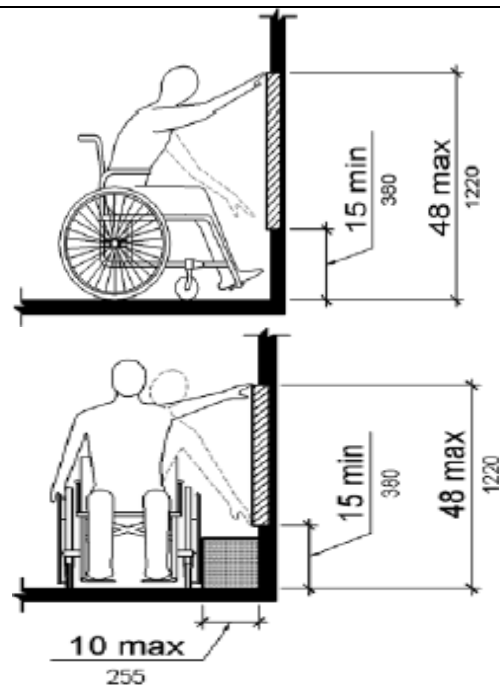
39	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				
40	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and Participant Areas?	If the building does not have a fire alarm system, check NA. 				

ELEVATORS

41	Is there an elevator?	Self explanatory.				
42 (CE)	If needed, is the elevator available for public/patient use during business hours?	Self explanatory.				
43 (CE)	Is the elevator equipped with both visible and audible door opening/closing and floor indicators?	A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement. 				
44 (CE)	Is there a raised letter and Braille sign on each side of each elevator jamb?	These signs allow everyone to know which floor they are on before entering or exiting the elevator.				

45
(CE)

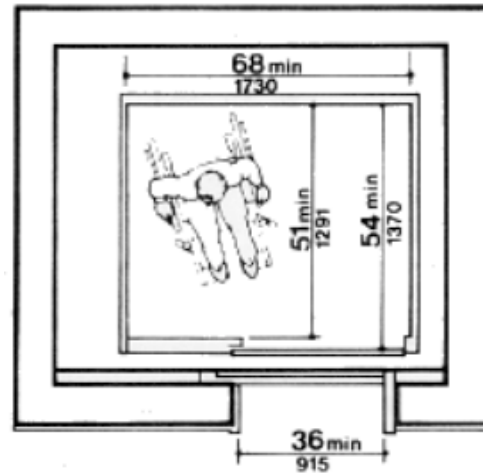
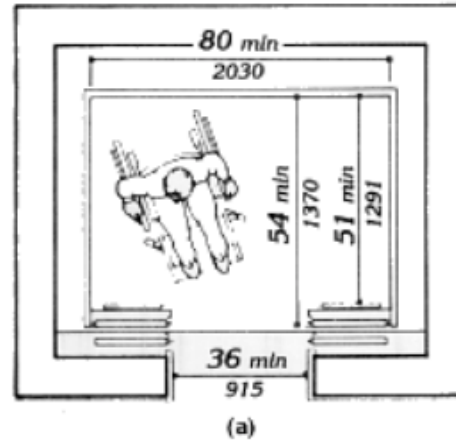
Are the hall call buttons for the elevator no higher than 48 inches from the floor?



46
(CE)

Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?

The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.

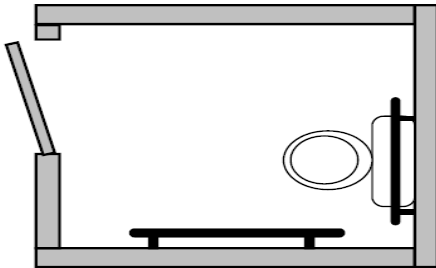


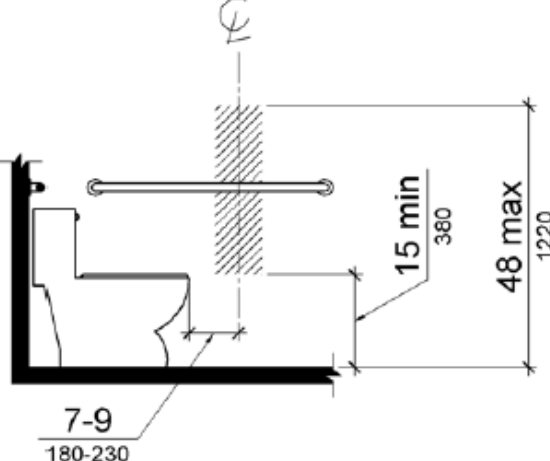
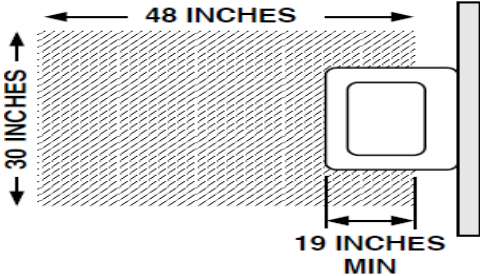
Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?

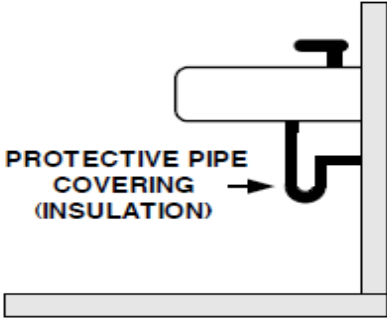
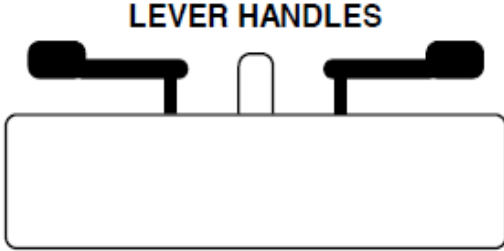
Self explanatory.

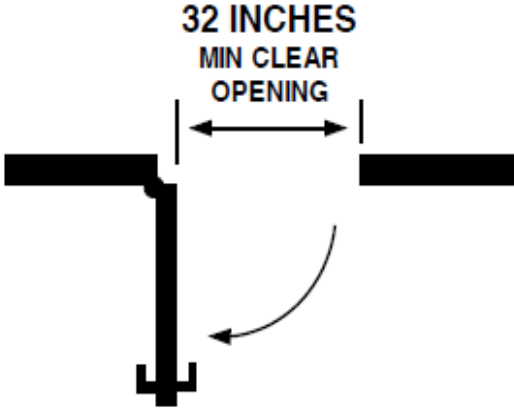
48	Is there an emergency communication system in the elevator?	Self explanatory.				
49	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				
50	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				

ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):

51	Is there an accessible restroom/toilet room?	Self explanatory.				
52	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
53 (CE)	Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?	Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface. 				
54	Are all objects mounted at least 12 inches above and 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				

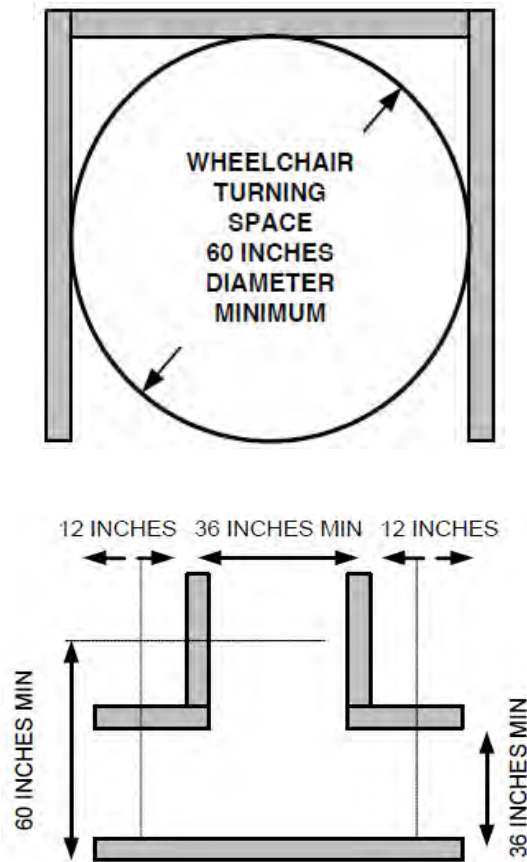
55 (CE)	Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?					
56 (CE)	Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?	This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath. 				
57	Is the space in front of the sink free of trashcans and other movable items?	Self explanatory.				

58	Are the pipes and water supply lines under the sink wrapped with a protective cover?					
59 (CE)	Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)	A knob handle would not be accessible. LEVER HANDLES 				
60	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
61	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				

62 (CE)	Do restroom doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?					
63	Is the space inside the restroom clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

64
(CE)

Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the restroom to allow a turn around for wheelchair and scooter users?

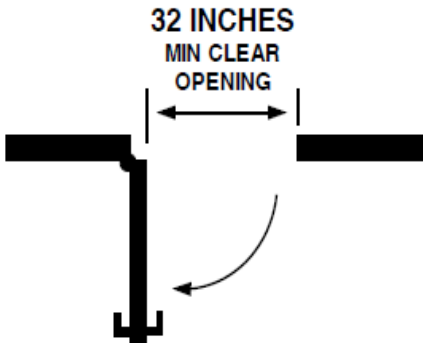
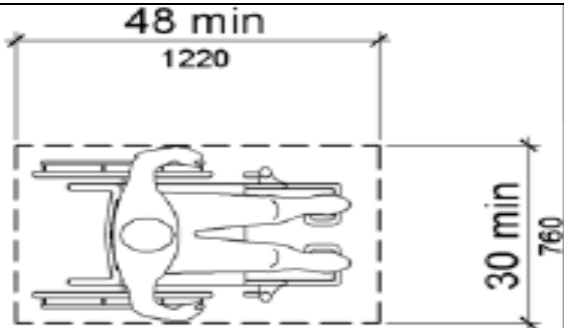


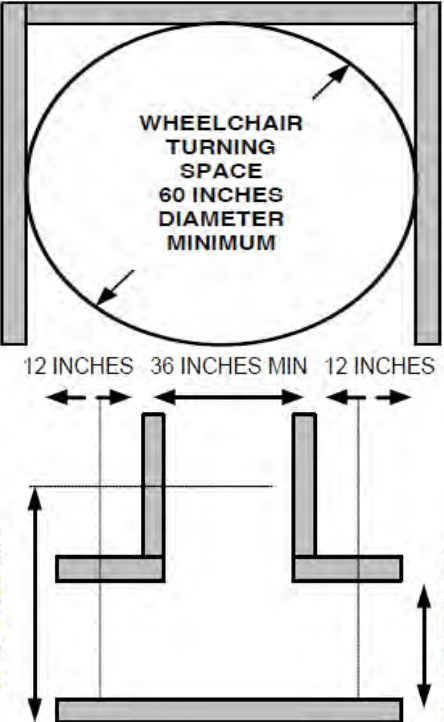
65

Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?

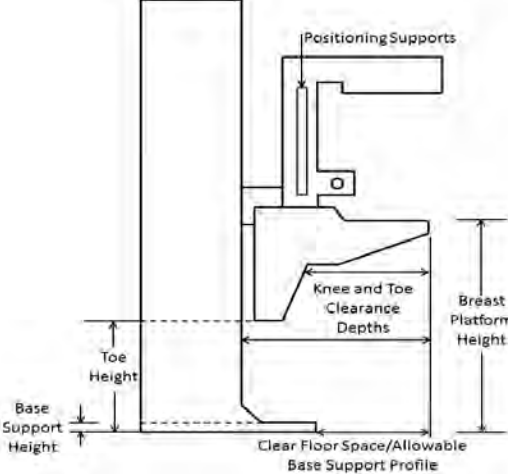
Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.

PATIENT AREAS (DIAGNOSTIC & TREATMENT, ROOMS)

	Do doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?	 32 INCHES MIN CLEAR OPENING				
	Is there space next to the equipment for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto following?	 48 in 1220 30 in 760				
	a. Equipment (such as PT)?					
	b. Diagnostic apparatus?					
	c. Patient activity areas (such as OT, dining)?					
	d. Infusion (chairs, beds for chemo, dialysis)?					

68	Patient Dressing Rooms are accessible (all bullet points need to be present) • Doorways are at least 32 inches • Turning Radius is 60x60 inches • Seating 17-19 inches from the floor • Grab bars	If there are reasonable alternative for dressing room accommodations, this measure is met.				
69	In the diagnostic/treatment area, is there a 60 inch diameter turning circle or a 60 inch x 60 inch "T" shaped space so that a wheelchair or scooter user can make a 180° turn?	 WHEELCHAIR TURNING SPACE 60 INCHES DIAMETER MINIMUM 12 INCHES 36 INCHES MIN 12 INCHES 60 INCHES MIN 36 INCHES MIN				
70 (CE)	If any diagnostic equipment or treatment tables/chairs are used, is there a patient pre-assessment process (i.e. phone, prior to appointment) to verify that the necessary services can be provided?	Self explanatory.				

71	Does the Diagnostic Table have a weight limit?	Document weight limit : ☐ MRI _____ ☐ CT _____ ☐ Fluoroscopy _____ ☐ PET _____ ☐ Bone Density/Dexascan _____ ☐ Ultrasound _____ ☐ Nuclear Medicine _____ ☐ Xray _____ ☐ _____ ☐ _____				
72 (T)	Is there height adjustable equipment (chairs and tables) that lowers between 17 inches and 19 inches from the floor to the top of the cushion?	Score each appropriate equipment that do or do not lower 17 to 19 inches from the floor to the top of the cushion:				
	a. MRI					
	b. CT					
	c. Fluoroscopy					
	d. PET					
	e. Bone Density/Dexascan					
	f. Ultrasound					
	g. Nuclear Medicine					
	h. Xray					
	i. Physical Therapy Table					
	j. Dialysis Chair					
	k. Other					
	l. Other					
73 (T)	Mammography machine can accommodate wheelchair users with knee and foot clearance under the breast plate allowing technologist to take quality	The top of breast platform needs to go to 26 inches above the floor to accommodate an individual seated in a wheelchair.				

	images.					
74 (T)	A Mammography chair is available for patients who must be seated. <i>Example: persons with balance difficulties, or cannot stand for any length of time.</i>	The chair's footrests must accommodate and ride over the base support.				
75	Are transfer and positioning supports available?	Examples include: Positioning supports while on the equipment as pillows, wedges, strapping, transfer supports Please list elements in comments.				
76 (CE)	Does staff provide patient transfer assistance on and off of equipment (this includes use of lift equipment when needed).	Self Explanatory				

77 (T)	Is lift equipment available to assist staff with transfers (portable, overhead, or ceiling mounted)?	Self Explanatory				
78 (CE)	Is staff trained yearly on safe transfer techniques?	Self explanatory				

WEIGHT MEASUREMENT

79	Are patients normally weighed at this provider site?	Self explanatory				
80 (T)	Is a weight scale available that can be used by a wheelchair or scooter user, obese patients whose weight exceeds the weight limits for standard scales, and for patients that cannot step onto a standard scale?	Accessible scale platform dimensions-should be a minimum of 32x 36 inches				
81 (T)	If there is no accessible scale, are other methods to weigh the patient in place?	Examples of other methods to weigh the patient are: weight scales integrated into examination tables, chairs, stretchers, and lifts, or an accessible scale located in a nearby office, within the same building.				

Community Based Adult Services (CBAS) Physical Accessibility Review Survey

California Department of Health Care Services
Managed Care Quality and Monitoring Division

Provider Name: ☒ CBAS ☐ Other		Date of Review:
		Name of Reviewer:
Address:		Health Plan Name: Partnership HealthPlan of CA
City:		
Phone:	FAX:	Contact Person Name:
(		
		<i>Level of Access:</i>
<u>Basic Access:</u> Demonstrates facility site access for the members with disabilities to parking, building, elevator, Participant Areas, and restroom. To meet Basic Access requirements, all (24) Critical Elements (CE) must be met.		☐ Basic Access
<u>Limited Access:</u> Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, participant areas, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.		☐ Limited Access

Below are the symbols that will be used in the provider directories to indicate areas of accessibility at a provider office/site. These should also be used in online directories. In order for a provider office to receive a symbol, the appropriate criteria must be met.

These symbols are in addition to identifying whether the provider office has Basic Access or Limited Access. A provider who has Basic Access will automatically meet the critical elements for the first six symbols (P, EB, IB, R, PA,). And a provider who has Medical Equipment Access will meet the medical equipment elements for the last symbol (T).

Accessibility Indicator	Must Satisfy these Criteria	Yes	No	N/A	Comments
P = PARKING	Critical Elements (CE): 6,7,8				
EB = EXTERIOR BUILDING	(CE): 9,15,16,17,20				
IB = INTERIOR BUILDING	(CE): 23,26,36,37,38,39,40,41				
R=RESTROOM	(CE): 47,49,50,53,56,58				
PA= PARTICIPANT AREAS	(CE): 60,61				

2nd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

Name: _____ Signature: _____ Date: _____

3rd Periodic PARS Review: I certify that there have been no changes since the last physical accessibility review:

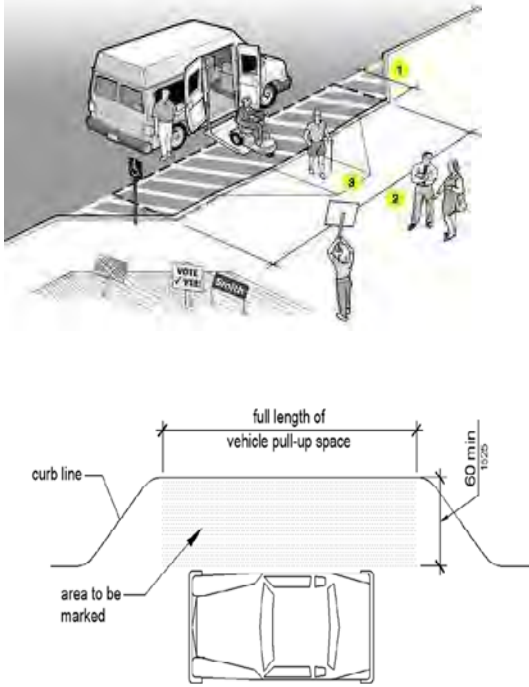
Name: _____ Signature: _____ Date: _____

PARKING

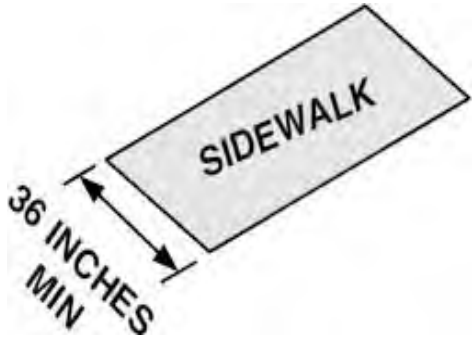
1	Are accessible parking spaces provided in the designated parking area?	Self explanatory.				
2	Are the correct number of accessible parking spaces provided? 1 to 25 total spaces – 1 required 26 to 50 – 2 required 51 to 75 – 3 required 76 to 100 – 4 required 101 to 150 – 5 required 151 to 200 – 6 required 201 to 300 – 7 required 301 to 400 – 8 required	If there are 25 total parking spaces or less, at least one accessible space is required. If there are between 26 and 50 total spaces, at least two accessible spaces are required, etc.				
3	Is the accessible parking space(s) closest to the main entrance?	The accessible parking space (s) should afford the shortest route of travel from adjacent parking to the accessible entrance.				

4	Does every accessible parking space have a vertical sign posted with the International Symbol of Accessibility?	Symbol in the illustration depicts the International Symbol of Accessibility. 				
5	Are signs mounted a minimum of 60 inches above the ground surface so that they can be seen over a parked vehicle?	Signs must be located so a vehicle parked in the space does not obscure them. (Van accessible spaces must be indicated with an additional sign)				

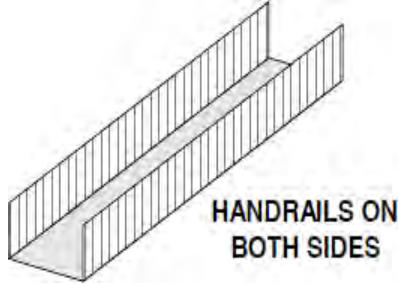
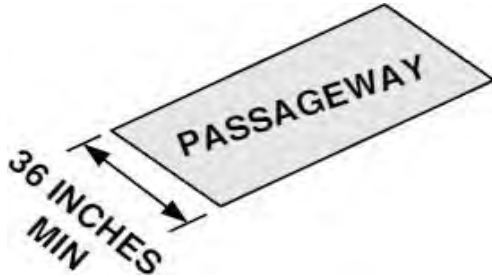
6 (CE)	Is a passenger loading zone provided with a vehicular pull-up space.	The vehicular pull-up space dimension is a minimum of 96 inches wide and 20 feet long				

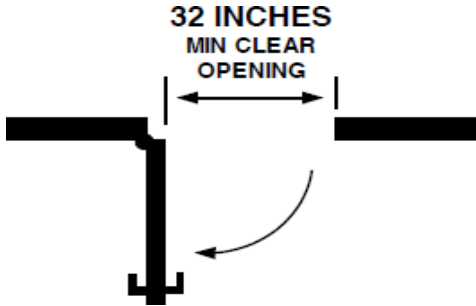
7 (CE)	Is there an access aisle that adjoins an accessible route and does not overlap the Vehicular way /driveway?	Access aisles serving vehicle pull-up spaces shall be a minimum of 60 inches wide. 				
8 (CE)	Do curbs on the route have curb ramps at the drop off locations?	Pathways should have curb ramps. Without curb ramps, wheelchair users may be required to travel in the street or behind parked cars where drivers cannot see them.				

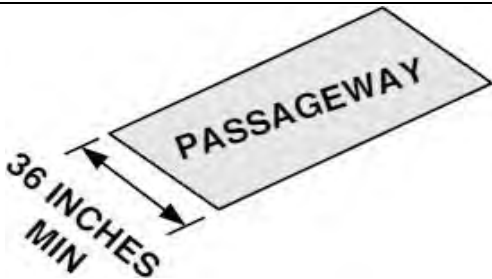
EXTERIOR ROUTE (FROM DROP OFF AND PICK UP LOCATIONS TO THE ENTRANCE)

9 (CE)	For exterior routes, if the accessible route crosses a curb, is a curb ramp provided to the building entrance from the following: (Please mark NA for those that do not apply.)	Self explanatory.			
	a. Public Transportation				
	b. Public sidewalk?				
	c. Drop off?				
10	Is the accessible route to the building entrance at least 36 inches wide for exterior routes from the following: (Please mark NA for those that do not apply.)	 A diagram showing a rectangular area labeled "SIDEWALK". A double-headed arrow indicates the width, with the text "36 INCHES MIN" written below it.			
	a. Public Transportation				
	b. Public sidewalk?				
	c. Drop off?				
11	Is the accessible route to the	An example of a stable surface is a floor or			

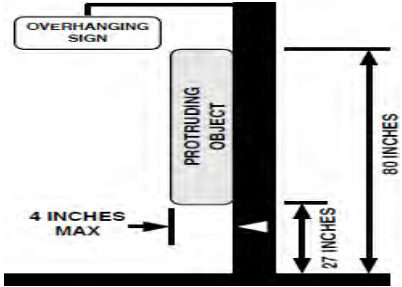
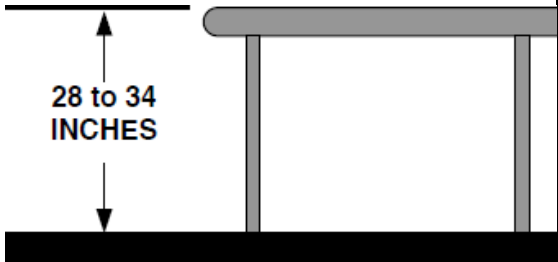
11	building entrance stable, firm, and slip resistant from the following: (Please mark NA for those that do not apply.)	ground surface without loose elements like gravel or wood chips. Firm surfaces include solid concrete or pavement as opposed to a grassy, graveled or soft soil surface. Avoid glossy or slick surfaces such as ceramic tile.						
	a. Public Transportation							
	b. Public sidewalk?							
	c. Drop off?							
12	Is there an accessible route that does not include stairs or steps?	Self explanatory.						
13	Is the route to the entrance from drop off, free of grates, gaps, and openings that are both greater than ½ inch wide and over ¼ inch deep?	Self explanatory.						

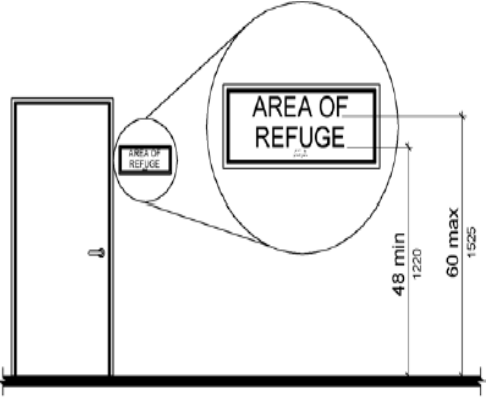
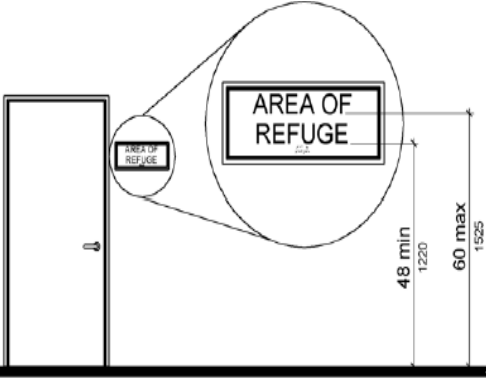
RAMPS:						
14	Is an access ramp present?	If there is more than one ramp, select the one that appears to be the primary access ramp.				
15 (CE)	Are handrails provided on both sides of the ramp that are mounted between 34 and 38 inches above the ramp surface, if it is longer than 6 feet?	If the ramp is not longer than 6 feet, check N/A. 				
16 (CE)	Are all ramps at least 36 inches wide?					

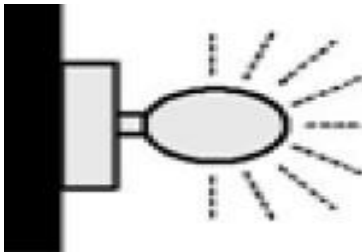
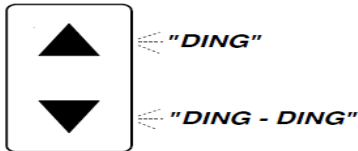
BUILDING ENTRANCE						
17 (CE)	Is the main entrance accessible?	Self explanatory.				
18	If a main entrance is not accessible, is there another accessible entrance?	Self explanatory.				
19	If a main entrance is not accessible, is there directional signage indicating the location of the accessible entrance?					
20 (CE)	Do doors have an opening at least 32 inches wide (at the narrowest point below the opening hardware) when opened to 90°?	When measuring double doors, measure the opening with one door open to 90°. 				

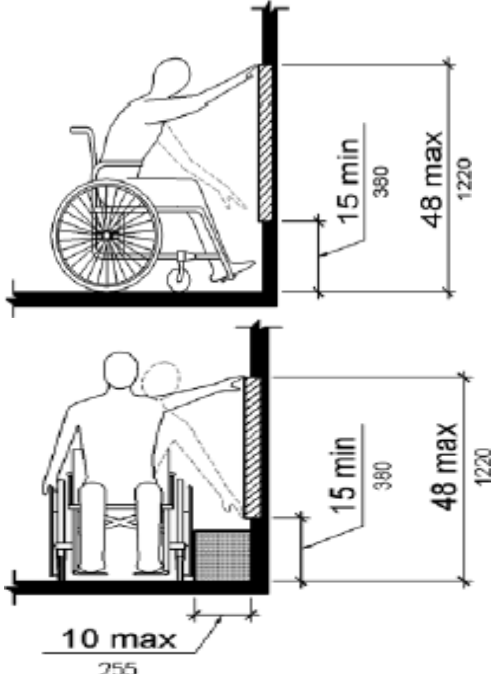
21	Are there automatic doors?	Self explanatory.				
INTERIOR ROUTE (FROM THE BUILDING ENTRANCE, TO THE REGISTRATION COUNTER/WINDOW, AND THROUGH TO THE PARTICIPANT AREAS						
22	Is there an interior route to the participant area?	Some participant areas are accessed directly from the street or drop off rather than being located within a larger building or complex, therefore they do not have interior routes.				
23 (CE)	Are <u>ALL</u> interior paths of travel at least 36 inches wide?					
24	Is the interior accessible route stable, firm, and slip resistant?	Avoid unsecured carpeting or other loose elements. It is easier for people using walkers, wheelchairs and other aids to walk or push on surfaces that have low pile carpeting without a pad underneath. Glossy or slick surfaces such as ceramic tile or marble can be slippery.				

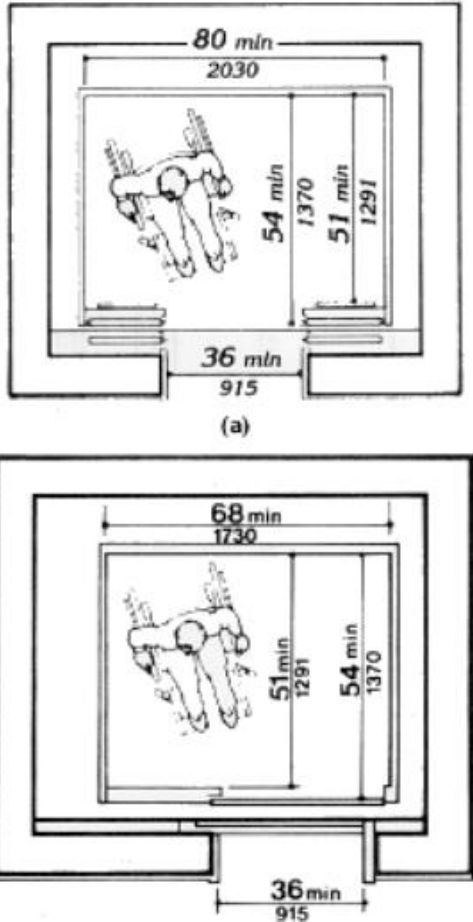
25	Is the interior accessible route well lighted?	A brightly lit corridor will help avoid falls.				
26 (CE)	If there are stairs on the accessible route, are there handrails on each side?	If there are no stairs, check N/A.				
27	If there are stairs, are all stair risers closed that are on the accessible route?					
28	If there are stairs, are all stair treads marked by a stripe providing a clear visual contrast to assist people with visual impairments?	Contrast striping must be provided on the upper approach and lower tread for interior stairs and on the upper approach and all treads for exterior stairs. Stripes must be 2" to 4" wide placed parallel to and no more than 1" from the nose of the step or upper approach. The stripe must extend the full width of the step or upper approach and should be made of material that is at least as slip resistant as the other stair treads (a painted stripe is acceptable).				

29	Is the path through the facility free of any objects that stick out into the circulation path that a blind person might not detect with a cane?	If an object protrudes more than 4 inches and is located between 27 inches above the walking surface and below 80 inches, a blind person walking with a cane will not detect it. 				
30	If floor mats are used, are the edges of floor mats stiff enough or secured so that they do not roll up?	If floor mats are not in use, check NA. Floor mats that are not secured to the floor can roll up or bunch up under walkers or wheelchair casters and cause a tripping hazard.				
31	Is a section of the sign-in/registration counter no more than 34 inches high and at least 36 inches wide and free of stored items.					

32	Do signs identifying permanent rooms and spaces include raised letters and Braille?					
33	Are the raised letters and Braille signs mounted between 48 inches and 60 inches from the floor?	 Raised letters and Braille signs are either on the latch side of doors or on the face of doors and are mounted between 48 inches and 60 inches from the floor.				

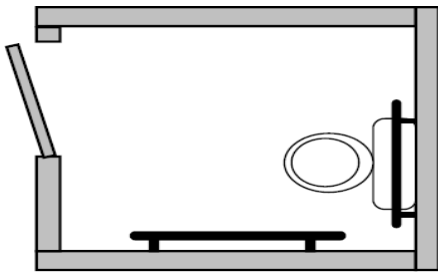
34	If the building has a fire alarm system, are visual signals provided in each public space, including toilet rooms and Participant Areas?	If the building does not have a fire alarm system, check NA. 				
ELEVATORS						
35	Is there an elevator?					
36 (CE)	If needed, is the elevator available for public/patient use during business hours?	Self explanatory.				
37 (CE)	Is the elevator equipped with both visible and audible door opening/closing and floor indicators?	A visible and audible signal is required at each elevator entrance to indicate which car is answering a call. An audible signal would be a "ding" or a verbal announcement. 				

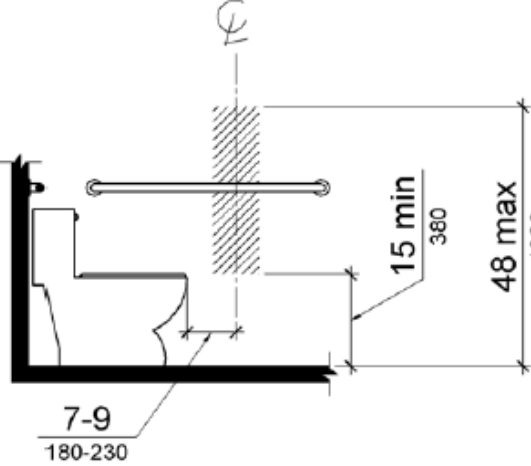
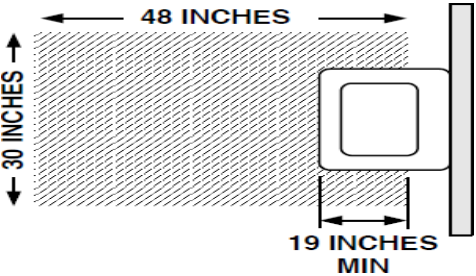
38 (CE)	Are there raised letter and Braille sign on each side of each elevator jamb?	These signs allow everyone to know which floor they are on before entering or exiting the elevator.				
39 (CE)	Are the hall call buttons for the elevator no higher than 48 inches from the floor?	 The diagrams illustrate the required reach ranges for elevator call buttons. The top diagram shows a person in a wheelchair reaching for a button, with a minimum height of 15 inches (380 mm) and a maximum height of 48 inches (1220 mm). The bottom diagram shows two people reaching for a button, with the same height requirements (15 min to 48 max) and a maximum width of 10 inches (255 mm) for the button.				

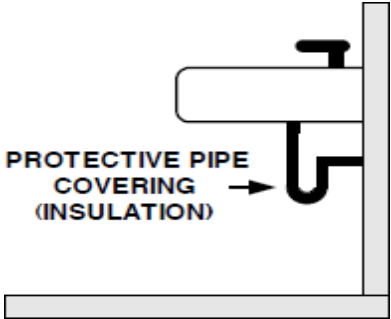
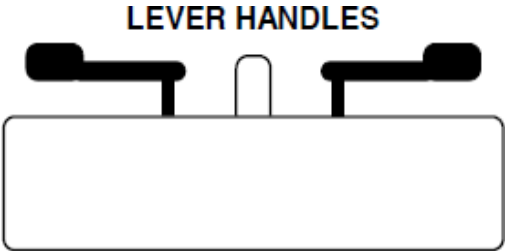
40 (CE)	Is the elevator car large enough for a wheelchair or scooter user to enter, turn to reach the controls, and exit?	The doorway should be at least 36 inches wide and the floor area should be at least 51 inches long and 80 inches wide or 54 inches long and 68 inches wide, depending on where the door is located.  (a)				
41 (CE)	Do the buttons on the control panel inside the elevator have Braille and raised characters/symbols near the buttons?	Self explanatory.				

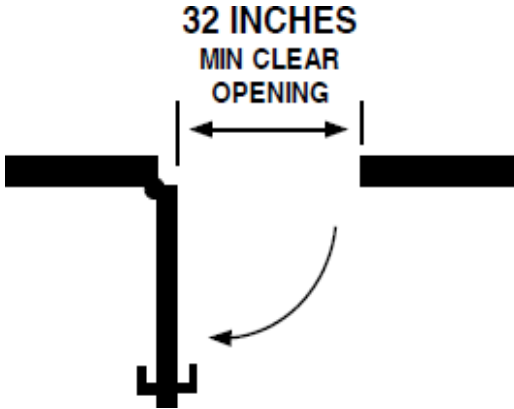
42	Is there an emergency communication system in the elevator?	Self explanatory.				
43	Is the elevator emergency communication system usable without requiring voice communication?	It is essential that emergency communication not be dependent on voice communications alone because the safety of people with hearing or speech impairments could be jeopardized. Visible signal requirement could be satisfied with something as simple as a button that lights when the message is answered, indicating that help is on the way.				
44	Do raised letters and Braille identify the emergency intercom in the elevator?	Self explanatory.				

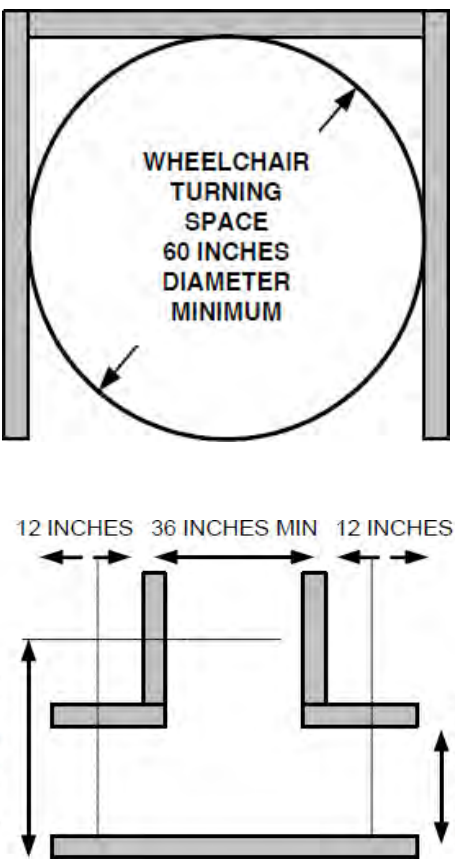
ALL RESTROOMS/TOILET ROOMS (WITH AND WITHOUT STALLS):

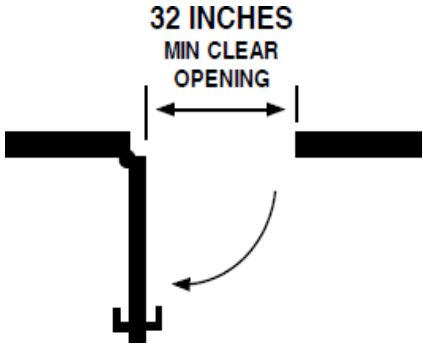
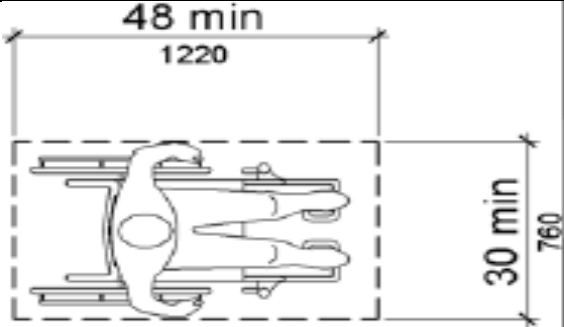
45	Is there an accessible restroom/toilet room?	Self explanatory.				
46	Does the interior door to the restroom require less than 5 pounds of pressure to open?	If restroom door is a fire door, check NA. For interior doors (not fire doors), labor force to open a door should be ≤ 5 lbs. Measure the weight of the labor force of the door after the door is unlatched; attach the hook end of the scale to the door handle and pull until the door opens and read the weight of the force.				
47 (CE)	Are grab bars provided, one on the wall behind the toilet and one on the wall next to the toilet?	Grab bars should be installed in a horizontal position between 33 and 36 inches above the floor measured to the top of the gripping surface. 				
48	Are all objects mounted at least 12 inches above and/or 1½ inches below the grab bars?	This includes seat cover dispensers, toilet paper dispensers, sanitizers, trash containers, etc.				

49 (CE)	Is the toilet paper dispenser mounted below the side grab bar with the centerline of the toilet paper dispenser between 7 inches and 9 inches in front of the toilet, and at least 15 inches high?					
50 (CE)	Is there a space that is at least 30 inches wide and 48 inches deep to allow wheelchair users to park in front of the sink?	This space must extend at least 17 inches under the sink from the front edge, although it can extend up to 19 inches underneath. 				
51	Is the space in front of the sink free of trashcans and other movable items?	Self explanatory.				

52	Are the pipes and water supply lines under the sink wrapped with a protective cover?	 PROTECTIVE PIPE COVERING (INSULATION)				
53 (CE)	Are faucet handles operable with one hand and without grasping, pinching, or twisting? (Check Yes if faucets are automatic.)	A knob handle would not be accessible.  LEVER HANDLES				
54	Are all dispensers mounted no higher than 40 inches from the floor?	Included are soap dispensers, paper towel dispensers, seat cover dispensers, hand dryers, etc.				
55	Are all dispensers (soap, paper towel, etc.) operable with one hand and without grasping, pinching, or twisting?	Self explanatory.				

56 (CE)	Do restroom doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?					
57	Is the space inside the restroom clear, without trashcans, shelves, equipment, chairs, and other movable objects?	Self explanatory.				

58 (CE)	Is there a 60-inch diameter turning circle or a 60 inch x 60 inch "T"-shaped space inside the restroom to allow a turn around for wheelchair and scooter users?	 The diagram consists of two parts. The top part shows a circle with a diameter of 60 inches, labeled 'WHEELCHAIR TURNING SPACE 60 INCHES DIAMETER MINIMUM'. The bottom part shows a T-shaped space. The horizontal bar of the T is 60 inches wide and 36 inches high. The vertical stem of the T is 36 inches wide and 60 inches high. The distance between the two vertical stems is 36 inches minimum. The distance from the outer edge of each vertical stem to the next wall is 12 inches.				
59	Can the hardware on the stall door be operated without grasping, pinching, or twisting of the wrist?	Handles, pulls, latches, locks, and other operating devices on accessible doors shall have a shape that is easy to grasp with one hand and does not require tight grasping, tight pinching, or twisting of the wrist to operate.				
PARTICIPANT AREAS (QUIET ROOM/THERAPY ROOM S-PT/OT, ACTIVITY AREA)						

60 (CE)	Do doorways have a minimum clear opening of 32 inches with the door open at 90 degrees, measured between the face of the door and the opposite stop?					
61 (CE)	There is space in the following areas for a wheelchair or scooter user to approach and park for participation in activities or use of exercise equipment:					
	a. Quiet room?					
	b. Physical Therapy Room {PT}?					
	c. Occupational Therapy {OT}?					
	d. Activity Area					

62	Is there a bed that is between 17 inches and 19 inches from the floor to the top of the cushion?	Self explanatory				

Date

Site Name

Attn: Contact name, Title

Address

City, State, Zip

RE: Physical Accessibility Review Survey (PARS) FSR Part C

Dear Ms. / Mr. last name of contact,

In compliance with the Department of Health Care Services (DHCS), Medi-Cal Managed Care Division Policy Letter 12-006, Partnership HealthPlan of California (Partnership) has been conducting assessments of our network providers' offices to determine the level of physical accessibility of provider sites, including primary care physician, and specialist and ancillary service providers, that serve a high volume of Seniors and Persons with Disabilities (SPDs).

The information gathered will allow PHC to provide information to assist Partnership members in choosing provider sites that will be able to meet their needs.

The access level below will be denoted in the Partnership Provider Directory and on the Partnership website, as well as the Accessibility Indicators next to your individual information.

Accessibility Levels:

☐ Basic Access	Demonstrates facility site access for the members with disabilities to parking, building, elevator, doctor's office, exam room and restroom. To meet Basic Access requirements, all (29) Critical Elements (CE) must be met.
☐ Limited Access	Demonstrates facility site access for the members with a disability is missing or is incomplete in one or more features for parking, building, elevator, doctor's office, exam room, and restroom. Deficiencies in 1 or more of the Critical Elements (CE) are encountered.
☐ Medical Equipment Access	The site has height adjustable exam table and patient accessible weight scales per guidelines (for wheelchair/scooter plus patient). This is noted in addition to level of Basic or Limited Access as appropriate.

Accessibility categories: (checked boxes indicate what will be identified in the directory):

- ☐ **P**-Parking and pedestrian walkways
- ☐ **EB**-Exterior entrance to medical office buildings or office complexes
- ☐ **IB**-Interior entrance to medical office buildings or office complexes
- ☐ **R**- Restroom accessibility
- ☐ **E**- Maneuverability and access to waiting rooms and exam/treatment rooms
- ☐ **T***- Adjustable exam table and a weight scale that can accommodate a wheelchair or scooter.

*Please note that this is in addition to the other Accessibility Indicators and will not affect the level of basic accessibility.

A copy of the survey tool was provided to you at the time the site visit was scheduled. Please let us know if you need another copy.

Deficiencies for each category are:

- **P (Parking)**: The guidelines state:
 - There must be at least 1 ADA parking space for every 25 regular spaces.
 - Curbs on the route from off-street public parking must have curb ramps at the parking locations.
 - Curbs on the route from off-street public parking must have curb ramps at the drop off locations
 - There must be at least 1 VAN accessible parking space provided. To qualify, the parking space and access aisle must be at least 92" each or at least a total of 192" overall.
- **EB (Exterior Building)**: The guidelines state:
 - If accessible route crosses a curb, there must be a curb ramp provided to the building entrance from: Parking, Public Transportation, and Public Sidewalk.
 - If ramp is present, each run (leg) of the ramp should be no longer than 30' between landings.
 - If ramp is over 6' long, handrails must be provided on both sides of the ramp and be mounted between 34" and 38" above the ramp surface.
 - Handrails must be at least 36" wide.
 - If the main entrance is not accessible, there must be another accessible entrance.
 - The entrance doors must have a minimum opening of at least 32" when opened at 90 degrees.
 - There must be space available for a wheelchair user to approach, maneuver, and open the door (Pull doors requires a clear space of 60" perpendicular X 18" parallel to the doorway; Push doors require 48" perpendicular to the doorway).
 - Entrance doors must have handles that can be opened without grasping, pinching or twisting the wrist.
- **IB (Interior Building)**: The guidelines state:
 - All interior paths of travel must be at least 36" wide.
 - If there are stairs on the accessible route, handrails must be on each side.
 - If a platform lift is used, it must be available without assistance.
 - If there is an elevator, is available for public/patient use during business hours?
 - The elevator equipped with both visible and audible door opening/closing and floor indicators.
 - The elevator must have raised letter and Braille signs on each side of each elevator jamb.
 - The elevator hall call buttons must be no higher than 48" from the floor.
 - The elevator car must be large enough for a wheelchair or scooter user to enter, turn to reach the controls, & exit (Must be 36" wide doorway with: centered doorway-51" long X 80" wide care, side doorway-54" long X 68" wide.

- o The buttons on the control panel inside the elevator must have Braille and raised characters/symbols.
- **R (Restroom):** The guidelines state:
 - o Grab bars must be provided, one on the wall behind the toilet and one on the wall next to the toilet (must be mounted in a horizontal position between 33” and 36” above the floor).
 - o The toilet paper dispenser must be mounted below the side grab bar with the centerline of dispenser between 7” and 9” in front of the toilet, and at least 15” high.
 - o There must be space which is at least 30” wide and 48” deep to allow wheelchair user to park in front of the sink (space must extend at least 17” under the sink from the front edge, although it can extend up to 19” underneath).
 - o Faucet handles must be operable with one hand and without grasping, pinching, or twisting.
 - o Doorways must have a minimum opening of 32” with the door open at 90 degree.
 - o For toilet rooms with stalls, there must be a 60” diameter turning circle or 60” x 60” “t”-shaped space inside the stall to allow a turnaround for wheelchair and scooter users.
- **E (Exam room):**
 - o The exam room doorways must have a minimum clear opening of 32” with the door open at 90 degrees.
 - o There must be a 60” diameter or a 60” x 60” “t”-shaped space for 180 degree turns.
- **T (Exam Table/Scale):**
 - o There must be a height adjustable exam table that lowers to between 17” and 19” from the floor to the top of the cushion.
 - o There must be space next to height adjustable exam table for a wheelchair or scooter user to approach, park, and transfer or be assisted to transfer onto the table (30” wide x 48” long).
 - o There must be a weight scale available within the medical office with a platform to accommodate a wheelchair or scooter and the patient.

Although these are considered a critical element, corrective action is not required as the assessment is for informational purposes only at this time.

Please contact me if you have any questions.

Thank you for your assistance with the review.

Sincerely,

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MCUP3041 (previously UP100341)			Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Treatment Authorization Request (TAR) Review Process			☒ External Policy ☐ Internal Policy	
Original Date: (UM-2) 04/25/1994 (Effective 06/19/2013 - TAR/RAF Review Policy split)		Next Review Date: ~~08/13/2026~~ <u>08/12/2027</u> Last Review Date: ~~08/13/2025~~ <u>08/12/2026</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage	
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: ~~08/13/2025~~ <u>08/12/2026</u>	

I. **RELATED POLICIES:**

- A. MCUP3124 – Referral to Specialists (RAF) Policy
- ~~A.B.~~ B. ~~MPUP3014 – Emergency Services~~
- ~~B.C.~~ C. MPUP3026 – Inter-Rater Reliability Policy
- ~~C.D.~~ D. MCUP3141 – Delegation of Inpatient Utilization Management
- ~~D.E.~~ E. MPUD3001 – Utilization Management Program Description
- ~~E.F.~~ F. MCRP4068 – Medical Benefit Medication TAR Policy
- ~~F.G.~~ G. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
- ~~G.H.~~ H. CGA024 – Medi-Cal Member Grievance System
- ~~H.I.~~ I. CMP36 – Delegation Oversight and Monitoring
- ~~I.J.~~ J. CMP26 – Verification of Caller Identity and Release of Information
- ~~J.K.~~ K. CMP30 – Records Retention and Access Requirements
- ~~K.L.~~ L. MPUP3139 – Criteria and Guidelines for Utilization Management
- ~~L.~~ M. ~~MCUP3064 – Communication Services~~

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. Authorized Representative: An adult Member has the right to designate a friend, family member, or other person to have access to certain protected health information (PHI) to assist the Member with making medical decisions. The Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership HealthPlan of California (Partnership) for review prior to releasing PHI. Until the form has been submitted and validated by Partnership staff, the Member can give verbal consent to release non-sensitive PHI to a designated person. Verbal consent expires at close of business the following business day. The Member can give additional Verbal Consent when the prior Verbal Consent window of time has expired.
- C. Cosmetic Surgery: Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance.
- D. Urgent Request: A request for medical care or services where application of the timeframe for making

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routine or non-life threatening care determinations:

1. Could seriously jeopardize the life, health or safety of the Member or others, due to the Member's psychological state, **or**
 2. In the opinion of a practitioner with knowledge of the Member's medical or behavioral condition, would subject the Member to adverse health consequences without the care or treatment that is the subject of the request.
- E. Non-urgent Request: A request for medical care or services for which application of the time periods for making a decision does not jeopardize the life or health of the Member or the Member's ability to regain maximum function and would not subject the Member to severe pain.
- F. Concurrent Request: A request for coverage of medical care or services made while a Member is in the process of receiving the requested medical care or services, even if Partnership did not previously approve the earlier care.
- G. Pre-service Request: A request for coverage of medical care or services that the organization must approve in advance, in whole or in part.
- H. Post-service Request: A request for coverage of medical care or services that have been received (e.g., retrospective review).

IV. ATTACHMENTS:

- A. [Partnership TAR Requirements list \(including Outpatient Surgical Procedures CPTs Requiring TAR list and Pain Management CPTs Requiring TAR list\)](#)

V. PURPOSE:

To describe the procedures used by the Partnership HealthPlan of California (Partnership) Utilization Management (UM) Department to process Treatment Authorization Requests (TARs) based upon the medical necessity of the request.

VI. POLICY / PROCEDURE:

A. GENERAL PROCEDURES

1. Partnership pays for authorized services according to the specific terms of each physician, hospital, or other provider contract. Partnership will reimburse only if individuals are eligible at the time the service is rendered.
2. Resources necessary to help in determining review decisions, include, but are not limited to the published, current, InterQual® criteria; Medi-Cal (State of California) criteria, Medicare criteria, and Partnership's internally developed and approved guidelines. Determinations also take into account individual ~~M~~member needs and characteristics of the local delivery system. (See policy MPUP3139 Criteria and Guidelines for Utilization Management for more details.)
 - a. The Provider of service must verify eligibility of the Member via Partnership systems at the time of service. This verification is necessary for all service authorizations.
 - b. Partnership's Online Services (OLS) portal <https://provider.partnershiphp.org/UI/Login.aspx> is available 24 hours per day, 7 days per week to verify eligibility and determine the Member's assigned primary care provider (PCP). Information required to verify the eligibility of an individual is as follows:
 - 1) Provider NPI (National Provider Identifier)
 - 2) Member Social Security number or Partnership Member ID number
 - 3) Date of Service
3. TARs are not processed by Partnership until the TAR form is complete; meaning that it -and- includes all ~~M~~member information and all attachments noted on the TAR are received. When completing information fields for the provider of service and the service(s) being requested, the correct and valid

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codes must be utilized.

4. Authorizations are only valid for the timeframe approved by Partnership. If the timeframe is exceeded due to an unforeseen delay, the Provider may submit a request for an extension of the time period, noting the reason for the delay.

B. SERVICES REQUIRING TREATMENT AUTHORIZATION

1. Certain procedures, services, and medications require prior authorization from Partnership before reimbursement is made.
 - a. ~~Non-behavioral (medical) healthcare~~ Those services requiring a Treatment Authorization Request (TAR) ~~that will be processed by Partnership's Utilization Management (UM) department are described in this policy and listed as in Attachment A, Partnership TAR Requirements, to this policy. The attachment consists of:~~
 - 1) ~~Partnership TAR Requirements List~~
 - 2) ~~HCPCS Codes Requiring a TAR~~
 - 3) ~~Outpatient Surgical Procedures Requiring TAR~~
 - e.b. Behavioral healthcare: Partnership covers Non-Specialty Mental Health Services (NSMHS) without prior authorization requirements. (See policy MPBP8003 Mental Health Services for further information.)
 - d.c. Pharmacy: Partnership covers Physician-Administered Drugs for Medi-Cal Members as described in policy MCRP4068 Medical Benefit Medication TAR Policy.
 - 1) All medications (Rx and OTC) which are provided by a pharmacy must be billed to the State Medi-Cal/ DHCS-contracted pharmacy administrator instead of Partnership, as per the implementation of Medi-Cal Rx described in APL 25-013.
2. Medicare coverage: For those providers contracting with Partnership, if a Member has primary coverage through Medicare Part A, a TAR is not required until the Member exhausts the benefits available under Medicare. Once benefits have been exhausted, the TAR must be submitted along with written verification from Medicare that the benefits have been exhausted. The TAR must be submitted within 15 business days of the date the benefits exhausted or within 60 calendar days of retrospective eligibility. This requirement applies only when Medicare coverage is primary and applicable to the requested service.
 - a. Exception: If the provider receives a denial from Medicare or any other primary payor source, they must submit a TAR to Partnership's Health Services Department, along with a copy of the Medicare denial and the medical record documentation. The TAR must be received by Partnership within 60 calendar days of the issue date of the denial from Medicare or the other payor source.
 - b. Note that requests for durable medical equipment (DME) for dually eligible Medi-Cal/ Medicare Members are exempt from the process outlined above in VI.B.2. Medicare does not issue denials and Explanations of Benefits (EOBs) for non-covered DME services.
3. TARs are not required for certain services, including but not limited to, services related to emergency services, minor consent, family planning and preventive services, basic prenatal care, sexually transmitted disease services and human immunodeficiency virus (HIV) testing.
4. Authorizations granted for single-encounter, outpatient medical services (dental anesthesia, sleep studies, surgical procedures, interventional pain management procedures, genetic testing, and laboratory studies) ~~will may~~ be limited to a ~~6-month~~ 12-month authorization period. Services excluded from this limit ~~will may~~ include: Transplants, Dialysis, Palliative Care, Cardiac Rehabilitation, and Pulmonary Rehabilitation. Please note this limit is only applicable to single-encounter, outpatient medical services requiring a TAR. Requests for extension of authorization when a service is not rendered within the authorization period should continue to be submitted as a correction (as described in VI.C.8 below) and will be reviewed on a case-~~by-~~case basis.

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C. TAR SUBMISSION PROCESS

TARs for Members who require services should be submitted electronically via Partnership's Online Services (OLS) portal <https://provider.partnershiphp.org/UI/Login.aspx>. TARs must be received by Partnership within fifteen (15) business days of the date of service or within 60 calendar days of either a denial from the primary insurance carrier or retrospective eligibility. (TARs submitted beyond these timeframes are considered late but will still be reviewed for medical necessity.) Electronic submission will allow for more expedient processing. If online submission is not possible, the TAR may be submitted via fax (707) 863 - 4118 or mail to Partnership's Health Services Department for review.

1. Urgent TAR Requests

- a. Urgent TAR submission is available for requests in which the provider indicates, or Partnership determines, that the standard timeframe could seriously jeopardize the Member's life or health or ability to attain, maintain, or regain maximum function.
- b. Requests for an urgent determination should be submitted by the provider and clearly marked "Urgent" or "Expedited" and should indicate the reason there is an urgent need for authorization.
- ~~a-c.~~ A TAR for an elective (non-emergent) surgery submitted urgently due only to an imminent date of service is NOT considered to be urgent. TARs submitted under these circumstances will be reviewed as a non-urgent pre-service request.

2. Non-urgent Elective Requests

- a. All elective inpatient hospital admissions require prior authorization EXCEPT anticipated two (2) day post vaginal delivery stays and four (4) day post C-Section stay.
 - 1) Obstetrical admissions do not require a TAR prior to admission, for obstetrical delivery. The hospital must notify Partnership if the mother and/or baby require additional days of acute care. The Nurse Coordinator concurrently reviews the case within 24 hours (1 calendar day) of receipt of clinical information.
 - b. A service being provided that is not pregnancy-related requires the admitting physician to submit the TAR for the elective procedure prior to the actual hospital admission. ~~Although an approved TAR will assign a specified number of initial days approved, the hospital is required to notify Partnership within one business day of the actual date of admission.~~
 - 1) Please note that Partnership will assign a number of initially-approved days, however, it is the hospital's responsibility to notify Partnership within one business day of the date of the actual admission.
 - 2) If the patient's condition necessitates hospitalization beyond the pre-approved timeframe, Partnership will perform concurrent review on the remainder of the stay.
- ~~b-c.~~ Authorization for non-obstetric elective hospital admissions must be submitted by the admitting physician and include the following:
 - 1) Procedure code or service being performed
 - 2) Facility where procedure will be performed
 - 3) Anticipated date of procedure
 - 4) Number of days being requested if inpatient admission
 - 5) Diagnosis
- d. Managed care plans are not required to cover cosmetic surgery (see definition in III.C).

3. Emergency Admissions

- a. For all emergency and obstetrical admissions, the hospital ~~or long-term care (LTC) facility~~ must notify Partnership and the Member's PCP of the admission as soon as possible, but not later than the first business day following the date of admission.
- b. The case is reviewed by the Nurse Coordinator and a decision on length of stay is authorized based on Partnership established criteria within 24 hours (1 calendar day).

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4. Dialysis Services
 - a. Initial TAR requests for Dialysis services for Members who have no other insurance will be authorized for a 90 calendar-day period only.
 - b. Per CCR Title 22 sections 50763 and 50777, “Medi-Cal beneficiaries must apply for any available health care coverage when no cost is involved.” All Members receiving dialysis must submit an application to Social Security for Medicare benefits.
 - c. The provider must submit a denial from Medicare for Partnership to approve services beyond the initial 90 calendar days.
 - d. Once a Medicare determination of denial of coverage is received, Partnership will assign the Member to a Direct Member status for End Stage Renal Disease (ESRD) as described in policy MPUP3039 Direct Members. This status will allow dialysis services to be approved issue a TAR that will remain valid for the Member’s lifetime or until the Member receives a kidney transplant.
5. Hospice Services

Hospice services do not require a TAR ~~ONLY for unless services are provided in an inpatient setting such as serviceeans (i.e.-acute or skilled nursing facility [SNF]/LTC facility.~~

 - a. ~~→ However, To ensure proper hospice claim processing and reimbursement for outpatient or inpatient services, all licensed and certified hospice providers must submit the Medi-Cal Hospice Program Election Notice form (DHCS 8052) to Partnership within five calendar days of a Medi-Cal Member’s certification and election of hospice services. a Hospice election form signed by the Member or their legal representative must accompany any initial claim for hospice services (all outpatient and inpatient services). See policy MCUP3020 Hospice Services for further details.~~
6. ~~Long Term~~Extended Care/~~Skilled~~ Nursing Services

All ~~Skilled Nursing or Extended Care (Custodial/ Long Term Care/ Skilled Nursing/ Subacute) -Care~~ facility admissions require approval prior to the admission, and throughout the length of stay.

 - a. When a Member is admitted for custodial care, a TAR submission may be approved for an initial six (6) month period and the Member’s condition will be re-evaluated at six (6) month increments. (See also policy MCUG3038)
 - b. For continued custodial care, a new TAR must be submitted within 15 calendar days of the expiration date of the original TAR.
7. Post-service (Retrospective) Requests

Retrospective (Retro) TARs must be received by Partnership within fifteen (15) business days of the date of service or within 60 calendar days of a denial from the primary insurance carrier. (Note that if a provider incorrectly submits a TAR for a Partnership ~~M~~member to the State Medi-Cal field office, Partnership will apply these timeliness requirements beginning on the date the request is received in our office.) Retro TARs received after that timeframe are considered for review only under the following conditions:

 - a. When a Member does not identify their self to the provider as a Partnership Member by deliberate concealment or because of physical or mental incapacity to so identify their self.
 - b. If a Member has obtained retroactive eligibility. The TAR must be received by Partnership within 60 calendar days of the Member having obtained Medi-Cal eligibility.
8. Correction TAR Requests
 - a. The provider has up to 12 months from the approved date of the ORIGINAL authorized TAR to submit modifications of approved services. A new TAR must be submitted with the requested modifications and MUST reference the ORIGINAL TAR number and code(s) or date(s) to be modified. Modifications will be accepted or made only on approved TARS for the following:
 - 1) Types of service. For example, only similar items or procedures may be modified

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- (e.g. ~~micropore tape versus paper tape~~, right wheels versus left wheels, ~~etc.~~).
- 2) Minor extension or change of dates may be requested (e.g. start of service May 15 versus May 20).
 - 3) Units of service (e.g. 9 visits versus 6 visits). This usually coincides with a change of, or extension of, dates of service requested.
9. Note that if a provider incorrectly submits a TAR for a Partnership Member to the State Medi-Cal field office, Partnership applies timeliness requirements to that request. If the Member was eligible with Partnership at the time of the request, TARs submitted beyond the 15 business day requirement are considered late but will still be reviewed for medical necessity.

D. UM REVIEW PROCESS

1. Nurse Coordinator Review

- a. A Nurse Coordinator can approve, modify, defer (pend) or deny the TAR for non-medical necessity determinations.
 - 1) The Nurse Coordinator reviews the information received from the provider utilizing Partnership approved review guidelines. The Nurse Coordinator approves the request if it meets medical necessity criteria.
 - 2) Requests that do not meet review guidelines and require clinician review due to questions of medical necessity are referred to the Chief Medical Officer (CMO) or Physician Designee for further evaluation. The Nurse Coordinator attaches all relevant documentation, InterQual® criteria and the Medical Director Worksheet.
 - 3) ONLY the Chief Medical Officer or Physician Designee can deny TARs for reasons of medical necessity.

2. Chief Medical Officer (~~CMO~~)/ Physician Designee Review

- a. The ~~Chief Medical Officer or CMO~~/ Physician Designee must be available physically or by telephone during business hours to assist with evaluating TAR requests.
- b. The ~~Chief Medical Officer or CMO~~/Physician Designee review is done in all cases of potential denial due to medical necessity, interpretation issues, or other issues as requested by the UM staff. Partnership's ~~Chief Medical Officer or CMO~~/ Physician Designee reviews all TARs referred to him/her, taking the action deemed appropriate.
- c. The ~~CMO/Chief Medical Officer or~~ Physician Designee may contact involved providers or consultants for additional information as required to assist them in rendering a decision about the case. They may contact the requesting provider for further information. The ~~CMO/Chief Medical Officer or~~ Physician Designee documents the rationale for any decision on the Medical Director Worksheet. Once the ~~CMO/Chief Medical Officer or~~ Physician Designee approves or modifies the request, the TAR will be returned to the Nurse Coordinator for completion.
- d. The ~~Chief Medical Officer or CMO~~/Physician Designee is the only person authorized to sign denials for medical necessity or to make any exceptions or modifications to the established Partnership medical criteria. Denials for medical necessity are made only by the ~~Chief Medical Officer or CMO~~/ Physician Designee.
- e. Partnership makes a physician reviewer available (~~Chief Medical Officer or CMO~~/Physician Designee) to discuss medical necessity determinations with providers by telephone (peer to peer review).
- f. For information on the process for a Member, Member's authorized representative, or a provider on behalf of a Member, to appeal Partnership UM decisions, see Partnership policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.

3. Delegated Entity Review

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- a. Partnership uses delegated entities to perform some aspects of utilization management. They make determinations on service requests for their assigned Members. All delegates will follow the decision making and notification timeframes set out below in section VI.D.6. for medical and behavioral health services.
- b. Partnership's Associate Director of UM Regulations is responsible for monitoring the Utilization Management activities of delegated entities. On a daily basis (during business days), the UM Associate Director of UM Regulations and the Delegation Program Manager monitor authorizations performed by delegated entities through Partnership's electronic authorization system. On a weekly basis, they generate timeliness reports for all delegated entities and analyze trends. Delegated entities are notified immediately of any areas of concern. On a quarterly basis, timeliness data reports are prepared for review and audit with each delegated entity. Reports are also reviewed by the CMO or physician designee at least annually or more often as needed if areas of concern are noted.
- c. Multi-specialty medical groups do not require pre-authorization from Partnership for services for which they are delegated. All elective hospital admissions must be pre-authorized by the medical group and reported to Partnership at the time of admission.
4. Non-Contracted Hospital Review
 - a. Elective admissions to non-contracted hospitals require approval of a TAR, which is subject to Partnership's timeline policies. When the admission is elective and has been given prior authorization, no further communication is required until the approved number of days is nearing expiration and the Member is expected to remain hospitalized beyond the days previously approved. The facility is required to provide to the Nurse Coordinator appropriate clinical information supporting the medical necessity of continued stay.
 - b. As most admissions to non-contracted hospitals are for emergency conditions, the procedure for non-contracting hospital review is as follows:
 - 1) If the admission does not meet admission criteria, it is referred to the Chief Medical Officer (CMO) or Physician Designee for review. The Nurse Coordinator notifies the non-contracting hospital of the ~~Chief Medical Officer or CMO~~-Physician Designee's decision and provides the process for appeal or the opportunity to discuss the determination with the CMO/Physician Designee (peer to peer review).
 - 2) Until the Member is medically stable for discharge or transfer to a lower level of care, clinical review should be sent to Partnership's Nurse Coordinator.
 - 3) For a Member capitated to an in-plan hospital who is admitted to a non-capitated hospital, please refer to policy MCUP3141 Delegation of Inpatient Utilization Management.
5. Post Stabilization Services
Upon receipt of an authorization request from an emergency services provider, UM shall render a decision within 30 minutes or the request is deemed approved, pursuant to Title 42 CFR section 438.114 and Title 28 CCR Section 1300.71.4.
6. UM Decision and Notification Timelines
 - a. Urgent Concurrent Review
 - 1) For urgent concurrent review, Partnership will render a decision (approve, modify, defer/pend, deny) within 72 hours.
 - 2) If the request to extend urgent concurrent care was not made prior to 24 hours before the expiration of the authorized period of time or number of treatments, the request will be reviewed as an urgent pre-service and a decision will be rendered within 72 hours from the original date of receipt.

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- 3) If the request to approve additional days for urgent concurrent care is related to care not approved by Partnership previously, Partnership will attempt to obtain necessary information related to the request ~~within 24 hours~~ as soon as possible. The decision will be rendered no later than 72 hours from the original date of receipt of the request.
 - 4) For urgent concurrent denials, Partnership ~~will~~ may inform the hospital Utilization Review (UR) department staff of the decision ~~, with the understanding that staff will inform the attending/treating prescriber.~~
 - 5) 4) If it is determined that additional information is required, or if a Member requests an extension, Partnership will extend the time frame one time by up to 14 calendar days. Partnership will document the specific reason for the extension in Partnership's electronic authorization system. The provider is then notified immediately in writing of the extension and what specific additional information is required to complete the review.
 - 6) 5) Electronic or written notification of the decision is communicated to the provider within 24 hours of the decision, and no later than 72 hours after receipt of the request. If the time frame was extended, the provider will be notified at the time of decision, but no longer than 72 hours from receipt of the additional information requested, not to exceed 14 calendar days from the date of the original request. Partnership is not required to notify the Member of an urgent concurrent decision as the Member is not at financial risk for the services being requested.
- b. Urgent Pre-service Review
- 1) For urgent pre-service review, Partnership will render a decision (approve, modify, defer/pend, deny) within 72 hours.
 - 2) If it is determined that additional information is required, or if a Member requests an extension, Partnership will extend the time frame one time by up to 14 calendar days. Partnership will document the specific reason for the extension in Partnership's electronic authorization system. The Member and the provider are then notified immediately in writing of the extension and what specific additional information is required to complete the review. Any decision delayed beyond the time limits will be escalated to a Physician Designee for review of medical necessity. Partnership will re-review the request if the clinical information requested is received after a decision has been made.
 - 3) Electronic or written notification of the decision and how to initiate a routine or expedited appeal, if applicable, is communicated to the provider within 24 hours of the decision and no later than 72 hours from the receipt of the request. Written notification is mailed to the Member within two (2) business days of the decision. If the time frame was extended, the notification is communicated at the time of decision, but no later than 72 hours from receipt of the additional information requested, not to exceed 14 calendar days from the date of the original request.
- c. Non-urgent Pre-service Review and Non-urgent Concurrent ~~and~~ Review
- 1) For non-urgent pre-service review, Partnership will render a decision (approve, modify, defer/pend, deny) within ~~five-seven (75)~~ business-calendar days from the receipt of the request, but no later than 14 calendar days from the receipt of the request.
 - 2) For non-urgent concurrent review (inpatient care e.g. LTC/SNF), Partnership will render a decision (approve, modify, defer/pend, deny) within 72 hours of receipt of the request and will continue concurrently reviewing the authorization within one (1) business day of receipt each time clinical information is received.
 - 3) If the request is received during non-business hours, Partnership will process the request the next business day.
 - 4) If the TAR lacks clinical information necessary to render a decision, the TAR may be

Policy/Procedure Number: MCUP3041 (previously UP100341)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Treatment Authorization Request (TAR) Review Process		☒ External Policy ☐ Internal Policy	
Original Date: (UM-2) 04/25/1994 (Effective 06/19/2013 - TAR/RAF Review Policy split)		Next Review Date: <u>06/12/202508/12/2027</u> Last Review Date: 08/13/202508/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

deferred/pended up to 14 calendar days from the date of the original receipt of the request. Partnership will document the specific reason for the extension in Partnership's electronic authorization system. The Member and the Provider are then notified immediately in writing of the extension and what specific additional information is required to complete the review. In addition to electronic or written notification, the UM Staff will contact the Provider and/or designated office staff member to remind them of the specific information requested and the regulatory timeframe for submission. ~~-In the event that a Member requests an extension on a deferred/pended TAR with Partnership's grievance department, or if Partnership determines an extension of the pended request is in the best interest of the Member after the initial 14 calendar days are exhausted, Partnership may extend the deferred/pended period up to an additional 14 calendar days, for a total of 28 calendar days from the original date of receipt of the request.~~ Any decision delayed beyond the time limits will be escalated to a Physician Designee for review of medical necessity. Partnership will re-review the request if the specified clinical information requested is received after a decision has been made.

5) Notification of Decision:

- a) Non-urgent pre-service review: Electronic or written notification of the decision and how to initiate a routine or expedited appeal, if applicable, is communicated to the provider within 24 hours of the decision and written notification is mailed to the Member within two (2) business days of the decision. If the time frame for the review was extended, the notification will be provided at the time of decision, but no longer than ~~five-seven (75) business calendar~~ days from receipt of the additional information requested, not to exceed 14 calendar days from the date of the original request. ~~or 28 calendar days if a second extension is applied.~~
- b) For a non-urgent concurrent review, electronic or written notification of the decision is communicated to the provider within 24 hours of the decision and no later than 72 hours after receipt of the request. Partnership is not required to notify Members of non-urgent concurrent review decisions as the Member is not at financial risk for the services being requested.
- d. Post-service (Retrospective) Review
 - 1) For post-service review, Partnership will render a decision (approve, modify, defer/pend, deny) no longer than 30 calendar days from the receipt of the request.
 - 2) Electronic or written notification of the decision and how to initiate a routine or expedited appeal if applicable, is communicated to the provider within 24 hours of decision, but no longer than 30 calendar days from the date of the receipt of the request. Written notification is mailed to the Member within two (2) business days of the decision.

E. MONITORING OF THE TAR PROCESS

1. Aggregate TAR data is subject to retrospective analysis by Partnership's UM Department. This review is designed to:
 - a. Identify individual provider practice patterns relative to standards of medical practice.
 - b. Evaluate over and under-utilization of services.
2. Partnership monitors turnaround times of internal processing for compliance with standards.
3. Denials or modifications for medical necessity are monitored weekly to ensure accuracy in regulatory requirements, review processes, and correspondence.
4. Partnership performs inter-rater reliability (IRR) audits as outlined in policy MPUP3026 Inter-Rater Reliability Policy, at least biannually on both physician and nurse reviewers. IRR audits are also conducted with pharmacist reviewers and lead pharmacy technicians for TARs reviewed by Partnership's pharmacy department according to policy MCRP4068 Medical Benefit Medication

Policy/Procedure Number: MCUP3041 (previously UP100341)		Lead Department: Health Services Business Unit: Utilization Management	
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Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

TAR Policy.)

5. Member & provider grievances, as well as Partnership's member and provider satisfaction survey responses, serve as an evaluation tool.
6. Administrative denials (as defined in policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions) are reviewed monthly by the Chief Medical Officer. A summary is presented to the Internal Quality Improvement Committee (IQI) at least annually or more often as needed.
7. 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:
 - a. Consistent with sound clinical principles and processes
 - b. Evaluated and updated at least annually
 - c. 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~~ Member upon request
 - d. The materials provided are guidelines used by 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 Partnership.
 - e. Partnership's authorization requirements comply with the requirements for parity in mental health and substance use disorder benefits in 42 CFR 438.910.

VII. REFERENCES:

- A. DHCS Contract Exhibit A, Attachment ~~III Section 2.35~~ Utilization Management Program
- B. DHCS All Plan Letter (APL) 21-011 Revised Grievance and Appeals Requirements, Notice and "Your Rights" Templates (~~08/31/2021~~08/31/2022)
- C. DHCS All Plan Letter (APL) 22-01225-013 Revised Governor's Executive Order N-01-19 Regarding Transitioning Medi-Cal Rx Pharmacy Benefits and Cell and Gene Therapy Coverage from Managed Care to Medi-Cal Rx (~~12/30/2022~~09/18/2025)
- D. California Health and Safety Code (HSC) Sections 1363.5 and 1367.01(h)(3)
- E. Title 42 Code of Federal Regulations (CFR) section 438.114 Emergency and Poststabilization Services and 438.910 Parity requirements for financial requirements and treatment limitations~~and~~
- F. Title 22 California Code of Regulations (CCR) Section 50763 Beneficiary Responsibility - Other Health Care Coverage and Section 50777 Requirements to Apply for Medicare
- ~~E.G.~~ G. Title 28 California Code of Regulations (CCR) Section 1300.71.4 Emergency Medical Condition and Post-Stabilization Responsibilities for Medically Necessary Health Care Services
- ~~F.~~ Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule (CMS-0057-F) Federal Register 89, no. 11 (January 17, 2024): 8758-8973.
- ~~H.~~ G.I. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 202~~65~~) UM 5 Timeliness of UM Decisions ~~Elements A and E~~

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

Policy/Procedure Number: MCUP3041 (previously UP100341)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Treatment Authorization Request (TAR) Review Process		☒ External Policy ☐ Internal Policy	
Original Date: (UM-2) 04/25/1994 (Effective 06/19/2013 - TAR/RAF Review Policy split)		Next Review Date: ~~06/12/2025~~ 08/12/2027 Last Review Date: 08/13/202508/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

X. **REVISION DATES:** TAR Procedure [UM-2]: 11/19/96; 12/15/99; 01/12/00 – RAF Procedure [UM-1]: 12/27/95; 05/27/99); (TAR/RAF [UP100341] - 06/21/00; 04/18/01; 03/20/02, 05/21/03 attachments revised 10/01/03; 04/21/04; 01/19/05; 04/20/05; 09/21/05, 10/18/06, 08/20/08, 07/15/09; 05/19/10; 07/20/11); 06/19/13; 06/17/15; 09/16/15; 05/18/16; 04/19/17; *06/13/18; 02/13/19; 05/08/19; 09/11/19; 04/08/20; 09/09/20; 04/14/21; 08/11/21; 05/11/22; 06/14/23; 06/12/24; 08/13/25; 08/12/26

*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

Administrative denials are reviewed monthly by the Chief Medical Officer and monitored quarterly to identify trends and/or the need for additional provider education, outreach, or other intervention. A summary is presented to the Internal Quality Improvement Committee every six months. 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 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 Partnership.

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

PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

- A. **Acupuncture** (see policy MPUG3002 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. **Behavioral Health Treatment** (see policy MCUP3126 Behavioral Health Treatment (BHT) for Members Under the Age of 21)
- C. **Cardiac Rehabilitation** – Phase II and pediatric (see policy MCUP3128 Cardiac Rehabilitation)
- D. **Chiropractic Services** (see policy MPUG3010 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 MPAP7004 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 MCAP7003 CalAIM Community Supports (CS) and MCAP7001 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**
 - A. **Magnetic Resonance Angiography (MRA)** (~~MR Angiogram~~)
 - B. **Mass Spectrometry Imaging (MSI)**
 - C. **Magnetoencephalography (MEG)**
 - D. PET scan [see policy MPUP3116 Positron Emission Tomography Scans (PET Scans)]
 - E. Transcranial Doppler
 - F. 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 MPUG3110 Evaluation and Management of Obstructive Sleep Apnea in Adults (Medi-Cal))
 - ~~G.~~ Non-specific radiology codes for X-rays and ultrasound including 76497, 76380, 76506

Note: No TAR is required for CT scans or MRIs
- I. **Doula Services** (see policy ~~MP~~NP9006 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 MPUG3019 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

PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

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)
11. 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-MCAP7002](#) CalAIM Enhanced Care Management (ECM) and MCAP7001 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) and Microbiota-Based Therapeutics (MBT)** A TAR is required for all procedures related to [microbiota-based therapeutics, including](#) fecal microbiota transplant. (see policy MPUP3136 ~~Fecal Microbiota-Based Transplant Therapeutics [MBT]~~)
- 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. **Hearing Aids** (see policy MPUG3019 Hearing Aid Guidelines)
- Q. **Home Health Care** (see policy MPUG3011 Criteria for Home Health Services)
- R. **Home Infusion Therapy**
- S. **Hysterectomy**

PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

- T. **Hospice Care (Inpatient Only)** (see policy MCUP3020 Hospice Service Guidelines)
- U. **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.
- V. **Hyperbaric Oxygen Pressurization**
- W. **Intermediate Care Facility for developmentally disabled services** (see policy MCUG3058 Utilization Review Guidelines ICF/DD, ICF/DD-H, ICF/DD-N Facilities)
- X. **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 Extended Care (Custodial/Long Term Care, ~~Skilled or Subacute~~-(LTC) Facilities.
- Y. **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 22-01225-013 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
- Z. **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 25-01322-012 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.
- AA. **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 TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

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*.

- BB. **Non-Emergency Medical Transportation:** [see policy MCCP2016 *Transportation Guidelines for Non-Emergency Medical (NEMT) and Non-Medical Transportation (NMT)*]
- CC. **Occupational Therapy** (see policy MPUP3114 *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
- DD. **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.)
- EE. **Outpatient Surgical Procedures** – see CPTs Requiring TAR list (page 5)
- FF. **Pain Management** – see Pain Management CPTs Requiring TAR list (page 8) and policy MCUP3049 *Pain Management Specialty Services*
- GG. **Phototherapy** for dermatological condition
- HH. **Physical Therapy** (see policy MPUP3114 *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
- II. **Pulmonary Rehabilitation** (see policy MPUP3111 *Pulmonary Rehabilitation*)
- JJ. **Speech Therapy** (see policy MPUP3114 *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 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
- KK. **Transplants** (see policy MCUP3104 *Transplant Authorization Process*)
- LL. **ANY UNLISTED OR MISCELLANEOUS CODE**

HCPSC Codes	Description
P9020	Platelet rich plasma unit
V2531	Contact Lens, Scleral, Gas Permeable, Per Lens

PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

HCPCS Codes	Description
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
37700	Ligation and Division of Long Saphenous Vein at Saphenofemoral Junction, or Distal Interruptions

PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	Description
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
43999	Stomach Surgery Procedure

PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

Outpatient Surgical Procedures CPTs Requiring TAR	
CPT Code	Description
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, lumbar (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
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

PARTNERSHIP TAR REQUIREMENTS

[Treatment Authorization Request (TAR) to be submitted by the provider performing these services]

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
62290, 62291	Injection procedure for Discography, Lumbar (62290) and Cervical/Thoracic (62291)
62360, 62362	Implantable or replacement of device for intrathecal or epidural drug infusion; subcutaneous reservoir
63650, 63655, 63661, 63662, 63663, 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	Radiological supervision and interpretation for Cervical and Thoracic Discography
72295	Radiological supervision and interpretation for Lumbar discography

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
POLICY/ PROCEDURE

Policy/Procedure Number: MCUP3140			Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Palliative Care: Pediatric Program for Members Under the Age of 21			☒ External Policy ☐ Internal Policy	
Original Date: 05/08/19 Effective Date: 01/01/2019 per DHCS		Next Review Date: ~~10/08/2026~~ <u>10/08/2027</u> Last Review Date: ~~10/08/2025~~ <u>10/08/2026</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIALING	☒ PAC
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~10/08/2025~~ <u>08/12/2026</u>	

I. RELATED POLICIES:

- A. MCUP3020 – Hospice Service Guidelines
- B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- C. MCUP3124 – Referral to Specialists (RAF) Policy
- D. MPUP3137 – Palliative Care: Intensive Program (Adult)
- E. MCCP2022 – Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
- F. MPCR300 – Physician Credentialing and Re-credentialing Requirements
- G. MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements
- H. MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist
- I. CGA024 – Medi-Cal Member Grievance System
- J. MPQP1022 – Site Review Requirements and Guidelines
- K. MCUP3106 – Waiver Programs
- L. MPQP1038 – Physician Orders for Life-Sustaining Treatment (POLST)

II. IMPACTED DEPTS:

- A. Health Services
- B. Provider Relations
- C. Member Services
- D. Claims

III. DEFINITIONS:

- A. ED: Emergency Department
- B. Hospice Care: Services provided to a terminally ill patient with a prognosis of life of 6 months or less, if the disease follows its normal course. For children, curative services may be provided concurrently with hospice services.
- C. Outpatient Pediatric Palliative Care (OPPC): A Partnership HealthPlan of California-defined outpatient palliative care program for Members under age 21 years, provided by a team over an extended period of time, usually in the home. Defined by the Department of Health Care Services (DHCS) as covered as part of the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services.
- D. Medical Necessity: 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.
- E. Palliative Care: Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care can be provided as part of Hospice Care at the end of life, or as a set of supportive services for individuals with life-threatening conditions who have a life expectancy that is longer than 6 months.

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- F. Palliative Care Team: A group of healthcare individuals such as a Doctor of Medicine (MD) or Osteopathy (DO), Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN), Medical Social Worker (MSW) and/or Chaplain who work together to meet the physical, medical, psychological, emotional and spiritual needs of a Member and his/her family and assist in identifying sources of pain and discomfort.
- G. RAF: Referral Authorization Form – The primary care provider (PCP) submits a RAF to Partnership HealthPlan of California to refer a Partnership Member to a specialist for evaluation and/or treatment.
- H. TAR: Treatment Authorization Request – A request for a treatment, procedure, or service to be performed by a requested specialist or professional services in a health care setting, normally outside the requesting practitioner's office.

IV. ATTACHMENTS:

- A. [Outpatient Pediatric Palliative Care Eligibility Assessment](#)
- B. [Engagement and Enrollment Process for Outpatient Palliative Care](#)
- C. [Application to be a Contracted Outpatient Palliative Care Provider](#)

V. PURPOSE:

To define Partnership HealthPlan of California's Palliative Care services to Partnership Medi-Cal eligible beneficiaries under age 21. See policy MPUP3137 for a description of palliative care for Members age 21 and over.

VI. POLICY / PROCEDURE:

- A. Range of palliative care services available for pediatric Members.
 1. In its general definition, palliative care services may range in intensity and be provided in different settings and by different configurations of teams. Any level of palliative care services may be part of the care plan for a Member under age 21, as developed by the primary care provider, specialist, case management team, or specialty care center. Members under age 21 may have concurrent curative and palliative treatments. The major categories that may apply for Members under age 21 are:
 - a. Primary palliative care
 - b. Outpatient specialty palliative care—low intensity
 - c. Outpatient pediatric palliative care—high intensity
 - d. Hospice
 2. Primary palliative care is provided by primary care clinicians or by specialists who are not board certified or specialty trained in palliative care. It may be provided in the inpatient or outpatient setting. Partnership considers such services as integral parts of usual evaluation and management services; no prior authorization is required; no special billing codes apply.
 3. Outpatient specialty palliative care—low intensity is provided by specialty trained palliative care physicians outside the hospital setting, independent of a supporting team. Board Certified Palliative Care Physicians may apply to be a credentialed Palliative Care Specialist (See policy MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist). Like other outpatient specialist consultation, Partnership's specialty referral policies apply (See policy MCUP3124 – Referral to Specialists (RAF) Policy).
 4. Outpatient pediatric palliative care is provided by a team over an extended period of time, usually in the home. Services are similar in scope to hospice, but the eligibility criteria are different. Sections VI. B. through F. define criteria and services for outpatient palliative care for Partnership Members under age 21.
 5. Hospice services are limited to Members with a life expectancy of 6 months or less but may also include curative care [for pediatric members](#). (See policy MCUP3020 Hospice Services Guidelines)

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B. Outpatient Pediatric Palliative Care Eligibility Criteria

1. Members must meet criteria stated in a. through f. below:

- a. Have Partnership HealthPlan of California as their primary insurance, or Partnership as secondary coverage with a rejection of coverage by the primary insurance.
- b. Are under 21 years of age
- c. The parent(s) or legal guardian and the child (if cognitively able) agree to the provision of pediatric palliative care services; and
- d. The parent or legal guardian declines hospice enrollment or the Member is not eligible for hospice enrollment
- e. Documentation of an Eligible Medical Condition: Member must have a life-threatening diagnosis. Conditions may include but are not limited to:
 - 1) Conditions for which curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease); or
 - 2) Conditions requiring intensive long-term treatment aimed at maintaining quality of life (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy); or
 - 3) Progressive conditions for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta); or
 - 4) Conditions involving severe, non-progressive disability, or causing extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms)
- f. Projected Level of Care: At least one of the following
 - 1) The Member has started to use the hospital or emergency department as a means to manage the unanticipated decompensation of the Member's disease.
 - 2) The attending physician estimates that the Member would be expected to be hospitalized for at least 30 days in the next year.

2. If the Member continues to meet eligibility criteria, the Member may continue to access both palliative care and curative care until the condition improves, stabilizes, or results in death.

C. Outpatient Pediatric Palliative Care Engagement and Enrollment Process

1. Palliative Care Assessment and Consultation (Engagement):

- a. Partnership contracted Outpatient Pediatric Palliative Care providers will contact Members referred to their program for evaluation within 7 calendar days to arrange an evaluation and assessment.
- b. No prior authorization is required for the engagement process before speaking with a Member.
- c. No prior authorization is required prior to providing initial coordinated care (G9001). However, payment will require submission of a TAR. If the patient meets enrollment criteria specified in VI. B. above, the TAR for G9001 should be submitted with a TAR for ongoing case management and other services being requested (see VI. C.f. below). If the patient does not meet criteria, the TAR may be submitted for only the initial coordinated care service (G9001).
- d. The initial TAR for initial coordinated care (G9001) should include the Outpatient Pediatric Palliative Care Eligibility Assessment Form (Attachment A).
- e. The initial coordinated care covers a comprehensive assessment and support services for a period of 30 days. The applicable time period should be indicated on the TAR and on the claim submitted.
- f. A TAR for ongoing services (enrollment) based on the care plan developed in the initial coordinated care visit should be submitted during the initial coordinated care period (30 days). To ensure no gap in services, it is recommended that this TAR be submitted no later than 20 days after the initiation of the one month of initial coordinated care. The TAR for ongoing services should include

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- 1) Dates of visits of the palliative care team ~~m~~Members to the Partnership Member (for G9001 services)
- 2) Advanced care ~~d~~ **planning** discussion with goals of care document
- 3) A multidisciplinary comprehensive assessment, including assessment by a Registered Nurse and a Licensed Clinical Social Worker
- 4) Care Plan addressing medical, social, emotional and spiritual needs
- g. Partnership intensive care management teams may identify and refer care--managed Members (who are potentially eligible for this benefit) to a contracted Partnership palliative care provider.
2. Pediatric Enrollment Process
 - a. Submit a TAR for the Member's enrollment into the Outpatient Pediatric Palliative Care program to Partnership in accordance with Partnership policy MCUP3041 TAR Review Process. With an enrollment TAR, the Provider must submit the information required for the engagement TAR (VI.B.1.e. and f.), as well as the Outpatient Pediatric Palliative Care Eligibility Assessment Form (Attachment A).
 - b. For Members in the hospital, enrollment will take place after discharge.
 - c. Continued approval will require subsequent TAR submission, every 6 months, with the following information included:
 - 1) Detailed progress notes, documenting current disease status
 - 2) Dates of face--to--face and telemedicine visits
 - d. TAR is required for these services (typically submitted as a package for a single patient):
 - 1) Minimum ongoing services required is **monthly care coordination** (T2022) which includes 4-12 hours of care coordination services per 30 day period. Included in this monthly care coordination is at least one monthly visit to the Member in their home by one of the OPPC staff. Additional services that should be included on the TAR include:
 - a) **Activity therapy** (G0176), 45 minutes or more per session, includes art, music, child life therapy and massage therapy. Maximum of three units per day, up to 60 hours per 90 days.
 - b) **Initial case management** (G9001) as detailed above in section VI.C.1
 - 2) **Other specified case management** (G9012), provided by any OPPC staff, hourly for each hour of case management beyond 12 hours, which is covered by T2022. Maximum of 60 hours per 90 days.
 - 3) **Family home care training** by a Registered Nurse (S5110), 15 minutes per unit, maximum of 12 units per day, 100 hours per year.
 - 4) **Family Counseling** (90837) provided by psychologist or LCSW. One unit = 15 minutes; with a maximum of 22 units per rolling 12 month period (equal to 330 minutes per rolling 12 month period).
 - 5) **Pain and Symptom Management** (S9123), provided by a Registered Nurse, one hour per unit. Maximum of 100 hours per year.
3. Pediatric Re-Enrollment Criteria

A new TAR is required every six (6) months for all Members receiving Pediatric Palliative Care services. The TAR must include documentation and submission of the following items:

 - a. Current clinical summary of Member's condition and individualized care plan.
 - b. Detailed progress notes completed by the palliative care physician, nurse practitioner or specialist documenting relevant specific clinical information showing continued eligibility for palliative care.
 - c. Medical records must include a recent face to face visit by the registered nurse, medical provider (MD or DO, nurse practitioner, or physician assistant) that documents the patient's current clinical condition.

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4. OPPC Disenrollment Criteria
 - a. Member is not eligible for Partnership for more than 30 days
 - b. Member moves out of the service area
 - c. Member, parent(s) or legal guardian declines participation after enrollment
 - d. Member, parent(s) and legal guardian refuses to be contacted
 - e. Member, parents(s) and legal guardian cannot be reached or is lost to follow-up for 30 days
 - f. Member, parent or legal guardian exhibits inappropriate or threatening behavior towards staff
 - g. Member, parent or legal guardian poses a safety or security risk to staff, other patients or clinic property
 - h. Member is deceased
 - i. Member begins hospice services
 - j. Member's condition changes such that palliative care is no longer medically necessary or no longer reasonable. (Consultation with Partnership Palliative Care team may be necessary in some cases)
- D. Outpatient Pediatric Palliative Care: Scope of Services
 1. Outpatient Pediatric Palliative Care (OPPC) Services include the following:
 - a. Care Coordination, including monthly in person or telephonic meetings with Partnership Care Coordination staff
 - b. Advance care planning conversations
 - c. Development of a treatment plan, including patient goals
 - d. Control of pain, medication side effects, and other symptoms
 - e. Addressing spiritual concerns
 - f. Addressing social service needs
 - g. Basic child and family counselling
 - h. Expressive therapies
 - i. Telephone advice line, available 24 hours per day, 7 days per week
 - j. Close communication with Primary Care Provider
 2. Outside optional auxiliary services that may be ordered by the palliative care team are not strictly part of the package of services specified above as part of OPPC. These are provided fee for service, according to usual Partnership processes.
 - a. Skilled nursing visits
 - b. Home health aide visits
 - c. Physical therapy visits
 - d. Occupational therapy visits
 - e. Speech therapy visits
 - f. Registered dietician visits
 - g. Respiratory therapy visits
 - h. Psychotherapy - More intensive counselling may be provided outside the OPPC services by licensed therapists through the Partnership mental health benefit
 - i. Durable Medical Equipment
- E. Providers of Services
 1. General:
 - a. In order to receive payment for services described in this policy, provider organizations must submit an application for approval (Attachment C) and have a palliative care contract in place with Partnership.
 - b. Partnership will contract with qualified palliative care providers such as hospitals, long-term care facilities, clinics, hospice agencies, home health agencies, and Community Based Adult Service (CBAS) facilities who utilize providers with current palliative care training and/or certification to deliver authorized palliative care services to Members in accordance with this

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policy, existing Medi-Cal contracts and/or All Plan Letters. Certification of qualified palliative care providers shall occur in accordance with Partnership policy MPCR13A Credentialing of Hospice and Palliative Care Medicine Specialist. Partnership will authorize palliative care services to be provided in a variety of settings including, but not limited to, inpatient, outpatient or community-based settings. Palliative care provided in a Member's home must comply with existing Partnership policies and Medi-Cal requirements for in-home providers, services, and authorization such as physician assessments and care plans.

2. All approved Palliative Care service providers shall be listed in Partnership's Provider Directory.
 3. Outpatient Pediatric Palliative Care: Provider organization must submit an application to become contracted Outpatient Palliative Care Providers (See Attachment C for application).
 - a. Criteria for consideration includes the following:
 - 1) Completed application (Attachment C)
 - 2) Organization or all providers are contracted Medi-Cal providers
 - 3) Organization must have the capacity to bill Partnership for services provided
 - 4) Organizations that are already contracted with Partnership for other services must be providers in good standing
 - 5) Clinical staff are trained in palliative care. Minimum training is the [Cal State San Marcos Shiley Haynes Institute for Palliative Care Training Curriculum](#), or equivalent, which must be completed by a staff Member no later than 3 months after beginning to work for the Outpatient Palliative Care Organization. Medical Director may be board certified, board eligible or have one year (at least 200 hours) in hospice or palliative care experience.
 - 6) Provider organizations that include pediatric patients must have staff trained in the principles of pediatric palliative care.
 - 7) Core staffing identified (hired or contracted to be hired by contract start date):
 - a) Medical Director
 - b) Registered Nurse
 - c) Social Worker
 - d) Administrator
 - 8) Organization or Medical Director already providing services in the region for at least 6 months prior to contracting
 - b. Submission of an application does not guarantee that Partnership will contract with an organization. Submitted applications will be evaluated based on a variety of criteria including, but not limited to, the quality and completeness of the application, geographic network adequacy, and history of the organization submitting the application.
 - c. Contracted sites must pass a Partnership facility and medical records site audit within 3 months of contract start date, and every 3 years afterwards. Sites which do not pass the audit may have their contract terminated for cause, or may be required to submit and complete a corrective action plan. Timelines and appeals process for this audit will follow the general standards defined in Partnership Policy MPQP1022 Site Review Requirements and Guidelines.
- F. Respite Care
1. Respite care services, out-of-home for use in a Congregate Living Health Facility, are covered for Members under age 21 and require prior authorization and submission of a TAR. A maximum of 30 days per year is covered. Other approved facilities, such as skilled nursing facilities, should use policies and procedures for that location of services.
 2. Home-based respite therapy services are not covered by Partnership.
- G. Transition of Care When Member Turns 21
- a. Pediatric Members receiving palliative care who are turning 21 will be transitioned to the appropriate program or service, such as adult palliative care (see policy MPUP3137 – Palliative

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Care: Intensive Program [Adult]) or applicable state waiver program (see policy MCUP3106 – Waiver Programs).

VII. REFERENCES:

- A. Medi-Cal Provider Manual/ Guidelines: Palliative Care ([palli care](#))
- B. Section 2302 of the Patient Protection and Affordable Care Act (ACA)
- C. Centers for Medicare & Medicaid Services *Medicare Benefit Policy Manual*
- D. Department of Health Care Services, *SB 1004 Medi-Cal Palliative Care October 2, 2015* (2015).
- E. Title 22, California Code of Regulations (CCR) / [Hospice Care 51349](#)
- F. [Social Security Act 1812\(d\)\(1\)](#)
- G. Welfare and Institutions Code Section [14132.75](#)
- H. Department of Health Care Services (DHCS) All Plan Letter [\(APL\) 18-020](#) Palliative Care (12/07/2018)
- I. DHCS Numbered Letter [\(NL\) 12-1119 Subject: Palliative Care Options for CCS Eligible Children-Revised \(11/18/2019\)](#)
- J. DHCS All Plan Letter [\(APL\) 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)

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

X. REVISION DATES:

05/13/20; 05/12/21; 06/08/22; 08/09/23; 09/11/24; 10/08/25; ~~08/12/26~~

PREVIOUSLY APPLIED TO:

N/A

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 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 Partnership.

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
Outpatient Pediatric Palliative Care
Eligibility Assessment Form**

MCUP3140 Attachment A
10/08/2025

Member Name: _____ CIN: _____

County of Residence: _____ Contact Phone Number: _____

DOB: _____ Today's Date: _____ Current Age: _____

Name of Palliative Care Provider Organization: _____

General criteria: Check each of the following that apply (All needed for eligibility)

- ☐ **Has Partnership HealthPlan of California as their primary insurance**
- ☐ **Parent(s) or legal guardian and the child (if cognitively able) agree to accept Outpatient Pediatric Palliative Care Services**
- ☐ **Is 20 years of age or younger**
- ☐ **Has an eligible medical condition**
- ☐ **Parent or legal guardian declines hospice enrollment or the Member is not eligible for hospice enrollment**
- ☐ **Meets the Level of Care criteria**

Diagnosis: _____ **ICD10 Code:** _____

Date of Diagnosis _____

Date(s) of most recent hospitalizations (in the last 6 months) _____

Highlights of Treatment Course to Date:

Estimate of anticipated unplanned inpatient days in the next calendar year if palliative care is not provided: _____

Which one or more of the following apply:

- ☐ Curative treatment is possible, but may fail (e.g., advanced or progressive cancer or complex and severe congenital or acquired heart disease)
- ☐ Intensive long-term treatment aimed at maintaining quality of life is required (e.g., human immunodeficiency virus infection, cystic fibrosis, or muscular dystrophy)
- ☐ Progressive condition for which treatment is exclusively palliative after diagnosis (e.g., progressive metabolic disorders or severe forms of osteogenesis imperfecta)
- ☐ Severe, non-progressive disability
- ☐ Extreme vulnerability to health complications (e.g., extreme prematurity, severe neurologic sequelae of infectious disease or trauma, severe cerebral palsy with recurrent infection or difficult-to-control symptoms).

Supporting Details:

Engagement and Enrollment Process for Outpatient Palliative Care

Partnership does not require a Referral Authorization Form (RAF) from a primary care provider (PCP) to refer patients for palliative care services. A Treatment Authorization Request (TAR) will be required for all Palliative Care Services (engagement and enrollment) and should be faxed or electronically submitted from the palliative care provider to the Health Services Department for review, no less than once every ~~three~~ six months, based upon medical necessity criteria and in accordance with Partnership policy MCUP3041 Treatment Authorization Request (TAR) Review Process. The TAR request for Palliative Care services must include, at a minimum, documentation and/or treatment plan addressing the following:

1. Advanced Care Planning: includes discussions about advance directives and Physicians Authorization for Life Sustaining Treatment (POLST) forms. These discussions take place between a physician and other qualified healthcare professional and a Member, family member or surrogate in counseling. See also policy MPQP1038 Physician Orders for Life-Sustaining Treatment (POLST).
2. Assessment and Consultation: ~~P~~palliative care assessment and consultation services may be provided at the same time as advanced care planning, or in subsequent patient conversations. The goal of the palliative care consultation is to collect both routine medical data and additional personal information not regularly included in a medical history or Health Risk Assessment. During an initial and/or subsequent palliative care consultation or assessment, topics may include but are not limited to:
 - a) Treatment plans, including palliative care and curative care
 - b) Pain control, medication side effects, symptom control
 - c) Emotional and/or social challenges
 - d) Spiritual concerns
 - e) Patient goals
 - f) Advance Directives, including POLST forms
3. Plan of Care: ~~A~~a plan of care should be developed with the engagement of the Member and/or ~~his/her~~their healthcare representative. If a Member already has a plan of care in place, that plan should be updated to reflect any changes resulting from the palliative care consultation. A Member's plan of care must include all authorized palliative care including, but not limited to, symptom management and curative care.

If a Member continues to meet the above minimum eligibility criteria, ~~he/she~~they may continue to access both palliative care services and curative care until the condition improves, stabilizes, or results in death. Partnership will review treatment plan notes with TAR submission to assess for changes in the Member's condition and continued palliative care needs. Partnership may discontinue palliative care for Members for whom palliative care is no longer medically necessary.



Partnership HealthPlan of California

Application to be a Contracted Outpatient Palliative Care Provider

Please submit the following to contracting@partnershiphp.org

Organization Information

1. Name of Organization (

2. Contact Information:

Administrative Contact of Parent Organization (if applicable)

Name

Title

Phone

e-mail

Billing Department

Name

Title

Phone

e-mail

Palliative Care Program Director

Name

Title

Phone

e-mail

Palliative Care Medical Director

Name

Title

Phone

e-mail

3. Does your organization currently contract with Partnership HealthPlan of California?

Yes ☐ No ☐

4. Medi-Cal provider number:

Palliative Care Program Description

5. Describe any palliative care services *currently provided* by your organization. Include current volume of services, the service delivery model, outcomes and the criteria for enrollment.

6. Number of patients enrolled annually in your organization's palliative care program (if applicable)

Medicare:

Medi-Medi:

Medi-Cal only:

Uninsured:

Total:

Not applicable ☐

7. Number of patients enrolled annually in your organization's ☐ hospice or ☐ home care program (if applicable)

Medicare:

Medi-Medi:

Medi-Cal only:

Uninsured:

Total:

Not applicable ☐

8. Does your organization provide palliative care services to children? ☐ Yes ☐ No
If Yes, please describe level of experience and training in pediatric palliative care:

Program Information

9. What strategies will your organization use to identify patients who may be eligible and interested in community-based palliative care?
10. What geographic areas will your palliative care program serve?
11. Describe how your organization will partner with local hospice agency(s) and/or home health agencies.
12. Provide a narrative outlining:
 - (1) Staff disciplines and FTE your organization will use to provide 24/7 telephonic care (with access to a nurse), assessments, pain/symptom management, advance care planning, POLST, acute management plan, assess caregiver support, transition support, case management and medical oversight? If your organization will contract for some of these services, please describe the contractual arrangements. Include description of current and planned training and/or certification in palliative care.

13. How will your palliative care program be distinct from chronic disease case management and hospice programs? How will this distinction be communicated to providers and patients?

14. Attachments:

- a. C.V. of Medical Director of program
- b. Letter of commitment from applicant's parent organization or major funder of a new organization not affiliated with a larger corporate sponsor
- c. Letters of support from major expected referral sources (hospitals, health centers, at least one oncologist, at least one other specialist from this group: gastroenterology, pulmonology, cardiology)
- d. If organization is not a hospice organization, a letter or memorandum of understanding with local hospice organizations who can accept patients who need hospice care.
- e. Annual Audited Financial Statements

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MPUG3025 (previously UG100325)			Lead Department: Health Services Business Unit: Utilization Management	
Guideline/Procedure Title: Insulin Infusion Pump and Continuous Glucose Monitor Guidelines			☒ External Policy ☐ Internal Policy	
Original Date: 04/19/1996		Next Review Date: ~~06/11/2026~~ 08/12/2027 Last Review Date: ~~06/11/2025~~ 08/12/2026		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
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: ~~06/11/2026~~ 08/12/2026	

I. RELATED POLICIES:

- A. MCUP3041 - Treatment Authorization Request (TAR) Review Process
- B. MCUG3007 - Authorization of Ambulatory Procedures and Services
- C. ~~MP~~UP3042 - Technology Assessment
- D. MCUP3013 - Durable Medical Equipment (DME) Authorization
- E. MPUP3139 – Criteria and Guidelines for Utilization Management

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims
- C. Member Services

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. Continuous glucose monitor: A device to measure glucose levels in the interstitial fluid through the use of a sensor placed under the skin. A transmitter sends information about glucose levels to a wireless monitor attached externally. These devices display glucose levels at either 1 or 5 minute intervals with the option to set alarms alerting the individual to abnormal glucose levels. Greater amounts of data collection may provide more insight regarding glucose patterns.
- C. Diabetologist: A physician who is Board Certified in Advanced Diabetes Management (BC-ADM). [Note that this is not an American Board of Medical Specialties (ABMS) board certification.]
- D. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would ~~not meet their care needs~~ ~~be inappropriate~~. Assignment to Direct Member status ~~may be~~ is based on the ~~M~~member's aid code, prime insurance, demographics or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers (or Medicare providers as applicable for Partnership Advantage enrollees) willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP. When a PCP is not assigned, Partnership supports coordination of care among providers.
- E. Insulin pump: Also known as subcutaneous insulin infusion (CSII), an insulin pump is an external ambulatory infusion device used for managing insulin-requiring Diabetes Mellitus (DM). By continuous administration of short acting insulin at preselected rate, the insulin pump can improve the patient glycemic control and delay, prevent, or reduce their risk of complications (e.g. neuropathy, nephropathy, retinopathy.)

Guideline/Procedure Number: MPUG3025 (previously UG100325)		Lead Department: Health Services Business Unit: Utilization Management	
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Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

- F. Partnership Advantage: Effective January 1, 2028~~7~~, 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~~Members 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 January 1, 2028 and subject to CMS and DHCS approval.
- G. Whole Child Model (WCM): ~~A This program provides~~ comprehensive program treatment for the whole child encompassing providing comprehensive diagnostic and treatment services and care coordination in the areas of primary, specialty, and behavioral health for any Partnership HealthPlan of California (Partnership) pediatric ~~M~~members with a CCS-eligible condition(s) insured by Partnership.

IV. ATTACHMENTS:

- A. [CCS NL 06-1120 Authorization of Insulin Infusion Pumps - Revised 11/17/2020](#)
- B. ~~CCS NL 15-1222 Continuous Glucose Monitoring Systems as a CCS/GHPP Program Benefit —12/23/2022~~

V. PURPOSE:

To describe the guidelines used by Partnership HealthPlan of California's Utilization Management (UM) staff when reviewing a Treatment Authorization Request (TAR) for an external insulin infusion pump and/or a continuous glucose monitor.

VI. GUIDELINE / PROCEDURE:

- A. Partnership reviews Treatment Authorization Requests (TARs) for external insulin infusion pumps and/or a continuous glucose monitors according to appropriate regulatory guidance (as described in policy MPUP3139 Criteria and Guidelines for Utilization Management).
1. For Partnership Medi-Cal Members: TARs are reviewed according to required standards set forth by the State of California Department of Health Care Services (DHCS) and criteria provided in the [DHCS Medi-Cal Provider Manual Guidelines](#).
 - a. InterQual® and other industry-accepted guidelines will also be used, along with other policies developed by Partnership, as described in MPUP3139 Criteria and Guidelines for Utilization Management.
 - b. For Members under the age of 21 who are eligible for California Children's Services (CCS), please also refer to CCS guidelines for Insulin Infusion Pumps in Attachment A ~~and CCS guidelines for Continuous Glucose Monitoring (CGM) in Attachment B.~~
 2. For Partnership Advantage EnrolleesMembers: TARs are reviewed according to [Section 40 of the CMS Medicare guidance for Part C & D Organization/ Coverage Determinations](#) and other CMS guidelines and criteria sets that may include, but are not limited, to the following:
 - a. Medicare National Coverage Determination ([NCD](#)) [Manual](#)
 - 1) For insulin infusion pumps see [NCD 280.14](#)
 - b. Medicare Local Coverage Determination (LCD) policy
 - 1) For external insulin infusion pumps see [L33794](#)
 - 2) For glucose monitors see [L33822](#)
 - c. In the event that national and/or local coverage determination is silent on the matter, Partnership uses InterQual® and other industry accepted guidelines, along with other policies developed by Partnership, as described in MPUP3139 Criteria and Guidelines for Utilization Management.

B. INSULIN INFUSION PUMPS

Guideline/Procedure Number: MPUG3025 (previously UG100325)		Lead Department: Health Services Business Unit: Utilization Management	
Guideline/Procedure Title: Insulin Infusion Pump and Continuous Glucose Monitor Guidelines		☒ External Policy ☐ Internal Policy	
Original Date: 04/19/1996		Next Review Date: ~~06/11/2026~~ 04/08/202706/10/2027 Last Review Date: ~~06/11/2025~~ 04/08/202606/10/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

An insulin infusion pump must be ordered by the Primary Care Provider (PCP) or endocrinologist or diabetologist treating the Mmember through a referral from the PCP. For Direct Members, the insulin infusion pump must be ordered by the physician who is currently managing the medical care for the Mmember.

3.1. Partnership utilizes InterQual® criteria to determine the necessity of a pump.

a. For Partnership Advantage ~~enrollees~~Members, Medicare guidelines will also be considered.

4.2. The TAR for an insulin infusion pump must include documentation of the medical necessity for home use of the insulin infusion pump that includes the following information related to the condition:

- a. A valid order/prescription
- b. The most recent Hgb A1c results
- c. Chart notes from the PCP or specialist managing the diabetes care of the Mmember which include the following:
 - 1) Length of time the Mmember has had diabetes
 - 2) Documentation the insulin pump is needed as part of the plan of care in managing the diabetes
 - 3) Evaluation of the Mmember's compliance with the diabetes treatment plan
 - 4) Documentation that the Member is insulin dependent or on agents that are associated with hypoglycemia 30 consecutive day self-tested blood glucose log

5.3. Partnership authorizes the least costly medically necessary insulin pump.

- a. Omnipod pumps may be considered for CCS Mmembers on a case-by-case basis, according to criteria specified in CCS Numbered Letter 06-1120 (Attachment A).
- b. Omnipod pumps may be considered for Partnership Advantage ~~Members-enrollees~~ on a case-by-case basis according to Section 40 of the CMS Medicare guidance for Part C Organization Determinations and criteria stated in NCD 280.14 and LCD L33794.

6.4. Insulin infusion pumps should only be prescribed and managed by practitioners familiar with this operation.

C. CONTINUOUS GLUCOSE MONITORING (CGM) SYSTEMS

Continuous glucose monitoring (CGM) requests received by Partnership will be reviewed on a case by case basis for medical necessity according to Medi-Cal or Medicare guidelines (including Medicare LCD L33822), as applicable for Partnership Medi-Cal Members or Partnership Advantage Members-enrollees. ~~CGMs can be authorized through Partnership if ordered through a contracted Durable Medical equipment (DME) provider, or they can be dispensed through a pharmacy provider as described below.~~

1. CGMs Dispensed through a Pharmacy Provider:

a. Partnership Medi-Cal Members: CGM systems are covered as pharmacy-billed items through Medi-Cal Rx. Refer to the Medi-Cal Rx Provider Manual for details.

1) Partnership does not review TARs received for medications and services in the scope of Medi-Cal Rx. The pharmacy or provider submitting the TAR should send the TAR to the DHCS-contracted pharmacy administrator for review and processing.

a) According to the Medi-Cal Rx Provider Manual, prior authorization is required for Members who are pregnant or up to 12 months postpartum and have gestational diabetes, Type 1 diabetes or Type 2 diabetes.

i. Estimated date of delivery and recent glycosylated hemoglobin (Hemoglobin A1c) results are required for medical justification.

b. Partnership Advantage Enrollees: Effective January 1, 2028, the pharmacy benefit for Partnership Advantage enrollees is delegated to a pharmacy benefit manager.

1) Note that Medicare prohibits Part D (pharmacy) coverage when Part B (DME) is available.

7.2. To Authorization of CGMs through Partnership if when ordered through a Contracted DME Provider:

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Original Date: 04/19/1996		Next Review Date: ~~06/11/2026~~ 04/08/202706/10/2027 Last Review Date: ~~06/11/2025~~ 04/08/202606/10/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

- a. ~~In the event that a CGM system is not available to the Member through a Medi-Cal Rx pharmacy, The a~~ TAR for a CGM should may be submitted to Partnership with include documentation of the medical necessity for home use of CGM therapy that includes the following information related to the condition:
 - 1) A valid order/prescription
 - 2) The most recent Hgb A1c results
 - 3) Chart notes from the PCP or specialist managing the diabetes care of the Mmember with the following information:
 - a) Length of time the Mmember has had diabetes
 - b) Documentation that CGM is needed as part of the plan of care in managing the diabetes
 - c) Evaluation of the Mmember's compliance with the diabetes treatment plan
 - d) Documentation by provider that Mmember checks blood glucose readings 3- 4 times daily
 - 4) Documentation that the device is not available from a Medi-Cal Rx pharmacy
- ~~8.1. CGMs Dispensed through a Pharmacy Provider:~~
 - 1) ~~Partnership Medi-Cal Members: The pharmacy (prescription) benefit was carved out to State Medi-Cal as of January 1, 2022. For State Medi-Cal authorization requirements, please refer to the State Medi-Cal Rx Education & Outreach page at this website <https://medi-calrx.dhes.ca.gov/home/education/>~~
 - b. ~~Partnership Advantage Members: Effective January 1, 2027, the pharmacy benefit for Partnership Advantage Members is delegated to a pharmacy benefit manager.~~
 - 2) ~~Note that Medicare prohibits Part D (pharmacy) coverage when Part B (DME) is available.~~
3. Continuous Glucose Monitoring is proven and considered medically necessary in the following clinical scenarios:
 - a. Short-term (3 - 7 days) of continuous glucose monitoring by a healthcare provider for diagnostic purposes is proven and medically necessary for patients with diabetes. Current Procedural Terminology (CPT) codes used for this service are 95250 and 95251. Limit one of each code per dates of service in a single calendar month. No TAR is required.
 - b. Long-term continuous glucose monitoring for personal use at home is proven and medically necessary as a supplement to self-monitoring of blood glucose (SMBG) for patients with type 1 diabetes, cystic fibrosis related diabetes, or sequelae of a CCS eligible condition that requires chronic insulin therapy, who have demonstrated adherence to a physician ordered diabetic treatment plan.
 - 1) InterQual® criteria will apply for coverage determination for adults and children with type 1 diabetes mellitus.
 - 2) CGMs are a covered benefit for children 20 years of age or younger with type 1 diabetes mellitus.
 - c. Long-term continuous glucose monitoring for patients with type 2 or gestational diabetes are reviewed on a case-by-case basis for medical necessity.
 - e. ~~CGM for patients with type 2 diabetes may be indicated for patients with:~~
 - 1) ~~Recurrent severe hypoglycemic {two of more episodes in a 30-day period of ADA Level 2 hypoglycemia [blood glucose less than 3.0 mmol/L (54 mg/dl) with unawareness in a patient taking insulin]} or despite appropriate modifications in insulin regimen and compliance with frequent self-monitoring (at least 4 finger sticks/day), OR~~
 - 2) ~~Frequent nocturnal hypoglycemia {ADA Level 1 hypoglycemia [blood glucose of 3.9 mmol/L (70 mg/dl) or less despite modifications to insulin treatment]} and compliance with frequent glucose self-monitoring (at least four times a day), OR~~
 - 3) ~~Poor diabetes control when ordered by a diabetologist as defined in III.C., a board-certified endocrinologist, or an internal medicine or family physician.~~

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~~InterQual® criteria will apply for coverage determination.~~

- ~~3. Long term CGM is considered experimental and investigational for nesidioblastosis (primary islet cell hypertrophy) and for monitoring blood glucose in non-diabetic persons following gastric bypass surgery.~~
- ~~4. CGM using an implantable glucose sensor is considered investigational and unproven and therefore not covered for non-U.S. Food and Drug Administration (FDA) approved devices.~~

~~VH.VI.~~ REFERENCES:

- ~~A. Medi-Cal Provider Manual/Guidelines: Durable Medical Equipment (DME): Infusion Equipment (dura inf); Durable Medical Equipment (DME): Billing Codes (dura cd); Pregnancy: Early Care and Diagnostic Services (preg early)~~
- ~~B. Medi-Cal Rx Provider Manual~~
- ~~A.C. InterQual® 20265 DME criteria – Continuous Glucose Monitoring, Insulin Pumps, and Automated Insulin Delivery Technology.~~
- ~~B.D. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Section 280.14 Infusion Pumps. Implementation date 02/18/2005 or any subsequent updates published by CMS.~~
- ~~C.E. Medicare Local Coverage Determination (LCD) L33794 External Infusion Pumps Revision Effective Date 10/01/2024 or any subsequent updates published by CMS.~~
- ~~D.F. Medicare Local Coverage Determination (LCD) L33822 Continuous Glucose Monitors, Revision Effective Date 10/01/2024 or any subsequent updates published by CMS.~~
- ~~E.G. McCulloch DK. Blood glucose self-monitoring in management of adults with diabetes mellitus. UpToDate Inc., Waltham, MA.~~
- ~~F.H. International Hypoglycemia Study Group. Diabetes Care. November 21, 2016 <http://care.diabetesjournals.org/content/early/2016/11/09/dc16-2215>~~
- ~~E. Diabetes Care 2019;42(8):1593-1603. International Consensus Report: Clinical Targets for Continuous Glucose Monitoring Data Interpretation: Recommendations from the International Consensus on Time in Range.~~
- ~~F. Diabetes Therapy 2019;10:853-863. A View Beyond HbA1c: Role of Continuous Glucose Monitoring.~~
- ~~G. CCS Numbered Letter (NL) 06-1120 Authorization of Insulin Infusion Pumps - Revised 11/17/2020~~
- ~~H. CCS Numbered Letter (NL) 15-1222 Continuous Glucose Monitoring Systems as a CCS/GHPP Program Benefit—12/23/2022~~
- ~~H. Department of Health Care Services (DHCS) All Plan Letter (APL) 22-01225-013 Governor's Executive Order N-01-19, Regarding Transitioning Medi-Cal Rx Pharmacy Benefits and Cell and Gene Therapy Coverage from Managed Care to Medi-Cal —RX (Revised 12/30/202209/18/2025)~~

~~VH.VII.~~ DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

~~X.IX.~~ REVISION DATES:

Partnership Advantage (Effective 01/01/20287)
06/11/25; 08/12/26

Medi-Cal

04/28/00; 06/20/01; 09/18/02; 09/15/04; 11/16/05; 08/20/08; 10/01/10; 05/16/12; 04/15/15; 03/16/16;

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04/19/17; 10/18/17; *11/14/18; 11/13/19; 10/14/20; 02/10/21; 04/14/21; 03/09/22; 03/08/23; 03/13/24;
06/11/25; ~~06/11/08/12/26~~

*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 MPUG3025 (Healthy Kids program ended 12/01/2016)
08/20/08; 10/01/10; 05/16/12; 04/15/15; 03/16/16 to 12/01/2016

Healthy Families

MPUG3025 - 10/01/10 to 03/01/2014

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 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 Partnership.

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



State of California—Health and Human Services Agency
Department of Health Care Services



DATE: November 17, 2020

N.L.: 06-1120
Supersedes N.L.: 11-1017,
N.L.: 08-0799
Index: Benefits

TO: All County California Children's Services Program and Integrated Systems of Care Division Staff

SUBJECT: Authorization of Insulin Infusion Pumps - Revised

I. PURPOSE

The purpose of this Numbered Letter (N.L.) is to update policy for the California Children's Services (CCS) county Program and Integrated Systems of Care Division (ISCD) staff on authorization of equipment for Insulin Infusion Pump (IP) systems.

The CCS Program publishes this N.L. under the program's authority to authorize services that are medically necessary to treat CCS-eligible conditions.^{1,2,3}

II. BACKGROUND

Insulin IPs have been used for treatment of difficult-to-control diabetes mellitus since the late 1970s. Use of IPs allows for continuous basal delivery of insulin in addition to as-needed supplemental insulin at mealtimes, simulating "normal" insulin secretion. The use of IPs has been shown to improve glycosylated hemoglobin (HbA1c) levels, reduce hypoglycemic episodes, and reduce blood glucose variability and improve quality of life when compared to multiple daily injections (MDI) in adults. In children, these effects have been demonstrated in observational studies, but not in randomized controlled trials.

The insulin IP is an open-looped system that has two modes of insulin delivery. The first is a continuous basal infusion of insulin that can be pre-programmed to a specific blood glucose level. The second mode of delivery is a bolus of insulin controlled by the user for meals and snacks and for correction of elevated blood glucose levels. The insulin IP is comprised of an insulin reservoir, a microcomputer controlled IP, and a range of additional features.⁴

Currently, available IP systems are insulin IP only, insulin IP with wireless connectivity to continuous glucose monitoring system (CGM), and insulin IP with

integrated CGM. Associated supplies include infusion sets and syringes.

Considerable evidence has shown that IPs are safe in infants and children with negligible risk of pump malfunction in the current generation of pumps. At least one study of benefits of IPs in children under ten has found no problems with parent operation of pumps.⁵

IPs have been found to be effective and safe used in infants and children under the supervision of a multidisciplinary diabetes team consisting of at a minimum: an Endocrinologist/Diabetologist experienced in administration and monitoring of IPs in children, Nurse Specialist, Diabetes Educator, Social Worker, and a Registered Dietitian. Additionally, a high level of parental/guardian/caretaker knowledge and intense supervision of diabetes management has been reported to be essential to successful IP initiation and ongoing use.

III. POLICY

A. Effective the date of this letter, IPs without integrated mandatory CGM capacity are a benefit of the CCS Program for CCS Program-eligible clients regardless of payer when the following criteria are met:

1. The IP is requested by a CCS Program-approved Metabolic/Endocrine Special Care Center (SCC) endocrinologist.
2. The client has insulin dependent diabetes mellitus requiring basal bolus therapy for glucose management.
3. The client follows a program of multiple daily injections of insulin with a history of adhering to the MDI regimen and blood glucose monitoring.

B. Documentation from SCC team with evaluation within 180 days of the request must support all of the following:

1. Client and/or family/guardian demonstrates the ability to adequately monitor blood glucose levels using conventional multiple-injection procedures by providing logs confirming this activity.
2. Client and or family/guardian demonstrates knowledge and skills necessary for compliance with recommended diet;
3. Client demonstrates that he/she has sufficient skills to enable him/her to manage the essentials of using an insulin IP system independently or with strong family/guardian support and supervision.
4. Client and/or family/guardian has high level of motivation to achieve and maintain glycemic control and to understand the benefits of this control.

C. The following are benefits of the CCS Program when the client meets the additional criteria described below:

1. Omnipod insulin infusion system. The CCS Program authorizes the least costly medically necessary services. The Omnipod system is substantially more costly than the alternatives after one year of use. Therefore, the Omnipod pump is a CCS Program benefit only when the center presents a compelling case for approval describing or more of the following characteristics of the client:
 - a. Behavioral need including biting or pulling of tubing or pump,
 - b. Physical need including loss of vision or other medical issue that interferes with the safety or efficacy of the standard insulin pumps, or
 - c. Participation in athletics that requires removal of the pump for a substantial amount of time on most days.
2. Integrated CGM.

IPs with integrated CGM functions can be authorized if the client requires a new insulin pump at time of CGM initiation and meets the criteria above for insulin pump and criteria for CGM as defined in N.L. 03-0317.
3. Rental of CGM components. Authorization may be issued for 72-hour CGM procedure when requested by a SCC.
4. Wireless insulin tracking and dosing device.
 - a. InPen and other similar FDA approved devices are a benefit for CCS clients with type 1 diabetes mellitus who are not on an insulin pump.
 - b. These devices should be authorized using miscellaneous Durable Medical Equipment (DME) code E1399.

D. Additional consideration for medical necessity determination:

For clients who do not meet the criteria described in Sections III. A. through III. C., providers may demonstrate medical necessity by submitting any other clinical documentation and/or evidence that would support the initial or reauthorization of the client's authorization of equipment for Insulin IP systems. Providers, SCCs, or pharmacies should submit this documentation to the ISCD Medical Director or Designee.

IV. POLICY IMPLEMENTATION

A. The CCS Program medical consultant or designee shall review the request to ensure that the following are in evidence:

1. The request for the external IP is from the CCS Program authorized Endocrine SCC physician.
2. The request is accompanied by the necessary documentation to determine medical necessity, including a full team SCC evaluation within the past 180 days with reports by all team members.

B. Authorizations

1. Initial authorization for the purchase of an IP and pump supplies will be for a one year-period or up to the expiration of program eligibility.
2. Authorization to the SCC shall be in place to cover ongoing care of the client with CCS Program eligible insulin dependent diabetes.
3. Initial authorization of the external IP and pump supplies shall include education by a diabetes team member. Although education provided by the vendor may be helpful, it is not a substitute for the training and monitoring that must be provided by the SCC team. Re-authorizations of the pump supplies will be dependent upon documentation by the SCC physician of need for continuation of the pump after a full SCC team evaluation at least annually.
4. Refer to "This Computes!" for current CCS Program process regarding authorization of DME and DME supplies.
5. Replacement of an external IP is covered when medically necessary as described in (II), when there is medical documentation from the physician that the pump is not functioning properly, and it is no longer under warranty and cannot be repaired. CCS Program does not authorize replacement of a pump that is still functioning simply because the warranty (usually 4 years) has expired or the model has been updated. Most pumps can be expected to function beyond this time period with the usual pump lifespan 4-6 years.
6. New clients who enter into the CCS Program already in possession of a previously acquired IP with mandatory CGM function, shall have medically necessary associated supplies authorized for the life of the pump. Future new pump authorizations should follow criteria listed in (III.) above.
7. Denials of IP must be approved by the state Integrated Systems of Care Division regional office or local county medical consultant.

The ISCD will continue to monitor newly developed treatment modalities available for CCS Program clients with insulin dependent diabetes mellitus.

Beginning April 1, 2021, all requests for prior authorization of medications billed by National Drug Code and dispensed by a Medi-Cal enrolled pharmacy provider, shall be sent from the pharmacy provider to the Medi-Cal Rx vendor, Magellan Medicaid Administration, Inc. (Magellan). The Medi-Cal RX website provides guidance: <https://medi-calrx.dhcs.ca.gov/home/>.

If you have any questions regarding this N.L., please contact the ISCD Medical Director or designee at ISCD-MedicalPolicy@dhcs.ca.gov.

Sincerely,

ORIGINAL SIGNED BY

Roy Schutzengel
Medical Director
Integrated Systems of Care Division

¹ 22 Cal. Code Regs. § 41515.1 et. seq. Determination of Medical Eligibility
<https://govt.westlaw.com/calregs/Document/I28E30090D4B811DE8879F88E8B0DAAAE?viewType=FullText&originalContext=documenttoc&transitionType=CategoryPageItem&contextData=%28sc.Default%29>

² 22 Cal. Code Regs. § 41700 Availability
[https://govt.westlaw.com/calregs/Document/I2F1A7E70D4B811DE8879F88E8B0DAAAE?viewType=FullText&originalContext=documenttoc&transitionType=CategoryPageItem&contextData=\(sc.Default\)&bhcp=1&ignorebhwarn=IgnoreWarns](https://govt.westlaw.com/calregs/Document/I2F1A7E70D4B811DE8879F88E8B0DAAAE?viewType=FullText&originalContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)&bhcp=1&ignorebhwarn=IgnoreWarns)

³ 22 Cal. Code Regs. § 41740 Eligibility for Treatment Services
<https://govt.westlaw.com/calregs/Document/I2FDD8050D4B811DE8879F88E8B0DAAAE?viewType=FullText&originalContext=documenttoc&transitionType=StatuteNavigator&contextData=%28sc.Default%29>

⁴ Current Pumps
<http://www.diabetesnet.com/diabetes-technology/insulin-pumps/current-pumps>

⁵ Pediatrics 114: 1601 – 1605, 2004.



MICHELLE BAASS
DIRECTOR

State of California—Health and Human Services Agency
Department of Health Care Services



GAVIN NEWSOM
GOVERNOR

DATE: December 23, 2022

NL: 15-1222

Supersedes: NL: 14-0818

Index: Benefits

TO: All County California Children's Services Program Administrators, Medical Directors and Consultants, Genetically Handicapped Persons Program and Integrated Systems of Care Division Staff

SUBJECT: CONTINUOUS GLUCOSE MONITORING SYSTEMS AS A CALIFORNIA CHILDREN'S SERVICES PROGRAM AND GENETICALLY HANDICAPPED PERSONS PROGRAM BENEFIT

I. PURPOSE

The purpose of this California Children's Services (CCS) Numbered Letter (NL) is to modify policy for the CCS Program and the Genetically Handicapped Persons Program (GHPP) regarding authorization of continuous glucose monitoring (CGM) systems for CCS Program and GHPP clients.

The CCS Program publishes this NL under the program's authority to authorize services that are medically necessary to treat CCS-eligible conditions.^{1, 2, 3}

II. BACKGROUND

CGM systems are minimally invasive devices that measure subcutaneous interstitial fluid glucose. The availability of real-time CGM data allows the individual or caregiver to monitor glucose levels, receive alerts for dangerously high or low blood glucose levels, and adjust diet and medications to avert adverse hypoglycemic or hyperglycemic events.

The CGM systems are particularly beneficial for those with hypoglycemic unawareness, consistent hyperglycemia, nocturnal hypoglycemia, and fear of hypoglycemia resulting in hyperglycemia. The CGM system is comprised of up to three main components:

- A. **Sensor:** An adhesive device containing a small wire placed subcutaneously which measures interstitial glucose and remains in place for a various number days, depending on the CGM system used. For application site information, product specific information should be followed.
- B. **Transmitter:** A device that attaches to the top of the sensor and sends glucose levels via radio waves to the receiver and/or part of a combined system that

sends information to the receiver. With some systems, the sensor and transmitter are integrated.

- C. Receiver: A device that collects and tracks data so the client, caregiver, and/or healthcare provider can adjust diet and/or insulin regimen for improved diabetes management. Some receivers are equipped with an alarm that alerts the client or client's caregiver when an individual is at risk for hypoglycemia or hyperglycemia. Some CGM systems allow for the use of a compatible smart device instead of receiver.

Numerous insulin pumps now have the ability to integrate with specific CGM systems. This includes two recently Food and Drug Administration (FDA) approved integrated insulin pumps with an automatic low glucose suspend feature and one pump with auto-corrections. The American Diabetes Association states, "These devices may offer the opportunity to reduce severe hypoglycemia for those with a history of nocturnal hypoglycemia."⁵

In 2017, the FDA separated CGMs into therapeutic and non-therapeutic. Therapeutic CGM are FDA approved for non-adjunctive use and can be used for making diabetic treatment decisions while non-therapeutic CGM are for an adjunct use only. When using non-therapeutic CGMs, diabetic treatment decisions must be made using home blood glucose monitoring testing. Both therapeutic CGMs, which currently include Dexcom and Abbott Libre models, and non-therapeutic CGMs are now covered as a pharmacy benefit through Medi-Cal Rx.

III. POLICY

Effective October 1, 2022, non-therapeutic CGMs are also processed through Medi-Cal Rx according to the Medi-Cal Rx integrated coverage policy. Prior Authorization is required on all CGM requests through Medi-Cal Rx.

1. Section 13.4 of the [Medi-Cal Rx Provider Manual](#)
2. Under Covered continuous Glucose Monitoring (CGM) Systems [Medi-Cal Providers | Forms and Information](#).

- A. Therapeutic and non-therapeutic CGMs may be prescribed by one of the following:
1. A CCS Program-paneeled endocrinologist affiliated with an Endocrine Special Care Center (SCC) or SCC nurse practitioner if the physician has ordered CGM for the client, as documented in the medical record.
 2. A CCS-paneeled community pediatric endocrinologist if the client meets all of the following:

- a. Is within the age approved by the FDA for the specific CGM.
 - b. Has had a multidisciplinary team visit by the Endocrine SCC in the past 12 months.
 - c. Plans to continue to follow up at an Endocrine SCC at least annually.
3. For GHPP clients, an adult endocrinologist at an approved Endocrine SCC or an adult endocrinologist or internal medicine specialist with an active Medi-Cal provider number treating the GHPP-eligible condition.
- B. The CCS Program or GHPP client must meet all of the following
1. The client has a diagnosis of type 1 diabetes mellitus, cystic fibrosis (CF) related diabetes, insulin-dependent type 2 diabetes, or sequelae of a CCS Program-eligible condition that requires ongoing insulin use.
 2. The client requires glucose testing by finger stick or CGM at least three times per day.
 3. The client requires analog insulin injections at least three times per day or uses an insulin pump.
 4. The client's insulin regimen requires frequent adjustment on the basis of finger stick or CGM blood glucose readings.
- C. Documentation containing all of the following information must be submitted by the Endocrine SCC or provider to Medi-Cal Rx.
1. CGM is medically necessary based on the medical report from an approved Endocrine SCC.
 2. The client meets eligibility criteria described in Section III B.1-4 of this policy.
 3. The CCS Program client has been seen for a comprehensive team visit at an Endocrine SCC, including consultation with SCC endocrinologist, within the past 12 months.
 4. The client and/or caregiver agrees to use the CGM on most days.
 5. The client and/or caregiver demonstrate a high-level of motivation to achieve tighter glucose control and competency to accurately use the CGM system and comply with recommended use.

6. The client has completed at least one session of general diabetes education within the past 12 months.

D. Reauthorization:

A CGM system may be reauthorized for up to 12 months when documentation from the Endocrine SCC or the CCS Program-paneled provider demonstrates consistent uses.

E. Additional considerations for medical necessity determination:

For clients who do not meet the criteria described in policy Section III. A through D, providers may demonstrate medical necessity by submitting other clinical documentation and/or evidence that would support the medical necessity of the CGM system for the client. Providers should submit this documentation to Medi-Cal Rx for a PA approval.

F. Integrated Insulin Pumps - A CGM system integrated with insulin pump may be authorized if the client:

1. Meets criteria for an insulin pump, described in CCS NL 06-1120⁶ or CCS NL superseding CCS NL 06-1120 and does not have a pump or requires a new pump, and
2. Meets the criteria described above for CGM.

G. Disposable Insulin Delivery Devices (DIDD) are a Medi-Cal Rx benefit. All DIDD requests must be submitted to Medi-Cal Rx according to the Medi-Cal Rx integrated policy.

1. Section 43.3 of the [Medi-Cal Rx Provider Manual](#)
2. [Covered Disposable Insulin Delivery Devices.xls](#)

H. The following items related to CGM systems are non-benefits of the CCS Program and GHPP and are not reimbursable:

1. Smart/mobile phone, tablet, or computer for downloading glucose values.
2. Mobile phone plans, even if the CGM systems has a way to share downloaded values with client's healthcare provider.
3. Mobile applications or PC software related to CGM systems.
4. Professional or personal CGM systems when used intermittently.

I. Whole Child Model (WCM) Counties:

For CCS clients who are enrolled in a Medi-Cal managed care health plan (MCP) and reside in a WCM County, CGMs and DIDD may be covered through the MCP. The client's MCP is responsible for coordinating coverage, and authorizing these items and other CGM systems, which are billable by HCPCS code only.

IV. POLICY IMPLEMENTATION

A. The following must be verified prior to authorizing CGMs:

1. The request for the CGM is from a provider listed in Section II. A of this policy.
2. The request is accompanied by all necessary documentation and the client meets the full criteria as stated in Section III of this policy.

B. Reauthorization:

Reauthorization requires documentation that the client is meeting the recommended use guidelines and the CGM has contributed to improved diabetes management. A CGM system may be reauthorized for up to one year with a PA renewal along with a report from a CCS Program-approved Endocrine SCC. This can occur after the CGM was initiated, which contains or summarizes the following information:

1. Date CGM use was initiated.
2. Medical record documentation of:
 - a. Percent of time glucose is in target range or a statement in the medical record that the client used CGM most days.
3. Hemoglobin A1C level or equivalent assessment of glucose control within the last 180 days. A hemoglobin A1c level the same or lower than baseline, or use of an insulin pump or justification for continued use by endocrinology team, is required for reauthorization.

C. Medi-Cal RX is responsible for the review for CGM replacements.

ISCD will continue to monitor developments in the use of CGM systems and will update policy as appropriate.

If you have any questions regarding this NL, please send an email to the Medical Policy Team at ISCD-MedicalPolicy@dhcs.ca.gov.

Sincerely,

ORIGINAL SIGNED BY

Cortney Maslyn
Division Chief
Integrated Systems of Care Division

¹ [22 CCR § 41515.1 et. seq. Determination of Medical Eligibility](#)

² [22 CCR § 41700 Availability](#)

³ [22 CCR § 41740 Eligibility for Treatment Services](#)

⁴ [Medi-Cal Rx Provider Manual](#)

⁵ Numerous insulin pumps have the ability to integrate with a CGM system. This includes two recently FDA-approved integrated insulin pumps with an automatic low glucose suspend feature. The American Diabetes Association states, "These devices may offer the opportunity to reduce severe hypoglycemia for those with a history of nocturnal hypoglycemia."

⁶ [CCS Numbered Letters](#)

ARCHIVED 08-12-2026 per DHCS

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPUP3039 (previously MCUP3039, UP100339)			Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Direct Members			☒ External Policy ☐ Internal Policy	
Original Date: 04/25/1994		Next Review Date: ~~08/13/2026~~ 08/12/2027 Last Review Date: ~~08/13/2025~~ 08/12/2026		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☒ CEO	☐ COO	☐ CREDENTIALS	☒ PAC
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~08/13/2025~~ 08/12/2026	

I. RELATED POLICIES:

- A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- B. MCCP2024 – Whole Child Model for California Children’s Services (CCS)
- ~~C. MPCP2002 – California Children’s Services~~
- ~~D. C. MCUP3104 – Transplant Authorization Process~~
- ~~E. D. MCUP3020 – Hospice Service Guidelines~~
- ~~F. E. MCUP3103-MCBP8015 – Coordination of Care for Child Welfare-Involved Members in Foster Care~~
- ~~G. MCUP3051 – Long Term Care SSI Regulation~~
- ~~H. F. CGA024 – Medi-Cal Member Grievance System~~

II. IMPACTED DEPTS:

- A. Health Services
- B. Member Services
- C. Claims

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. Other Health Coverage (OHC): Where Partnership does not act as primary insurance.
- C. Partnership Advantage: Effective January 1, 202~~8~~7, 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 ~~Members~~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 January 1, 2028 and subject to CMS and DHCS approval.
- D. Whole Child Model (WCM): ~~This A comprehensive~~ program ~~provides comprehensive treatment~~ for the whole child ~~encompassing providing comprehensive diagnostic and treatment services~~ and care coordination in the areas of primary, specialty, and behavioral health for ~~any Partnership HealthPlan of California (Partnership)~~ pediatric Members with ~~a~~ CCS-eligible condition(s) insured by Partnership.

IV. ATTACHMENTS:

- A. Direct Member/ Health Conditions Category Designation Grid

Policy/Procedure Number: MPUP3039 (previously MCUP3039, UP100339)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Direct Members		☒ External Policy ☐ Internal Policy	
Original Date: 04/25/1994		Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026	
Applies to:	☒ Employees	☒ Medi-Cal	☒ Partnership Advantage

V. PURPOSE:

To define criteria for assigning Members to Direct Member status to ensure access to covered services.

VI. POLICY / PROCEDURE:

- A. Direct Members are those whose service needs are such that assigning a Primary Care Provider (PCP) would not meet their care needs~~assignment would be inappropriate~~. Assignment to Direct Member status is based on the Member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers (or Medicare providers as applicable for Partnership Advantage ~~Members-enrollees~~) willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP. When a PCP is not assigned, Partnership shall ensure supports coordination of care among providers.
- B. Under the Whole Child Model (WCM), Partnership is responsible for authorizing and coordinating care for Members under age 21 with California Children's Services (CCS)-eligible conditions. To maximize the patient-provider relationship and to best coordinate care, these Members are assigned to a medical home and a "Whole Child Model" Direct Member status (as per Attachment A). The provider identified as the child's medical home is responsible for managing the child's primary care needs and coordinating specialty services.
- C. Services for Direct Members will be paid on a fee-for-service basis based upon prevailing Partnership rates. The Treatment Authorization Request (TAR) system will be in place for all Partnership services that require the use of a TAR. (Refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process)
- D. Generally, Members become eligible for Direct Member status either due to a specific clinical condition or ~~due by meeting to~~ a specific-defined administrative service category (refer to Attachment A, Direct Member/ Health Conditions Category Designation Grid).
- E. Members, their authorized representative, or the primary care office they are assigned to, may request consideration for Direct Member status.
 1. Member requests will be processed through the Member Services department and reviewed by Health Services staff who will contact the Member's providers as necessary to obtain medical documentation.
 - a. Health Services staff will notify the Member and their assigned primary care office of the decision.
 - b. If the request is approved, an alternate provider (other than the previously assigned PCP) will be identified and informed of Partnership's TAR procedures. The Member will be encouraged to obtain all care from the alternate provider.
 - c. If the request is denied, the ~~reason(s) will be outlined in a letter to the~~ Member will receive written notice that includes the reason for the decision and appeal rights.
 - 1) Partnership Medi-Cal Members may appeal a Direct Member status decision according to the process outlined in policy CGA024 Medi-Cal Member Grievance System.
 - 2) Partnership Advantage ~~Members-enrollees~~ may appeal a Direct Member status decision according to the process outlined in Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance (ODAG).
 - 3) For Members with a Continuity of Care health condition, appeals of decisions will go through the physician review process.
- F. Other Considerations

Policy/Procedure Number: MPUP3039 (previously MCUP3039, UP100339)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Direct Members		☒ External Policy ☐ Internal Policy	
Original Date: 04/25/1994		Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026	
Applies to:	☒ Employees	☒ Medi-Cal	☒ Partnership Advantage

1. Member assignment to Direct Member status is based on a time-limited or condition-limited (e.g., pregnancy) interval. After the interval has elapsed, the case will be reconsidered, and the Member removed from Direct Member status if circumstances warranting this status no longer exist.
2. The Chief Medical Officer or physician designee may review cases where the circumstances of a clinical condition warrant consideration of the status change by the HealthPlan and may consult with other specialty physicians as needed to complete the review.
3. The Health Services Department will encourage all Direct Members to utilize the Partnership network.
4. Members assigned to Direct Member status will receive a letter with a new ID card from the Member Services Department. The Member ID Card will reflect "Direct Member" in lieu of a PCP name.
5. Agencies/facilities will continue to administer their case management activities as mandated by state, federal and regulatory agencies.

VII. REFERENCES:

- A. Medi-Cal Aid Codes Master Chart
- B. Department of Health Services (DHCS) All Plan Letter [\(APL\) 21-015](#) Benefit Standardization and Mandatory Managed Care Enrollment Provisions of the California Advancing and Innovating Medi-Cal Initiative (CalAIM) (10/18/2021 with Attachments Revised 10/14/2022)
 1. [Attachment 1: Mandatory Managed Care Enrollment \(MMCE\) Requirements](#)
 2. [Attachment 2: Major Organ Transplant Requirements](#)
- C. [Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#) Section 40 Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations (11/18/2024)
- ~~C.D.~~ [Code of Federal Regulation, Title 42 § 438.206](#)

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2028~~7~~)
08/13/25; 08/12/26

Medi-Cal: 03/01/95; 10/10/97 (name change only); 6/14/00; 8/15/00; 11/20/00; 03/07/01; 10/17/01; 11/11/03; 03/10/04; 02/08/05; 10/10/06; 11/19/08; 08/18/10, 06/19/13; 03/18/15; 03/16/16; 01/18/17; *02/14/18; 03/13/19; 03/11/20; 09/09/20; 01/13/21; 03/09/22; 10/12/22; 11/08/23; 04/10/24; (MPUP3039) 08/13/25; 08/12/26

*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

Policy/Procedure Number: MPUP3039 (previously MCUP3039, UP100339)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Direct Members		☒ External Policy ☐ Internal Policy	
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Applies to:	☒ Employees	☒ Medi-Cal	☒ Partnership Advantage

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 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 Partnership.

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

Direct Member / Health Conditions Category Designation Grid

This grid has been updated to crosswalk the transition to Partnership's new core claims system, HealthRules Payer (HRP), which is estimated to occur in 2026. At that time, the previous Direct Member designation (shown in first column) will be replaced with one or more of the following four eligibility components (shown in 4th column):

Health Condition, Benefit Plan, User Defined Terms (UDT) and/or Pseudo PCP.

(Members may qualify for more than one component at the same time.)

Partnership Direct Member Designation	Direct Member Type	Criteria	HRP Categories and Eligibility Components (effective when HRP is active)
~~D1~~			~~Transition to PCP Benefit Plan: Full Scope PCP: Pseudo0001~~
Default1	New Member	Upon becoming eligible to Partnership, new Members will have up to 30 calendar days to select a primary care provider (PCP). During the interim, the Member will not be assigned to a PCP or a case managed pool unless the Member has selected a PCP in advance.	Transition to PCP <u>Assigned by the system to new Member or a returning Member with a gap in coverage of 12 months or more. Allows Member one month to pick a PCP.</u>
Default2	Member no longer eligible for a Health Services (HS) Direct Member designation.	Members who no longer qualify for a Health Services' approved Direct Member status such as WCM/CCS, LTC or H5 are placed in Default 2 for one month if the Member cannot be relinked, family-linked or assigned based on claims data.	Transition to PCP
Default4	Members who no longer have prime insurance status (H20, H21, H24)	Members who no longer qualify for prime insurance coverage status are placed in Default 4 for one month if the Member cannot be relinked, family linked or assigned based on claims data.	Transition to PCP
WELLNESS 0001	W&R Substance Use Treatment Services Only	Wellness & Recovery - Substance Use Treatment Services Only As of 7/1/2020 – Medi-Cal residents of Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano Counties. SUBSTANCE USE TREATMENT SERVICES ONLY Members will have a pseudo aid code of 99 (internal use only)	Wellness and Recovery <u>Benefit Plan: Wellness and Recovery</u> <u>PCP: No PCP</u>
WELLNESS 0011	W&R Deceased	Wellness & Recovery – Deceased W&R Member As of 7/1/2020 – Medi-Cal residents of Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano Counties.	<u>Wellness and Recovery</u> <u>Benefit Plan: Wellness and Recovery</u> <u>PCP: No PCP</u> <u>Dates of death are noted on the general tab and deceased user defined term (UDT) tab.</u>

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Partnership Direct Member Designation	Direct Member Type	Criteria	HRP Categories and Eligibility Components (effective when HRP is active)
		Members will have a pseudo aid code of 99 (internal use only)	
WELLNESS 0026	W&R with SOC	Wellness & Recovery – with Share of Cost (SOC) As of 7/1/2020 – Medi-Cal residents of Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, or Solano Counties. Members will have a pseudo aid code of 99 (internal use only)	Unmet Share of Cost Wellness and Recovery <u>Benefit Plan:</u> Unmet Share of Cost Wellness and Recovery <u>PCP:</u> No PCP
HealthWCM 0001 – 0004	CCS Members Who Do Not Have a Medical Home	If a WCM child has not been assigned to a medical home, they will be assigned as follows: HEALTHWCM 0001- Solano, Marin and Sonoma Counties HEALTHWCM 0002- Lake, Mendocino and Northern and Eastern Region Counties HEALTHWCM 0003- Napa County HEALTHWCM 0004- Yolo County	Whole Child Model (WCM) <u>Health Condition:</u> CCS <u>Benefit Plan:</u> Full Scope <u>PCP:</u> Yes, medical home is optional Historical <u>and new</u> CCS mbrs <u>may be converted with No PCP will be auto assigned to medical homes</u>
H1	Emergency & Pregnancy Only OBRA Aid codes	Effective January 1, 2022, as per APL 21-015 <u>Attachment 1 “Mandatory Managed Care Enrollment (MMCE) Requirements,”</u> OBRA beneficiaries transitioned from the Medi-Cal managed care delivery system to Medi-Cal Fee for Service (FFS). Beneficiaries receiving pregnancy-related Medi-Cal services prior to January 1, 2022, will remain in their current delivery system through the end of the individual’s postpartum period.	<u>No PCP assignment for the restricted services.</u> OBRA- Restricted Services <u>Benefit Plan:</u> ER and Pregnancy (<u>Limited to counties: Solano, Napa and Yolo, Aid Codes</u> ~~ER, C1, C2, C3, C4, C5, C6, C7, C8, C9, D1, D8, D9, 58, 5F, C3, C7, 5F, 58;~~ <u>C9, C1</u>) <u>Benefit Plan:</u> ER (<u>Limited to counties: Solano, Napa and Yolo, Aid Code 5G</u>) <u>Benefit Plan:</u> <u>Pregnancy- (Limited to counties: Solano, Napa and Yolo, Pregnancy (Aid Code 5N)</u> <u>Benefit Plan:</u> ER, Pregnancy, LTC and BCCT Aid Code 0U <u>Benefit Plan:</u> ER, Pregnancy and LTC; (<u>Limited to Solano, Napa and Yolo, aid codes: D2, D3, D4, D5, D6, D7, 55</u> <u>UDT: Aid Code</u> ~~Benefit Plan Selection~~ <u>PCP: No PCP</u>
H3	Acquired Immune Deficiency Syndrome (AIDS)	Effective date of assignment is the day of Partnership notification. Members approved when the <u>2008 CDC criteria for AIDS</u> is met.	AIDS <u>Health Condition:</u> AIDS <u>Benefit Plan:</u> Full Scope <u>PCP:</u> No PCP

Transplant
Health Condition: Transplant
Benefit Plan: Full Scope
PCP: No PCP

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Partnership Direct Member Designation	Direct Member Type	Criteria	HRP Categories and Eligibility Components (effective when HRP is active)
Continued <i>Cont'd</i> H5	Continuity of Care, Transplants, and Sonoma Members approved	<u>Bone Marrow (including CAR T-cell therapy and gene therapy)</u> Member is approved upon notification from a Medi-Cal designated transplant facility that the Member has completed the evaluation process, a donor match has been found and is currently listed and waiting transplant. Bone Marrow Transplant Members become eligible for assignment to a PCP two years after receiving the transplant but may qualify for continued H5 based on continuity of care criteria above. Sonoma Members Approved for House Calls: Sonoma Members approved for "House Calls" (a St. Joseph's System Provider Group). "House Calls" is a provider group that provides care for home bound patients.	
H6	Hospice	Effective date is the day the Member signs the hospice election form and continues in this category as long as their care is provided by a <u>qualified</u> hospice program.	Hospice <u>Health Condition:</u> N/A <u>Benefit Plan:</u> Hospice <u>PCP:</u> No PCP
H7	Members in Foster Care, Adoption, or Members with aid code(s) from the Department of Developmental Services (DDS)	Aid Codes: Foster and Adoption: 03, 04, 06, 07, 2P, 2R, 2S, 2T, 2U, 40, 42, 43, 45, 46, 49, 4A, 4C, 4F, 4G, 4H, 4K, 4L, 4M, 4N, 4S, 4T, 4U, 4W, 5K, 5L DDS: 6V	Developmental Disability <u>(Aaid code 6V) -</u> <u>Health Condition:</u> Developmental Disabilities <u>Benefit Plan:</u> <u>Full Scope</u> <u>Foster Care members - UDT:</u> Foster Member <u>PCP:</u> <u>Yes, optional</u> <u>Benefit Plan:</u> <u>Full Scope</u>
H8	Out of Area	Effective date is the day the Member <u>establishes residence</u> out-of-county for a 3-month period, except if the Member is an inpatient in an out-of-county hospital, then the Member can be placed in H8 the day after discharge. Exception: Members in a residential treatment facility for substance use disorders will be temporarily placed in H8 if the facility is out of the resident's county for the length of their stay.	<u>Pseudo Out of Area</u> <u>Benefit Plan:</u> <u>Full Scope</u> <u>Applicable to all benefit plans</u> <u>PCP:</u> Pseudo002
H9		LTC:	Long Term Care (LTC):

08/13/2025

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Partnership Direct Member Designation	Direct Member Type	Criteria	HRP Categories and Eligibility Components (effective when HRP is active)
	Long Term Care (LTC)	Effective date is the day of admission to SNF or LTC facility. LTC Psychiatric: Effective date is the date the Member is admitted to a long term care psychiatric facility. The Member is removed on the first day of the month following discharge and is re-linked to the previously assigned PCP at this time.	<u>Health Condition:</u> LTC – Admit <u>Benefit Plan:</u> Full Scope <u>or</u> <u>Limited LTC</u> <u>PCP:</u> No PCP
H10	Retroactive Members	Effective date of assignment is the first day of the month the Member becomes retroactively eligible with Partnership. The Member is removed and assigned to a PCP on the first day of the month after the retroactive period.	Retroactive Members <u>Benefit Plan:</u> Full Scope <u>PCP:</u> Pseudo003
H11	Deceased	Effective date of assignment is the date of death plus one day.	Deceased <u>Benefit Plan:</u> ~~N/A~~ <u>Any Medi-Cal benefit plan</u> <u>UDT:</u> Deceased Date, <u>General tab:</u> DOD <u>PCP:</u> No PCP
H13	Newborn (~~mother birthing Member~~ assigned to a non-capitated PCP)	The effective date of H13 depends on the ~~birthing mother's~~ <u>Member's</u> Partnership enrollment status. The newborn period is defined as one of the following: • Date of birth through the second month following birth or • Second month following birth only	Newborn <u>Benefit Plan:</u> Full Scope <u>UDT:</u> Newborn <u>PCP:</u> ~~Optional (TBD)~~ <u>PCP:</u> <u>None, Alt providers assigned to mimic ~~mom's~~ birthing Member</u>
H14	Administrative	Members placed in H14 for any of the reasons below: • Have a Pope Valley, Potter Valley, or a Sea Ranch address or • Qualify for Direct Member status due to a state fair hearing decision, or • County expansion • Members that exceed a 30 mile radius from the nearest PCP	Exempt from PCP <u>Benefit Plan:</u> ~~Active~~ <u>Full Scope</u> <u>UDT:</u> Exempt from PCP <u>PCP:</u> No PCP at the same time - Mbr may select PCP
H16	State Hospitals for Mental Health Services	Effective date of assignment is the date of admission to a State Hospital for Mental Health Services. The Member is removed on the first day of the month following discharge from the State Hospital.	State Hosp for Mental Health <u>Health Condition:</u> Mental Health <u>Benefit Plan:</u> ~~Active~~ <u>Full Scope</u> <u>PCP:</u> No PCP

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Partnership Direct Member Designation	Direct Member Type	Criteria	HRP Categories and Eligibility Components (effective when HRP is active)
H18	Native Americans Redding Rancheria Liberty site	Native American Indian – Redding Rancheria Liberty Site As of 9/1/2019: - Healthrurl 0018 is used only for Native American Members and/or their family Members <u>that were grandfathered into H18 that were</u> receiving services at Redding Rancheria Liberty site. <u>Members not grandfathered in do not have this option.</u> <u>Assignment to Healthrurl 0018 requires Redding Rancheria approval.</u>	Native Americans <u>Benefit Plan:</u> Full Scope <u>UDT:</u> Native American Alaskan <u>PCP:</u> Yes, Pseudo <u>Native American-H18</u>
H19	General Member Service (GMS) AND Prenatal Care 28+ weeks	GMS: Effective date of this assignment is at the discretion of Member Services for the following circumstances: - The Member has an appointment with a physician for primary care services other than the Member's assigned PCP, and - The Member was assigned to a PCP inappropriately due to an error in the assignment process. - Other criteria approved by a Member Services Director and the Chief Medical Officer or physician designee. The Member is removed when the Member no longer qualifies, based on the criteria listed above. Prenatal Care: Effective date of this assignment is the first of the month that Partnership is notified of eligibility with Partnership under the following conditions: - The Member is 28 weeks pregnant or more on the date of eligibility with Partnership, - The Member has been regularly cared for by an obstetrical provider prior to eligibility with Partnership, and; - The Member wishes to continue care and requests during pregnancy to continue with their established obstetrical provider for the duration of their pregnancy. The Member is removed on the first day of the	Access to Care <u>Health Condition:</u> Access to Care <u>Benefit Plan:</u> Full Scope <u>PCP:</u> No PCP at the same time - Mbr may select PCP

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Partnership Direct Member Designation	Direct Member Type	Criteria	HRP Categories and Eligibility Components (effective when HRP is active)
		month following 60 calendar days from the delivery date. If the Member does not meet qualifications for Direct Member status under made H19, the Member would be required to change OB providers due to PCP and hospital linkages.	
H20	Medi-Medi Members	Effective the date Member has Medicare Part A or Part B or both Part A and Part B status. Moved out of H20 the day they no longer have any Medicare status. <u>*Note when HRP goes live, Medicare Members with Part B qualify for Direct Member status. Members with Part A only are assigned to PCPs.</u>	Medi-Medi Member <u>Benefit Plan:</u> Full Scope <u>UDT:</u> Dual Medicare/Medicaid <u>PCP:</u> • No PCP for A/B & Part B only Member • Yes PCP for Part A only Members
H21	Continuous Insurance Premium Program (CIP)	Effective date of assignment is the first day of the month of notification that the Member is eligible for CIP and the Health Services Department determines that the Member's medical condition warrants continued eligibility for this program. If the Member is in H21, the Member's health insurance premium is paid by Partnership. The HS Director monitors H21 Members periodically. The Member is removed on the first day of the month after the Member no longer meets criteria for eligibility.	Health Ins. Payment Program <u>Health Condition:</u> OHC- CIP <u>Benefit Plan:</u> Full Scope <u>PCP:</u> No PCP
H22	Genetically Handicapped Persons Program (GHPP)	Effective date of assignment is the date Partnership is notified from the state that the Member has been included on the GHPP list. The Member is removed on the first day of the month that the Member is no longer eligible for GHPP.	GHPP <u>Health Condition:</u> GHPP <u>Benefit Plan:</u> Full Scope <u>PCP:</u> Defer to CC
H24	Other Insurance	Effective date of assignment is the first of the month of notification or identification that the Member has other health insurance. The Member is removed on the first day of the month that the other insurance ends. In this situation, since Partnership is the	Other Health Coverage <u>Benefit Plan:</u> Full Scope <u>PCP:</u> No PCP

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Partnership Direct Member Designation	Direct Member Type	Criteria	HRP Categories and Eligibility Components (effective when HRP is active)
		“payer of last resort”, the other insurance is always the primary payer. Members with an OHC code of C, F, H, K, P and have no Medicare (A and/or B) on the 834 file are placed in H24, effective the first of the current month or following depending on the 834 file information. Partnership is the “payer of last resort.” Includes Members who have prime insurance and are placed in an LTC.	
H26	Unmet Share of Cost (SOC)	LTC aid code 13, 23, 63 with an unmet SOC may be placed in H26.	Unmet Share of Cost <u>Benefit Plan</u> : Unmet Share of Cost <u>PCP</u> : No PCP
H27	Long Term Care Resident with aid code 53	Effective date of assignment is the day the Member is admitted to a long term care facility. The Member is removed on the first day of the month that the Member is discharged from the LTC facility <u>or</u> the Member no longer has aid code 53.	Long Term Care Residents – ER, Pregnancy, and LTC <u>Benefit Plan</u> : Limited to LTC (Aid Code 53) <u>Benefit Plan</u> : ER, Pregnancy, and LTC (Aid Codes 55, D2, D3, D4, D5, D6, D7) <u>UDT</u> : Aid Code - Benefit Plan Selection <u>PCP</u> : No PCP
H28	Long Term Care aid code <u>(13, 23, 63)</u> and not -in LTC <u>facility-(13, 23, 63)</u>	Member with long term care (LTC) aid code and Partnership has not received information of an admit to an LTC facility.	Long Term Care (Not in LTC facility) - 13, 23, 63 <u>Health Condition</u> : LTC – Aid Code <u>Benefit Plan</u> : Full Scope (<u>Aid Codes 13, 23, 63</u>) <u>PCP</u> : No PCP
H29	Duplicates	Effective date of assignment is the day the Member becomes eligible under more than one name or Membership number. Partnership pays for services under the valid Member number.	Duplicates <u>Health Condition</u> : <u>MissingAny</u> <u>Benefit Plan</u> : Full Scope <u>UDT</u> : Duplicate Invalid Record <u>PCP</u> : No PCP
H32	Holderman Patients	~~Effective date of assignment is the date of admission to Holderman facility. The Member is removed on the first day of the month following discharge from the Holderman facility.~~	Holderman Patients <u>Health Condition</u> : Mental Health <u>Benefit Plan</u> : Active <u>PCP</u> : No PCP
H38	End Stage Renal Disease (ESRD)	Members approved when the Medicare definition for ESRD is met. Effective date is the actual date of the first outpatient hemo/ peritoneal dialysis treatment. Exception: Member assigned to H9 who also	End Stage Renal Disease (ESRD) <u>Health Condition</u> : ESRD <u>Benefit Plan</u> : Full Scope <u>PCP</u> : No PCP

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Partnership Direct Member Designation	Direct Member Type	Criteria	HRP Categories and Eligibility Components (effective when HRP is active)
		meets the definition for ESRD will be assigned to H9 with special notation regarding ESRD status.	
H39	Breast / Cervical Cancer	A Member is placed in H39 when the Member has Single aid code of: 0U, 0T, 0R or Member has multiple aid codes and one of them is: 0U, 0T, 0R, , 0N, 0M, 0P 0W	Breast and Cervical Cancer <u>Benefit Plan:</u> BCCTP (Aid code 0T) <u>Benefit Plan:</u> BCCTP (Aid code 0R) <u>Benefit Plan:</u> ER, Pregnancy, LTC, and BCCTP (Aid code 0U) <u>UDT:</u> Aid Code - Benefit Plan Selection <u>PCP:</u> No PCP
H40	Continuity of Care due to large PCP contract termination	- Used at the discretion of Health Services and Large Provider Term Workgroups. - As of 2/5/2020 only available for HEALTHYOLO 0040 & HEALTHRURL 0040	Health Condition <u>Health Condition:</u> Health Condition <u>Benefit Plan:</u> Full Scope <u>PCP:</u> No PCP at the same time – Mbr may select PCP (check with CC)
H41	Continuity of Care due to large PCP contract termination for WCM	- Used at the discretion of Health Services and Large Provider Term Workgroups. - As of 2/5/2020, only available for HEALTHYOLO 0041 & HEALTHRURL0041	Continuity of Care <u>Health Condition:</u> Continuity of Care <u>Benefit Plan:</u> Full Scope <u>PCP:</u> No PCP at the same time – Mbr may select PCP

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY/ PROCEDURE

Policy/Procedure Number: MPUP3111 (Previously MCUP3111)			Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Pulmonary Rehabilitation			☒ External Policy ☐ Internal Policy	
Original Date: 10/20/2010 Effective Date: 01/01/2011		Next Review Date: ~~08/13/2026~~ <u>08/12/2027</u> Last Review Date: ~~08/13/2025~~ <u>08/12/2026</u>		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE ☒ PAC
	☐ CEO	☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~08/13/2025~~ <u>08/12/2026</u>	

I. RELATED POLICIES:

- A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- B. MCUP3104 – Transplant Authorization Process
- C. MCUP3113 – Telehealth Services

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims
- C. Member Services

III. DEFINITIONS:

- A. Partnership Advantage: Effective January 1, 202~~8~~⁷, 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 ~~Members~~ 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 January 1, 2028 and subject to CMS and DHCS approval.
- B. Pulmonary Rehabilitation: a multi-disciplinary program of care for patients with chronic respiratory impairment that is individually tailored and designed to optimize physical and social performance and autonomy and an evidence-based, multidisciplinary, and comprehensive intervention for patients with chronic respiratory diseases who are symptomatic and often have decreased daily life activities.

IV. ATTACHMENTS:

- A. [Pulmonary Rehabilitation Questionnaire](#)

V. PURPOSE:

To define covered services and medical necessity criteria for pulmonary rehabilitation.

VI. POLICY / PROCEDURE:

- A. This policy addresses indications for the use of pulmonary rehabilitation and its conditions, as well as the process for coverage for Partnership Medi-Cal Members and Partnership Advantage ~~Members~~ enrollees.
- ~~A. Medicare National Coverage Determinations apply only to Partnership Advantage enrollees and do not determine Medi-Cal coverage.~~

Policy/Procedure Number: MPUP3111 (previously MCUP3111)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Pulmonary Rehabilitation		☒ External Policy ☐ Internal Policy	
Original Date: 10/20/2010 Effective Date: 01/01/2011		Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

- B. All requests for pulmonary rehabilitation require prior authorization. The provider must submit a treatment authorization request (TAR) for consideration.
- C. The following codes may be used when applicable for TAR and claim submissions for pulmonary rehabilitation delivered to a Partnership Medi-Cal Member in an outpatient or virtual setting, or to a Partnership Advantage Member in a physician's office or a hospital outpatient setting:
1. G0237 – Pulmonary Therapeutic Procedure to Build Strength and Endurance
 2. G0238 – Pulmonary Rehab 1:1
 3. G0239 – Pulmonary Rehab Group Training
 4. 93041 – ECG Monitoring
 5. 94625 – Physician or other qualified health care professional* services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring [session]
 - a. The modifier -95 is added for telehealth provided services.
 6. 94626 - Physician or other qualified health care professional* services for outpatient pulmonary rehabilitation; with continuous oximetry monitoring [per session]
 - ~~b.a.~~ The modifier -95 is added for telehealth provided services.

Telehealth services must comply with applicable DHCS Medi-Cal or CMS telehealth coverage and billing requirements.

**Provider types who can bill for these services include physicians (doctor of medicine and doctor of osteopathic medicine), physician assistants, nurse practitioners and physical therapists. The ICD-10-CM diagnosis code on the claim must be one of the following: J41.0 thru J41.8, J43.0 thru J43.9, J44.9, U07.1, Z76.82 or Z94.2. Telehealth services must comply with applicable DHCS Medi-Cal or CMS telehealth coverage and billing requirements.*
- D. Partnership Advantage Criteria (Effective January 1, 2028):
1. Partnership Advantage covers pulmonary rehabilitation for Members-enrollees with:
 - a. Moderate to very severe COPD (defined as GOLD classification II, III and IV), when referred by the physician treating the chronic respiratory disease;
 - b. Confirmed or suspected COVID-19 and experiencing persistent symptoms that include respiratory dysfunction for at least four weeks.;
 2. D-SNP Medicare National Coverage Determinations regulations apply only applicable to the Partnership Advantage program are applied only to Partnership Advantage enrollees and do not determine Medi-Cal coverage.
 3. For pulmonary rehabilitation to be covered for Partnership Advantage Members-enrollees, the program must include the following components:
 - a. Physician-prescribed exercise during each pulmonary rehabilitation session
 - b. Education or training that is closely and clearly related to the individual's care and treatment which is tailored to the individual's needs and assists in achievement of goals toward independence in activities of daily living, adaptation to limitations and improved quality of life.
 - 1) Education must include information on respiratory problem management and, if appropriate, brief smoking cessation counseling.
 - c. A psychosocial assessment.
 - d. An outcomes assessment.
 - e. An individualized treatment plan detailing how components are utilized for each patient. The individualized treatment plan must be established, reviewed, and signed by a physician every 30 days.
 - f. A physician or nonphysician practitioner immediately available and accessible for medical consultations and emergencies at all times when items and services are being furnished under the program. This provision is satisfied if the physician or nonphysician practitioner meets the requirements for direct supervision for physician office services, which may include virtual presence through audio/video real-time communications.

Policy/Procedure Number: MPUP3111 (previously MCUP3111)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Pulmonary Rehabilitation		☒ External Policy ☐ Internal Policy	
Original Date: 10/20/2010 Effective Date: 01/01/2011		Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

g. The necessary cardio-pulmonary, emergency, diagnostic, and therapeutic life-saving equipment accepted by the medical community as medically necessary (for example, oxygen, cardiopulmonary resuscitation equipment, and defibrillator) to treat chronic respiratory disease.

E. Medi-Cal Coverage Criteria:

1. Partnership Medi-Cal covers pulmonary rehabilitation for Members who have a diagnosis listed in E.1.a. or E.1.b.2 below or who meet the criteria listed in E.1.3.c. A completed Pulmonary Rehabilitation Questionnaire (Attachment A) must be submitted with the TAR.
 - a. Chronic pulmonary conditions eligible for pulmonary rehabilitation include the following:
 - 1) Chronic Obstructive Pulmonary Disease (COPD) – chronic bronchitis or emphysema
 - 2) Interstitial lung disease or idiopathic pulmonary fibrosis
 - 3) Alpha-1-antitrypsin deficiency
 - 4) Asbestosis
 - 5) Asthma
 - 6) Bronchiectasis
 - 7) Chronic airflow obstruction
 - 8) Cystic fibrosis
 - 9) Fibrosing alveolitis
 - 10) Lung Reduction Surgery
 - 11) Pneumoconiosis
 - 12) Pulmonary alveolar proteinosis
 - 13) Pulmonary hemosiderosis
 - 14) Radiation pneumonitis
 - b. Other chronic conditions affecting pulmonary function which may be eligible for pulmonary rehabilitation include:
 - 1) Ankylosing spondylitis
 - 2) Bronchopulmonary dysplasia
 - 3) Guillain-Barre syndrome or other infective polyneuritis
 - 4) Lung cancer
 - 5) Muscular dystrophy
 - 6) Myasthenia gravis
 - 7) Pulmonary Arterial Hypertension (PAH)
 - 8) Paralysis of the diaphragm
 - 9) Sarcoidosis
 - 10) Scoliosis
 - c. A Member will also qualify for pulmonary rehabilitation if they meet the criteria detailed in Attachment A and have at least moderate functional pulmonary disability, with appropriate medical management, as demonstrated by one of the following within 12 months prior to the TAR -(unless there are special considerations as noted in Section VI.F):
 - 1) Obstructive disorders: Moderate to very severe COPD (defined as GOLD classification II, III, IV)
 - 2) Restrictive/fibrotic disorders FEV1, FVC, TLC, or DLCO less than 60% of predicted
 - 3) Either: A maximal pulmonary exercise stress test under optimal bronchodilatory treatment, as indicated, that demonstrates limitation to exercise with a maximal oxygen uptake (VO2max) equal to or less than 20ml/kg/min, or about 5 metabolic equivalents (METS)
2. Special Considerations: The following conditions may also be considered for pulmonary rehabilitation although the patient will not necessarily meet the same criteria stated above in VI.D-E.1.

Policy/Procedure Number: MPUP3111 (previously MCUP3111)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Pulmonary Rehabilitation		☒ External Policy ☐ Internal Policy	
Original Date: 10/20/2010 Effective Date: 01/01/2011		Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

- a. Members eligible for lung transplantation are eligible for pulmonary rehabilitation without demonstration of chronic lung disorders or dysfunction beginning at the time the Member is approved for a transplant by Partnership and continuing for six weeks after transplantation. For further transplant information, please review policy MCUP3104 Transplant Authorization Process.
- b. Members with post-COVID-19 pulmonary sequelae may also be eligible for pulmonary rehabilitation without demonstration of chronic lung disorders or dysfunction.

F. Limits on Coverage:

1. Partnership Medi-Cal Members and Partnership Advantage ~~Members-enrollees~~ who meet the criteria will initially be approved up to a maximum of 36 one-hour sessions. Additional visits can be requested with evidence of compliance with therapy, combined with improvement of function during pulmonary rehabilitation.
 - a. Medi-Cal generally limits pulmonary rehabilitation to up to 72 lifetime sessions when medically necessary. ~~has a lifetime limit of 72 sessions of pulmonary rehabilitation, if medically necessary.~~

VII. REFERENCES:

- A. American Thoracic Society Documents: Pulmonary Rehabilitation for Adults with Chronic Respiratory Disease. AJRCCM, Vol 208, No.4, Apr 15, 2023 <https://doi.org/10.1164/rccm.202306-1066ST>
- B. Medi-Cal Provider Manual/ Guidelines: Respiratory Care (*respir*)
- C. American Lung Association Public Policy Position on Lung Health: <https://www.lung.org/policy-advocacy/public-policy-positions/public-policy-position-lung-health>
- D. Rehabilitation Interventions for Post-Acute COVID-19 Syndrome: A Systematic Review Int J Environ Res Public Health. 2022 Apr 24;19(9):5185. DOI: [10.3390/ijerph19095185](https://doi.org/10.3390/ijerph19095185)
- E. Lin JS, Webber EM, Thomas RG. Screening for Chronic Obstructive Pulmonary Disease: A Targeted Evidence Update for the U.S. Preventive Services Task Force [Internet]. Rockville (MD): Agency for Healthcare Research and Quality (US); 2022 May. (Evidence Synthesis, No. 215.) Table 1, Classification of COPD as Defined by Global Initiative for Chronic Obstructive Lung Disease (GOLD) Available from: <https://www.ncbi.nlm.nih.gov/books/NBK580644/table/ch1.tab1/>
- F. Global Initiative for Chronic Obstructive Lung Disease 2026 Report
- G. Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Section 240.8 Pulmonary Rehabilitation Services. Implementation date 01/07/2008 or any subsequent updates published by CMS.
- H. Title 42 Code of Federal Regulations (CFR) Section § 410.26 Services and supplies incident to a physician's professional services: Conditions.
- I. 42 CFR § 410.47 Pulmonary rehabilitation program: Conditions for coverage.

VIII. DISTRIBUTION:

- A. Partnership Provider Manual
- B. Partnership Department Directors

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

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 20287)
08/13/25; 08/12/26

Medi-Cal

Partnership Enhanced Benefit approved by Board Resolution number 10.5, dated January 26, 2011.
DHCS added Pulmonary Rehabilitation as a benefit in 2018.

Policy/Procedure Number: MPUP3111 (previously MCUP3111)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Pulmonary Rehabilitation		☒ External Policy ☐ Internal Policy	
Original Date: 10/20/2010 Effective Date: 01/01/2011		Next Review Date: 08/13/2026 Last Review Date: 08/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

03/21/12; 02/18/15; 02/17/16; 02/15/17; *03/14/18; 11/13/19; 10/14/20; 10/13/21; 08/10/22; 09/13/23; 09/11/24; 08/13/25; [08/12/26](#)

*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:

MPUP3111 - 10/20/2010 to 01/01/2015

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 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 Partnership.

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

Pulmonary Rehabilitation Questionnaire

Patient's Name: _____ Date: _____

M or F _____ Weight: _____ Height: _____ Age: _____ DOB: _____

Pulmonary Function Testing (PFT) results must be submitted with TAR.

Note: Members with special considerations for pulmonary rehabilitation (patients eligible for lung transplant or those with Post-COVID-19 sequelae) are not required to submit PFT results (4.a. – c. below) but must otherwise complete and submit this form with the TAR.

MEMBER'S DIAGNOSIS:

Member must meet ALL of the following criteria:

	YES	NO
1. Reduction in exercise tolerance that restricts the ability to perform activities of daily living	☐	☐
2. Symptoms that persist despite appropriate medical management	☐	☐
3. No longer smoking or vaping any products (including marijuana) or at least actively quitting by evidence of use of a cessation protocol	☐	☐
4. Have at least moderate functional pulmonary disability, with appropriate medical management, as demonstrated by one of the following:		
a. Obstructive disorders: Pulmonary function tests showing FEV1/FVC less than 70%	☐	☐
b. Restrictive/fibrotic disorders FEV1, FVC, TLC, or DLCO less than 60% of predicted	☐	☐
c. Either: A maximal pulmonary exercise stress test under optimal bronchodilatory treatment, as indicated, that demonstrates limitation to exercise with a maximal oxygen uptake (VO ₂ max) equal to or less than 20ml/kg/min, or about 5 metabolic equivalents (METS)	☐	☐
9. The member is physically able, motivated and willing to participate and is a candidate for self-care post-program.	☐	☐
10. The member does not have any concomitant medical conditions that would otherwise imminently contribute to deterioration of pulmonary status or undermine the expected benefits of the program (e.g. symptomatic coronary artery disease, CHF, recent (6 months) myocardial infarction, dysrhythmia, active joint disease, claudication, malignancy).	☐	☐
11. Member has had no pulmonary exacerbation within the past four weeks.	☐	☐

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

Policy/Procedure Number: MPUP3139 (previously MCUP3139)			Lead Department: Health Services	
			Business Unit: Utilization Management	
Policy/Procedure Title: Criteria and Guidelines for Utilization Management			☒ External Policy ☐ Internal Policy	
Original Date: 08/12/2020		Next Review Date: ~~08/13/2026~~ 08/12/2027 Last Review Date: ~~08/13/2025~~ 08/12/2026		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIALS	☒ PAC
			☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~08/13/2025~~ 08/12/2026	

I. RELATED POLICIES:

- A. MPQP1002 – Quality/ Utilization Advisory Committee
- B. MPRP4001 – Pharmacy & Therapeutics (P&T) Committee

II. IMPACTED DEPTS:

- A. Health Services
- B. Compliance
- C. Provider Relations

III. DEFINITIONS:

- A. Partnership Advantage: Effective January 1, 202~~8~~7, 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 ~~Members~~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 January 1, 2028 and subject to CMS and DHCS approval.
- 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 circumstance.

IV. ATTACHMENTS:

- A. [Table of Approved Criteria and Guidelines Referenced for Utilization Management](#)

V. PURPOSE:

To establish an approved list of Utilization Management criteria and guidelines for reviewing Treatment Authorization Requests (TARs) and hospitalizations. (Note: The process for review and approval of criteria for pharmacy services can be found in policy MPRP4001 Pharmacy & Therapeutics [P&T] Committee.)

VI. POLICY / PROCEDURE:

- A. Partnership HealthPlan of California (~~Partnership~~) is responsible for reviewing requests for services submitted by network providers. A key element of these reviews is the use of specific criteria and guidelines to assist in determining the medical necessity and clinical appropriateness of services

Policy/Procedure Number: MPUP3139 (previously MCUP3139)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Criteria and Guidelines for Utilization Management		☒ External Policy ☐ Internal Policy	
Original Date: 08/12/2020		Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

requiring approval. When making decisions to approve, modify or deny service authorization requests, Partnership uses. It is important that the criteria and guidelines used in this process be that are known, and accessible and reflective of well-accepted standards of care. This policy will establish the process of Criteria and Guideline review and approval for use by the Partnership network of providers. All decisions are made in accordance with federal or state medical necessity requirements

B. Process of Review and Approval:

1. On an annual basis, the Quality/ Utilization Advisory Committee (Q/UAC) will review a list of criteria and guidelines to be used by Partnership Utilization Management staff and Partnership medical directors in performing reviews of treatment authorization requests (TARs).
 - a. This list will be evaluated during the Chief Medical Officer (CMO)/Medical Director (MD) meeting the month prior to presentation to Q/UAC.
 - b. To be included in this list, a criteria set or guideline must be developed by a nationally recognized entity or a Partnership policy that has been approved through the standard committee process.
 - c. These guidelines and criteria sets should be utilized by managed care organizations throughout the country or region. (This would mean that the criteria and guidelines reflect the generally accepted standard of care.)
 - d. Guidelines and criteria sets should be supported by clinical literature and peer review.
 - e. A specific guideline or criteria can be submitted for potential inclusion in the approved list by any provider within the Partnership network or by Partnership staff.
 - 1) This recommendation will be submitted to the Office of the CMO.
 - 2) The CMO will assign the suggested criteria or guideline to a specific medical director for evaluation. This medical director will present the review at the next CMO/MD meeting.
 - 3) After the medical directors have completed their evaluation of the guideline or criteria set, they will decide to either forward the document to Q/UAC with a recommendation for approval, or decide that the guideline or criteria should not be used by Partnership for performing reviews.
2. Hierarchy of Guidelines and Criteria Sets:
 - a. The guidelines and criteria can be grouped into the following groups:
 - 1) Required standards as set forth by the State of California (Department of Health Care Services [DHCS] or other agencies) where Partnership is contractually and legally obligated to follow the guidelines.
 - 2) Required Medicare standards as set forth by the Centers for Medicare & Medicaid Services (CMS) when applicable.
 - a) For Partnership Advantage Members: TARs are reviewed according to [Section 40 of the CMS Medicare guidance for Part C & D Organization/ Coverage Determinations](#). The hierarchy of guidelines and criteria sets is as follows:
 - i. Medicare National Coverage Determination (NCD) policy
 - a. NCDs are applicable nationwide in the US to specify the Medicare coverage of certain services.
 - ii. Medicare Local Coverage Determination (LCD) policy
 - a. In the absence of an NCD policy, an item or service may be covered based on an LCD. An LCD is a determination by a region-specific Medicare Administrative Contractor (MAC) whether to cover a particular service on a MAC-wide basis. *(When both NCD and LCD guidance exist, an LCD should never contradict NCD guidance but may be used for supplemental information.)*
 - iii. Partnership internal coverage criteria and evidence-based medical literature as described in this policy where no NCD or LCD is available.

Policy/Procedure Number: MPUP3139 (previously MCUP3139)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Criteria and Guidelines for Utilization Management		☒ External Policy ☐ Internal Policy	
Original Date: 08/12/2020		Next Review Date: 08/13/2026 Last Review Date: 08/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

- 3) Industry accepted guidelines that are used by a variety of other managed care organizations (e.g. InterQual® and National Comprehensive Cancer Network [NCCN]).
 - 4) Guidelines developed through government agencies (e.g. Center for Disease Control [CDC] or Agency for Healthcare Research and Quality [AHRQ]).
 - 5) Policies developed by Partnership.
 - b. There should be few circumstances where these groups of guidelines conflict. ~~In situations where there is a conflict~~ If they do, Partnership shall follow the guidelines required by the highest applicable legal or regulatory authority, and, when consistent with requirements, the use of the guidelines ~~should favor~~ will prioritize the patient's health and safety first.
 - c. The guidelines that are required by statute or contract ~~should~~ shall be followed at all times, as long as the patient's safety is not compromised.
 - d. Partnership policies should be followed as long as there is no conflict with legally required or contractually required services.
- C. See Attachment A for Table of Approved Criteria and Guidelines Referenced for Utilization Management.

VII. REFERENCES:

- A. National Committee for Quality Assurance (NCQA) Guidelines ~~(Effective July 1, 2025)~~ UM 2 Clinical Criteria for UM Decisions Elements A
- B. Contractual obligations with the Department of Health Care Services (DHCS)
- C. [Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#) Section 40 Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations (11/18/2024)

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership -Provider Manual

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Medical Officer

X. REVISION DATES:

Partnership Advantage (Program effective January 1, 2028)
08/13/2025; 08/12/26

Medi-Cal
08/11/21; 08/10/22; 08/09/23; 08/14/24; 08/13/25; 08/12/26

PREVIOUSLY APPLIED TO:

MCUP3139 (08/12/2020 – 08/12/2025)

APPROVED CRITERIA AND GUIDELINES REFERENCED FOR UTILIZATION MANAGEMENT

Criteria/ Guideline	Citation Style for Policy Reference	Abbreviation
Medi-Cal Provider Manual / Guidelines	Medi-Cal Guidelines then subsection used and abbreviation <i>Example:</i> Medi-Cal Guidelines Pathology: Molecular Pathology (path molec)	--
Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance	<i>As applicable for Partnership Advantage Members:</i> Medicare Manual title, subsection used (Date) <i>with hyperlink</i> <i>Medicare Manual Example:</i> Medicare Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance Section 40 Coverage Determinations, Organization Determinations (Initial Determinations) and At-Risk Determinations (11/18/2024) <i>NCD Example:</i> Medicare National Coverage Determinations (NCD) Manual 100-03: Chapter 1, Part 4, Section 280.14 Infusion Pumps. Implementation date 02/18/2005 or any subsequent updates published by CMS. <i>LCD Example:</i> Medicare Local Coverage Determination (LCD) L33794 External Infusion Pumps Revision Effective Date 10/01/2024 or any subsequent updates published by CMS.	CMS NCD LCD
InterQual® Criteria	InterQual® Criteria including version year and then subset used <i>Example:</i> InterQual® 2024 DME Criteria – Insulin Pump, Ambulatory	IQ
All Plan Letters from DHCS	Department of Health Care Services (DHCS) All Plan Letter (APL) (2 digit year)-(number) Title (Date) <i>with hyperlink</i> <i>Example:</i> Department of Health Care Services (DHCS) All Plan Letter (APL) 22-005 No Wrong Door for Mental Health Services Policy (03/30/2022)	APL (xx)-(xxx)
CCS Numbered Letters	California Children’s Services (CCS) Numbered Letter (NL) (2 digit year)-(number) Title (Date) <i>with hyperlink</i> <i>Example:</i> California Children’s Services (CCS) Numbered Letter (NL) 09-0514 Powered Mobility Devices (PMD) (05/29/2014)	CCS NL (xx)-(xxxx)
Agency for Healthcare Research and Quality	Agency for Healthcare Research and Quality: then guideline used <i>with hyperlink</i>	AHRQ
Centers for Disease Control and Prevention	Centers for Disease Control and Prevention (CDC): then guideline or article used <i>with hyperlink</i> <i>Example:</i> Centers for Disease Control and Prevention (CDC): Epigenetics, Health, and Disease	CDC
National Comprehensive Cancer Network	National Comprehensive Cancer Network (NCCN): then guideline used <i>with hyperlink</i> <i>Example:</i> National Comprehensive Cancer Network (NCCN): NCCN Guidelines for Treatment of Cancer by Site	NCCN

Criteria/ Guideline	Citation Style for Policy Reference	Abbreviation
United States Preventive Services Taskforce	United States Preventive Services Taskforce (USPSTF) guidelines: then guideline used <i>with hyperlink</i> <i>Example:</i> United States Preventive Services Taskforce (USPSTF): Cervical Cancer: Screening	USPSTF
Up-To-Date	<u>UpToDate:</u> Author(s), Article Title, publishing date <i>with hyperlink</i> or <u>UpToDate:</u> Search Term or Title of Article <i>Example:</i> <u>UpToDate:</u> D. Kline, Lewis R. MD et al. Clinical Presentation and Diagnosis of OSA in Adults ; published online 9 August 2019. or <u>UpToDate:</u> Obstructive Sleep Apnea	UTD
Cochrane Reviews	<u>Cite specific journal article located through Cochrane Reviews:</u> <u>Author(s), Article Title with hyperlink, Cochrane Database of Systematic Reviews, publishing date, DOI, Date Accessed.</u> <u>or</u> <u>Cochrane Reviews: Search Term or Title of Article</u> <i>Example:</i> <u>Reis S, Metzendorf M-I, Kuehn R, Popp M, Gagyor I, Kranke P, Meybohm P, Skoetz N, Weibel S. Nirmatrelvir combined with ritonavir for preventing and treating COVID-19. Cochrane Database of Systematic Reviews 2023, Issue 11. Art. No.: CD015395. DOI: 10.1002/14651858.CD015395.pub3. Accessed 15 May 2026.</u> <u>or</u> <u>Cochrane Reviews: Cochrane COVID-19 publications</u>	<u>CR</u>
OpenEvidence	<u>Cite specific journal article located through OpenEvidence</u>	
Other government or specialty society guidelines as noted in Partnership policies	Varies	--

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

GUIDELINE / PROCEDURE

Guideline/Procedure Number: MCUG3007 (previously UG100307)			Lead Department: Health Services	
			Business Unit: Utilization Management	
Guideline/Procedure Title: Authorization of Ambulatory Procedures and Services			☒ External Policy ☐ Internal Policy	
Original Date: 08/1998		Next Review Date: ~~10/08/2026~~ 08/12/2026 Last Review Date: ~~10/08/2025~~ 08/12/2026		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Applies to:	☒ Medi-Cal		☐ Employees	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD		☐ COMPLIANCE	☐ FINANCE
	☐ CEO	☐ COO	☐ CREDENTIALING	☒ PAC
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~10/08/2025~~ 08/12/2026	

I. RELATED POLICIES:

- A. MPUP3139 – Criteria and Guidelines for Utilization Management
- B. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
- C. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- D. MCUP3049 – Pain Management Specialty Services
- E. MCUG3024 – Inpatient Utilization Management
- F. CMP26 – Verification of Caller Identity and Release of Information

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims
- C. Member Services

III. DEFINITIONS:

- A. Adverse Benefit Determination (ABD): The definition of an Adverse Benefit Determination encompasses all previously existing elements of an “Action” as defined under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. An ABD is defined to mean any of the following actions taken by a Managed Care Plan (i.e. Partnership HealthPlan of California):
 - 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. 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. Authorized Representative: An adult Member has the right to designate a friend, family Member, or other person to have access to certain protected health information (PHI) to assist the Member with making medical decisions. The Member will need to provide appropriate legal documentation as defined in CMP26 Verification of Caller Identity and Release of Information and submit to Partnership HealthPlan of California (Partnership) for review prior to releasing PHI. Until the form has been submitted and validated by Partnership staff, the Member can give verbal consent to release non-sensitive PHI to a designated person. Verbal consent expires at close of business the following business

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Applies to:	☒ Medi-Cal	☐ Employees

day. The Member can give additional Verbal Consent when the prior Verbal Consent window of time has expired.

C. NC: Nurse Coordinator

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To provide guidelines for certification of ambulatory procedures and services. Certain outpatient procedures and tests must be prior authorized to evaluate and confirm the appropriateness of the proposed treatment plan along with the appropriateness of the location and level of care prior to the delivery of care. The process also allows the health plan to determine that the requested service is a covered benefit and that the patient is an eligible Member.

VI. GUIDELINE / PROCEDURE:

- A. Outpatient services which require authorization are defined in policy MCUP3041 Treatment Authorization Request (TAR) Review Process.
- B. Review Objectives
 1. Medical necessity
 2. Appropriate level of care
 3. Network eligibility of provider(s)
 4. Referral from primary care provider
 5. Member eligibility
 6. Covered Benefit
- C. Criteria used in medical necessity determinations
 1. The Nurse Coordinator (NC) compares the medical information against the criteria and guidelines described in policy MPUP3139 Criteria and Guidelines for Utilization Management to evaluate the appropriate use of services, matching medical needs and treatment plans.
 2. If a request is received for authorization of services for which review criteria are not available, the NC, in conjunction with the Chief Medical Officer (CMO) or Physician Designee, uses clinical judgment and noted documentation from authorized medical references, journals, and articles to make a determination regarding the request. (See MPUP3139 Criteria and Guidelines for Utilization Management)
- D. Authorization Process
 1. The provider of the service completes a Treatment Authorization Request (TAR) and submits it to Partnership's Health Services Department. This process should be initiated by the ordering provider a minimum of five business days prior to the procedure or test.
 2. The NC reviews the information received from the provider utilizing Partnership approved review guidelines. The NC approves the request if it meets medical necessity criteria. Refer to policy MCUP3041 Treatment Authorization Request (TAR) Review Process for a full description of the process. A determination decision is based upon:
 - a. The appropriateness of the proposed place of treatment
 - b. The number of treatments or services
 - c. The treatment plan
 - d. The appropriateness of the proposed treatment
 3. The provider should verify that the TAR has been approved prior to rendering services.
 4. Confirmation documents and/or telephone confirmation will be provided to any of the following depending on the service request (i.e. inpatient or outpatient)
 - a. Requesting provider
 - b. Facility
 - c. Member

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Original Date: 08/1998		Next Review Date: ~~10/08/2026~~ <u>08/12/2027</u> Last Review Date: ~~10/08/2025~~ <u>08/12/2026</u>	
Applies to:	☒ Medi-Cal		☐ Employees

5. Adverse Benefit Determinations
 - a. If a request for treatment does not meet established criteria, the NC may request more information or refer the request for review to the CMO/Physician Designee. The CMO/Physician Designee may consult with the requesting provider to evaluate the request.
 - b. If the CMO/Physician Designee determines the requested service is not medically necessary, the CMO/Physician Designee or NC will:
 - 1) Notify the requesting provider and Member
 - 2) Provide objective criteria for the decision
 - 3) Document reasons for the decision
 - 4) Notify the requesting provider and Member of rights to an appeal
 - c. A Notice of Action (NOA) letter from the Physician Designee and/or telephone confirmation will be forwarded to any of the following listed below depending on the service request (i.e. inpatient or outpatient).
 - 1) Requesting provider
 - 2) Provider of service
 - 3) Member
 - d. The NOA letter will clearly state the reason for the denial or modification in terms specific to the Member's condition and in language that a layperson would understand.
6. Appeals
 - a. A Member, a Member's authorized representative, or a provider acting on behalf of a Member may appeal an adverse benefit decision as described in Partnership's policy MCUP3037 Appeals of Utilization Management/ Pharmacy Decisions.
7. Reauthorization
 - a. All authorizations which may recur are subject to the following requirements:
 - 1) Assessment and demonstration of continued need for treatment/service
 - 2) Reevaluation of plan of treatment, appropriateness of level of care and physician orders
 - 3) Documentation of patient compliance with treatment/service

VII. REFERENCES:

- A. Medi-Cal Provider Manual/ [Guidelines](#)
- B. Current InterQual® Criteria
- C. DHCS All Plan Letter ([APL](#)) [21-011 Revised](#) Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2022)
- D. National Committee for Quality Assurance (NCQA) Guidelines ~~(Effective July 1, 2025)~~ UM 7 Denial Notices Element B

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

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

*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.

Guideline/Procedure Number: MCUG3007 (previously UG100307)		Lead Department: Health Services Business Unit: Utilization Management	
Guideline/Procedure Title: Authorization of Ambulatory Procedures and Services		☒ External Policy ☐ Internal Policy	
Original Date: 08/1998		Next Review Date: ~~10/08/2026~~ 08/12/2027 Last Review Date: ~~10/08/2025~~ 08/12/2026	
Applies to:	☒ Medi-Cal		☐ Employees

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 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 Partnership.

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

Guideline/Procedure Number: MCUG3134			Lead Department: Health Services	
			Business Unit: Utilization Management	
Guideline/Procedure Title: Hospital Bed/ Specialty Mattress Guidelines			☒ External Policy ☐ Internal Policy	
Original Date: 01/20/2016		Next Review Date: ~~08/13/2026~~ 08/12/2027 Last Review Date: ~~08/13/2025~~ 08/12/2026		
Applies to:	☐ Employees		☒ Medi-Cal	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO	☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~08/13/2025~~ 08/12/2026	

I. RELATED POLICIES:

- A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- B. MCUP3013 – Durable Medical Equipment (DME) Authorization
- C. MCUP3133 – Wheelchair Mobility, Seating and Positional Components
- ~~D.~~ MPUP3039 – Direct Members
- ~~D.E.~~ MPUP3139 – Criteria and Guidelines for Utilization Management

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims
- C. Member Services

III. DEFINITIONS:

- A. The stages of decubitus ulcer severity are follows:
 - 1. Stage I - a reddened area, skin unbroken
 - 2. Stage II - a superficial blister or open area involving the epidermis
 - 3. Stage III - a deeper lesion that invades the dermis and subcutaneous tissue
 - 4. Stage IV - an extension lesion that may involve muscle and bone
- B. Prevention of decubitus ulcers includes the following:
 - 1. Elimination of moisture
 - 2. Proper patient positioning with hourly changes
 - 3. Relief of spasticity
 - 4. Reduction of shear force
 - 5. Weight dispersion

Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would ~~not meet their care needs~~be inappropriate. Assignment to Direct Member status is based on the Member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see Partnership network providers and/or certified Medi-Cal providers willing to bill Partnership for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP. When a PCP is not assigned, Partnership supports coordination of care among providers.

IV. ATTACHMENTS:

- A. N/A

Guideline/Procedure Number: MCUG3134		Lead Department: Health Services Business Unit: Utilization Management	
Guideline/Procedure Title: Hospital Bed/ Specialty Mattress Guidelines		☒ External Policy ☐ Internal Policy	
Original Date: 01/20/2016		Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026	
Applies to:	☐ Employees		☒ Medi-Cal

V. PURPOSE:

These guidelines are used by Utilization Management (UM) staff to review Treatment Authorization Requests (TARs) for hospital beds and specialty (antidecubitus) beds or mattresses. They are utilizing medical necessity criteria as outlined in policy MPUP3139 Criteria and Guidelines for Utilization Management based on Partnership MCUP3013: Medi-Cal Durable Medical Equipment Authorization, applicable DHCS guidance, and 42 CFR §438.210 requirements.
The following guidelines are used by the Utilization Management (UM) staff when reviewing a Treatment Authorization Request (TAR) for a hospital bed or a specialty (antidecubitus) bed or mattress.

VI. GUIDELINE / PROCEDURE:

A. HOSPITAL BEDS

1. A hospital bed must be ordered by the Primary Care Provider (PCP) or specialist who is treating the Member through a referral from the PCP. For Direct Members, the hospital bed must be ordered by the provider who is currently managing the medical care for the Member.
2. Bariatric beds for a Member weighing greater than 350 pounds will be considered for authorization on a case-by-case basis. These requests will require:
 - a. Documentation from a specialist provider delineating the Member's medical need for this equipment.
 - b. Evaluation of the Member's home, documenting the compliance of the structure to safely install the bed in this home.
 - c. Documentation of Member/caretaker's ability to use the equipment safely.
 - d. A recent weight measurement of the patient within the last 12 months.
3. A hospital bed can be ordered for a Member with a medical condition that requires positioning of the body not feasible in a non-hospital bed; promotion of body alignment to prevent contractures in a patient with history of contractures or a documented medical condition that causes risk of contractures; recipient needs elevation of the head of the bed more than 30 degrees due to conditions such as congestive heart failure, chronic obstructive lung disease or history of aspiration; or recipient needs use of special attachments or traction equipment. Hospital beds are not covered if elevation of the head/upper body is less than 30 degrees. Documentation must also indicate that less intensive alternatives such as P pillows and wedges must be not sufficient to meet the Member's needs. be ruled out as an option.
4. The TAR must include documentation of medical necessity for the use of the hospital bed that includes the following information related to the condition:
 - a. Description of the severity and frequency of the symptoms
 - b. Description of need for any attachments for the bed
 - c. Evaluation of the Member's functional abilities
 - d. Length of time Member will need the equipment
 - e. Care giver status
5. The TAR must include information regarding the Member's or caretaker's ability to properly use the hospital bed.
6. For semi-electrical beds, the TAR must include documentation that the electric feature is medically necessary for one of the following reasons:
 - a. Condition requires the electric feature to allow the patient to independently transfer to chair or standing position by enabling the patient to sit up unassisted.
 - b. Condition requires frequent change in body position and/or an immediate need for a change in position and the patient can operate the controls to cause the required position changes.
 - c. Requests for full electric hospital beds will be reviewed on a case-by-case basis. Convenience or caregiver preference alone does not constitute medical necessity.
7. Durable Medical Equipment (DME) items are covered as medically necessary only to preserve the bodily functions essential to activities of daily living or to prevent significant physical disability, but

Guideline/Procedure Number: MCUG3134		Lead Department: Health Services Business Unit: Utilization Management	
Guideline/Procedure Title: Hospital Bed/ Specialty Mattress Guidelines		☒ External Policy ☐ Internal Policy	
Original Date: 01/20/2016		Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026	
Applies to:	☐ Employees		☒ Medi-Cal

not necessarily to restore the Member to previous function. Authorization will be based on the least costly medically appropriate item alternative that meets the Member's clinical needs, consistent with California Code of Regulations (CCR), Title 22, Section 51321(g) MCUP3013: Medi-Cal Durable Medical Equipment Authorization.

8. ~~The~~ UM staff will compare the cost of purchase versus rental of the equipment and authorize the most cost-effective option.

B. SPECIALTY BEDS/ MATTRESSES

1. A specialty bed or mattress must be ordered by the PCP or specialist who is treating the Member through a referral from the PCP. For Direct Members, the specialty bed or mattress must be ordered by the provider who is currently managing the medical care for the Member.
2. Documentation required for the initial TAR includes the following:

- a. Diagnosis
- b. Prescription signed by a prescribing clinician
- c. Documentation of bed-bound status and wound history
- d. Whether wound(s) are currently present or not
- ~~d-e.~~ If wounds are present, d) documentation of prior treatments and why they were not effective
- ~~e-f.~~ If wounds are present at time of TAR submission, the following clinical documentation must also be submitted with the TAR:

- 1) Number of wounds
- 2) The stage and size of each wound
- 3) Description of each wound
- 4) Location of each wound
- 5) Relevant wound history, including any prior pressure sore(s)
- 6) Relevant history of patient's use of pressure sore equipment

3. TARs will be reviewed in 3-month increments.

~~f.a.~~ Documentation requirements for reauthorization of a TAR include the following:

- 1) Updated treatment & care plans, as indicated
- 2) Re-evaluation of healing status of the pressure sore(s), including update of size, number and location of wounds
- 2)3) Evidence of clinical benefit, such as wound healing, stabilization, or prevention of deterioration.

- 3.4. A specialty bed or mattress may be ordered for a Member with a history of pressure decubitus ulcers unresponsive to conservative therapy.

- a. Requests for specialty beds (e.g., Clinitron, Mediscus, Hydrofloat, Hydrothermic, KinAir, Flexicair, etc.) are generally authorized only for a Member with the following conditions:
 - 1) Severe decubitus ulcers (Stage III or IV)
 - 2) History of recurrent Stage II or higher decubitus ulcers on the trunk or pelvis that are unresponsive to conservative therapy

- 4.5. There are three levels of bed support surfaces which may be authorized as appropriate:

- a. Group I includes gel overlays, foam mattresses and alternating pressure pads with pump which are appropriate for:
 - 1) Current Stage I or II pressure sore(s) on trunk of body
 - 2) History of stage III or IV pressure sore(s) on trunk of body, OR
 - 3) Member is bed bound & requires support surface for pressure sore prevention
- b. Group II includes Alternating Pressure Pump and Pad System (APP) mattresses and low air loss mattresses which are appropriate for current Stage III or IV pressure sore(s) on trunk of the body
- c. Group III includes complete bed systems also known as air-fluidized beds and requests will be reviewed on a case-by-case basis. Level of support surface authorized must align with severity of Member's condition and prior treatment response. Requests for higher-level surfaces may

Guideline/Procedure Number: MCUG3134		Lead Department: Health Services Business Unit: Utilization Management	
Guideline/Procedure Title: Hospital Bed/ Specialty Mattress Guidelines		☒ External Policy ☐ Internal Policy	
Original Date: 01/20/2016		Next Review Date: 08/13/202608/12/2027 Last Review Date: 08/13/202508/12/2026	
Applies to:	☐ Employees		☒ Medi-Cal

[require additional clinical justification.](#)

- ~~5.6.~~ Requests for decubitus wheelchair pads and cushions may be authorized for Members with the following conditions:
 - a. Stage I or II ulcer
 - b. Bed or wheelchair bound Member to prevent development of ulcers (see policy MCUP3133 Wheelchair Mobility, Seating and Positional Components for wheelchair specifics).
- ~~6.7.~~ The TAR must include information regarding the Member's or caretaker's ability to properly use the specialty bed and the type of care currently being provided for the ulcer.
- ~~7.8.~~ Durable Medical Equipment (DME) items are covered as medically necessary only to preserve the bodily functions essential to activities of daily living or to prevent significant physical disability but not necessarily to restore the Member to previous function.
- ~~9.~~ The UM staff evaluates all options for care of the decubitus ulcer and authorize the most appropriate modality that will assist in healing of the ulcer.
- ~~10.~~ Specialty beds/mattresses are initially approved for 3 months with reauthorization dependent upon documentation of significant improvement in the decubitus ulcers and prognosis of further healing that requires the continued use of the specialty bed.
 - ~~a.~~ Re-evaluation for the continued need of a specialty mattress will occur in 3-month authorization periods until the item capitates to purchase at the end of ~~12-ten~~ months, [consistent with Medi-Cal billing guidelines.](#)
 - ~~a-b.~~ Once a decubitus ulcer is healed, a Group 3 Low Air Loss Mattress should be downsized to a lesser product (i.e. gel overlay) for prevention of skin breakdown.
- ~~8.11.~~ Decubitus Pads, Cushions and Mattress
 - a. Pads, cushions, mattresses, alternating pressure pads, etc., require at least 3 to 4 inches thickness to be effective in the treatment of pressure sores.
 - b. Gel foam mattresses and other special mattresses are useful in the care of a decubitus ulcer and may be authorized as appropriate. Other options include alternating pressure mattresses and dry flotation mattresses.
- ~~9.12.~~ Specialty Beds
 - a. An anti-decubitus ulcer bed is generally authorized for use in long-term care facilities, or for home use, where it can be documented that appropriate nursing care and the use of more conservative treatments have failed, or would fail, to prevent or treat the patient's pressure sores.
 - b. The use of the bed permits care for a chronically ill patient at a lower level of care than acute hospital level and may prevent or reduce recurrent hospitalization for treatment of decubiti.

VII. REFERENCES:

- ~~A.~~ [Medi-Cal Provider Manual/ Guidelines: Durable Medical Equipment \(DME\): Therapeutic Anti-Decubitus Mattresses and Bed Products \(*dura thp*\) and Durable Medical Equipment \(DME\): Billing Codes \(*dura cd*\)](#)
- ~~B.~~ [California Code of Regulations \(CCR\), Title 22 - Medi-Cal Program](#)
- ~~C.~~ [CCR Title 22, Section 51321\(g\)](#)
- ~~A-D.~~ [Code of Federal Regulation, Title 42 §438.210: Coverage and Authorization of Services](#)

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

REVISION DATES:

Guideline/Procedure Number: MCUG3134		Lead Department: Health Services Business Unit: Utilization Management	
Guideline/Procedure Title: Hospital Bed/ Specialty Mattress Guidelines		☒ External Policy ☐ Internal Policy	
Original Date: 01/20/2016		Next Review Date: 08/13/2026 Last Review Date: 08/13/2025	
Applies to:	☐ Employees		☒ Medi-Cal

02/17/16; 02/15/17; 11/15/17; *02/13/19; 02/12/20; 02/10/21; 05/11/22; 06/14/23; 06/12/24; 08/13/25;
08/12/26

*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:

MCUG3021 (previously UG100321) Hospital Bed Guidelines

Original date: 05/30/1995

Revision Dates: 04/28/00; 11/28/01; 10/16/02; 04/16/03; 10/20/04; 10/19/05; 08/20/08; 01/19/11; 02/20/13; 02/18/15 ARCHIVED 01/20/2016

MCUG3040 (previously UG100340) Specialty Bed/Mattress Guidelines

Original date: 05/30/1995

Revision Dates: 04/28/00; 10/17/01; 10/16/02, 04/16/03; 10/20/04; 10/19/05; 08/20/08; 11/18/09; 05/18/11; 02/20/13; 03/18/15 ARCHIVED 01/20/2016

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 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 Partnership.

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

Policy/Procedure Number: MCUP3015 (previously UP100315)			Lead Department: Health Services	
			Business Unit: Utilization Management	
Policy/Procedure Title: Family Planning Bypass Services			☒ External Policy ☐ Internal Policy	
Original Date: 03/08/1995		Next Review Date: ~~11/12/2026~~ 08/12/2027 Last Review Date: ~~11/12/2025~~ 08/12/2026		
Applies to:	☒ Medi-Cal		☐ Employees	
Reviewing Entities:	☒ IQI		☐ P & T	
	☐ OPERATIONS		☐ EXECUTIVE	
Approving Entities:	☐ BOARD		☐ COMPLIANCE	
	☐ CEO ☐ COO		☐ FINANCE ☒ PAC	
			☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~11/12/2025~~ 08/12/2026	

I. RELATED POLICIES:

MCUP3050 - Medication Abortion in the First Trimester

II. IMPACTED DEPTS:

- A. Health Services
- B. Member Services
- C. Provider Relations
- D. Claims

III. DEFINITIONS:

- A. Bypass Services: Members may receive services from any family planning provider, including those not contracted with Partnership HealthPlan of California, without prior authorization.¹
- B. Medi-Cal Minor Consent Program: The Minor Consent program provides that a minor may, without parental consent, receive services related to sexual assault, pregnancy and pregnancy-related services, family planning, sexually transmitted diseases, drug and alcohol abuse, and outpatient mental health treatment and counseling.
- C. Prohibited Entity: According to H.R.1, a bill passed by the United States Congress on July 3, 2025, and enacted on July 4, 2025, a Prohibited Entity is an entity, including its affiliates, subsidiaries, successors, and clinics, that is an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code, and is an essential community provider described in section 156.235 of title 45, Code of Federal Regulations (as in effect on the date of enactment of this Act), that is primarily engaged in family planning services, reproductive health, and

¹ Effective July 4, 2025 through July 3, 2026, Prohibited Entities, as defined in III.C. above, cannot receive federal Medicaid reimbursement. As such, Partnership will be unable to reimburse Prohibited Entities for any services rendered to our Members in that timeframe. Please see the Department of Health Care Services (DHCS) All Plan Letter [APL 25-011 Revised](#) "H.R.-1 – Federal Payments to Prohibited Entities" (09/17/2025) for further information. Members may also contact Partnership's Member Services department for assistance (800) 863-4155.

Effective July 4, 2026, the one-year restriction on federal payments to "Prohibited Entities" under H.R. 1 Section 71113 will no longer be in effect. As such, Medi-Cal Providers who meet the definition of "Prohibited Entity," as described in H.R.1 Section 71113 can resume submitting claims or encounters for all Medi-Cal covered services rendered to Members with Dates of Service on or after July 4, 2026, and Partnership will process and pay these claims or encounters, as appropriate, per the usual claims process. Please see APL 26-013 "H.R.1 - Federal Payments to Prohibited Entities – Important Update: End of One-Year Restriction on Federal Payments" (06/23/2026) for further information.

Policy/Procedure Number: MCUP3015 (previously UP100315)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Family Planning Bypass Services		☒ External Policy ☐ Internal Policy	
Original Date: 03/08/1995		Next Review Date: 11/12/202608/12/2027 Last Review Date: 11/12/202508/12/2026	
Applies to:	☒ Medi-Cal		☐ Employees

related medical care; and provides for abortions, other than an abortion if the pregnancy is the result of an act of rape or incest; or in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed; and for which the total amount of Federal and State expenditures under the Medicaid program under title XIX of the Social Security Act for medical assistance furnished in fiscal year 2023 made directly, or by a covered organization, to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity, or made to the entity or to any affiliates, subsidiaries, successors, or clinics of the entity as part of a nationwide health care provider network, exceeded \$800,000.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To describe and define “family planning bypass” services as implemented and managed by Partnership HealthPlan of California.

VI. POLICY / PROCEDURE:

- A. Partnership provides Members with direct access to the full range of family planning services and providers without prior authorization.
- B. Federal law, Title 42 U.S. Code Section [1396a\(a\)23\(B\)](#), states that “enrollment of an individual eligible for medical assistance in a primary care case-management system [described in section 1396n(b)(1)], a Medicaid managed care organization, or a similar entity shall not restrict the choice of the qualified person from whom the individual may receive such services under Section 1396d(a)(4)(C) of this title.” Partnership must allow Members the freedom of choice with family planning providers. Members may receive services from any family planning provider, including those not contracted with Partnership, without prior authorization.²
- C. Partnership notifies its Members regarding the types of family planning services available, their right to access these services in a timely and confidential manner, and their freedom to choose a qualified family planning provider.² Members are encouraged to use their primary care provider (PCP) for family planning services, when appropriate.
- D. Family planning services are defined as:
 1. Health education and counseling necessary to understand contraceptive methods and make informed choices
 2. History and physical examination as indicated
 3. Laboratory tests, if medically indicated, as part of decision making process for choice of contraceptive methods. This includes cervical cancer screening methods recommended by the

² Effective July 4, 2025 [through July 3, 2026](#), Prohibited Entities, as defined in III.C. above, cannot receive federal Medicaid reimbursement. As such, Partnership will be unable to reimburse Prohibited Entities for any services rendered to our Members [in that timeframe](#). Please see- the Department of Health Care Services (DHCS) All Plan Letter [APL 25-011 Revised](#) “H.R. 1 – Federal Payments to Prohibited Entities” (09/17/2025) for further information. Members may also contact Partnership’s Member Services department for assistance (800) 863-4155.

[Effective July 4, 2026, the one-year restriction on federal payments to “Prohibited Entities” under H.R. 1 Section 71113 will no longer be in effect. As such, Medi-Cal Providers who meet the definition of “Prohibited Entity,” as described in H.R.1 Section 71113 can resume submitting claims or encounters for all Medi-Cal covered services rendered to Members with Dates of Service on or after July 4, 2026, and Partnership will process and pay these claims or encounters, as appropriate, per the usual claims process. Please see APL 26-013 “H.R.1 - Federal Payments to Prohibited Entities – Important Update: End of One-Year Restriction on Federal Payments” \(06/23/2026\) for further information.](#)

Policy/Procedure Number: MCUP3015 (previously UP100315)		Lead Department: Health Services Business Unit: Utilization Management
Policy/Procedure Title: Family Planning Bypass Services		☒ External Policy ☐ Internal Policy
Original Date: 03/08/1995	Next Review Date: 11/12/202608/12/2027 Last Review Date: 11/12/202508/12/2026	
Applies to:	☒ Medi-Cal	☐ Employees

- United States Preventative Services Task Force (USPSTF): For ages 21 – 29 cervical cytology every 3 years and for ages 30 to 65 years old cervical cytology every 3 years OR high risk human papillomavirus (HPV) testing every 5 years, OR high risk HPV testing in combination with cytology every 5 years. For Members under 21 years, cervical cancer screening is not recommended.
4. Diagnosis and treatment of sexually transmitted infections (STIs) when medically necessary.
 5. Screening, testing and counseling of individuals at risk for human immunodeficiency virus (HIV) and referral for treatment
 6. Provision of contraceptive pills/devices/supplies
 7. Tubal ligation
 8. Vasectomy
 9. Pregnancy testing and counseling
- E. Abortion-related services are available to Members from the provider of their choice without prior authorization.³
1. Partnership covers all medical services and supplies incidental or preliminary to an abortion, as per requirements stated in Medi-Cal Provider Guidelines: [Abortions](#)
 2. Partnership is prohibited from imposing annual or lifetime limits on coverage of outpatient abortion services.
 3. Minors who wish to receive abortion services may do so without parental consent under the Medi-Cal Minor Consent Program.
- F. The following services are NOT included under family planning bypass services:
1. Routine infertility studies or procedures
 2. Reversal of voluntary sterilization
 3. Hysterectomy for sterilization purposes only
 4. Evaluation and treatment of gynecological problems
 5. Evaluation and treatment of breast problems
- G. To be reimbursed for services, the family planning provider must meet the following requirements:
1. The provider is qualified to provide family planning services based on his/her scope of practice.
 2. The provider must submit claims on the appropriate billing form.
 3. The provider must maintain medical records that contain information regarding the eligible services rendered. Partnership reserves the right to request copies of records prior to paying a claim or for quality improvement audits.
 4. The provider must obtain appropriate consent for contraceptive methods including voluntary sterilization, consistent with the requirements of Title 22 CCR, Sections 51305.1 and 51305.3.
 5. The bypass provider should coordinate services with the PCP, by requesting the Member's consent to share information and sending a copy of pertinent medical records to the PCP.
 6. The provider should refer the Member to return to the PCP for all non- family planning related services.
 7. The provider must not be a Prohibited Entity as defined in III.C. above.

³ Effective July 4, 2025 through July 3, 2026, Prohibited Entities, as defined in III.C. above, cannot receive federal Medicaid reimbursement. Please see -the Department of Health Care Services (DHCS) All Plan Letter [APL 25-011 Revised](#) "H.R.-1 – Federal Payments to Prohibited Entities" (09/17/2025) for further information. Members may also contact Partnership's Member Services department for assistance (800) 863-4155.

Effective July 4, 2026, the one-year restriction on federal payments to "Prohibited Entities" under H.R. 1 Section 71113 will no longer be in effect. As such, Medi-Cal Providers who meet the definition of "Prohibited Entity," as described in H.R.1 Section 71113 can resume submitting claims or encounters for all Medi-Cal covered services rendered to Members with Dates of Service on or after July 4, 2026, and Partnership will process and pay these claims or encounters, as appropriate, per the usual claims process. Please see APL 26-013 "H.R.1 - Federal Payments to Prohibited Entities – Important Update: End of One-Year Restriction on Federal Payments" (06/23/2026) for further information.

Policy/Procedure Number: MCUP3015 (previously UP100315)		Lead Department: Health Services Business Unit: Utilization Management
Policy/Procedure Title: Family Planning Bypass Services		☒ External Policy ☐ Internal Policy
Original Date: 03/08/1995	Next Review Date: 11/12/202608/12/2027 Last Review Date: 11/12/202508/12/2026	
Applies to:	☒ Medi-Cal	☐ Employees

H. Access to Services to Which Contractor or Subcontractor Has a Moral Objection:
Unless prohibited by law, Partnership providers shall arrange for the timely referral and coordination of covered services including abortion services and family planning bypass services when the hospital, clinic or other provider may have religious or ethical objections to the request/ required service(s). The provider shall support and shall demonstrate ability to arrange, coordinate and ensure provision of abortion and family planning bypass services. If the provider is unwilling to arrange for or coordinate the provision of such services, the provider must refer the Member to Partnership Member Services Department for assistance.

VII. REFERENCES:

- A. United States Preventive Services Task Force:
<https://uspreventiveservicestaskforce.org/uspstf/recommendation/cervical-cancer-screening>
- B. Title 42 U.S. Code Sections [1396a\(a\)23\(B\)](#), [1396n\(b\)\(1\)](#), [1396d\(a\)\(4\)\(C\)](#)
- C. Title 22 California Code of Regulations (CCR) Sections [51305.1](#) and [51305.3](#)
- D. Medi-Cal Provider Manual/ Guidelines: Abortions ([abort](#)), Minor Consent Program ([minor](#))
- E. DHCS [APL 24-003](#) Abortion Services (03/28/2024)
- F. DHCS [APL 25-011 Revised](#) H.R. 1 – Federal Payments to Prohibited Entities (09/17/2025)
- G. Public Law No. 119-21, [H.R.1](#), 119th Congress. (2025)
- ~~G.~~H. [DHCS APL 26-013 “H.R.1 - Federal Payments to Prohibited Entities – Important Update: End of One-Year Restriction on Federal Payments” \(06/23/2026\)](#)

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

X. REVISION DATES:

Medi-Cal

10/10/97 (name change only); 06/14/00, 10/17/01; 8/20/03; 10/20/04; 10/19/05, 08/20/08; 11/19/08; 11/18/09; 08/15/12; 01/21/15; 01/20/16; 02/15/17; 11/15/17; *02/13/19; 02/12/20; 11/11/20; 10/13/21; 10/12/22; 10/11/23; 10/09/24; 11/12/25; [08/12/26](#)

*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

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:

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- 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

Policy/Procedure Number: MCUP3015 (previously UP100315)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Family Planning Bypass Services		☒ External Policy ☐ Internal Policy	
Original Date: 03/08/1995		Next Review Date: 11/12/202608/12/2027 Last Review Date: 11/12/202508/12/2026	
Applies to:	☒ Medi-Cal		☐ Employees

disclosed to the provider and/or enrollee upon request

The materials provided are guidelines used by 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 Partnership.

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

Policy/Procedure Number: MCUP3114			Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Physical, Occupational and Speech Therapies			☒ External Policy ☐ Internal Policy	
Original Date: 06/20/2012		Next Review Date: ~~09/10/2026~~ 08/12/2027 Last Review Date: ~~09/10/2025~~ 08/12/2026		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
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: 09/10/2025 08/12/2026	

I. RELATED POLICIES:

- A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- B. MCCP2024 – Whole Child Model for California Children’s Services (CCS)
- C. MCUP3125 – Gender Dysphoria/ Surgical Treatment
- D. MPUG3011 – Criteria for Home Health Services
- E. MCUP3113 – Telehealth Services

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims
- C. Member Services

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. 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.
- C. Occupational Therapy (OT) provides task-oriented therapeutic activities and exercises designed to significantly improve, develop or restore physical functions lost or impaired as a result of a disease or injury; or to help an individual relearn daily living skills or compensatory techniques to improve the level of independence in the activities of daily living.
- D. Physical Therapy (PT) is a service with an established theoretical and scientific base and widespread clinical applications in the restoration and promotion of optimal physical function. Physical therapists diagnose and manage movement dysfunction and enhance physical and functional abilities.
- E. Physical and Occupational therapy services are designed to:
 - 1. Assess the existence or extent of a medical condition;
 - 2. Assess the impact of a medical condition, injury or surgery upon function and role performance;
 - 3. Restore deterioration in physical function and physical performance of activities of daily living from previous function, due to medical condition, injury, or surgery.
 - 4. Treat physical limitations or physical dysfunctions in physical activities or activities of daily living, due to a medical condition, surgery or procedure.
 - 5. Restore deterioration in cognitive skills that impact the ability to perform activities of daily living from previous function, due to medical condition, injury or surgery and treat sensory dysfunctions

Policy/Procedure Number: MCUP3114		Lead Department: Health Services Business Unit: Utilization Management
Policy/Procedure Title: Physical, Occupational and Speech Therapies		☒ External Policy ☐ Internal Policy
Original Date: 06/20/2012		Next Review Date: 09/10/202608/12/2027 Last Review Date: 09/10/202508/12/2026
Applies to:	☒ Medi-Cal	☐ Employees

due to a medical condition, injury or surgery that impact oral/pharyngeal intake or lead to bodily damage.

- F. Speech Therapy (ST): The treatment of speech, swallowing and communication disorders. The approach used depends on the disorder. It may include physical exercises to strengthen the muscles used in speech and swallowing (oral-motor work), speech drills to improve clarity, or sound production practice to improve articulation.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define the treatment authorization process for physical, occupational and speech therapies in the outpatient setting.

VI. POLICY / PROCEDURE:

A. Criteria for Remote PT, OT, and ST:

PT, OT, and ST services may be provided virtually, if the service provided does not require in-person or manual examination, manipulation or therapeutic techniques (see CMS and DHCS policies and Partnership policy MCUP3113 Telehealth Services).

B. General Guidelines for Authorization of PT, OT and ST.

1. No Referral Authorization Form (RAF) is required for PT, OT, or ST services, but services must be ordered through a written prescription of a licensed physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, ~~or Nurse Practitioner~~ or Dentist).
2. For all Members, no TAR or RAF is required for the initial evaluation.

C. Services That Do NOT Require a TAR

1. Partnership does *not* require Treatment Authorization Requests (TARs) from contracted providers for PT, OT, or ST for:
 - a. Members age 21 and over: No TAR required for up to 12 visits for a specific diagnosis (limit one visit per day) in a rolling 12-month period of time.
 - 1) A TAR will be required for services in excess of 12 visits for a specific diagnosis.

D. Services That Require a TAR

1. After an initial evaluation, Partnership does ~~requires~~ a TAR for PT, OT, or ST services for the following circumstances:
 - a. Members under age 21
 - b. Non-contracted Providers
 - c. Home Health Services (A TAR is required for all ages for all PT, OT, or ST services provided through a home health agency. Refer to policy MPUG3011 Criteria for Home Health Services.)
2. Submission Guidelines When a TAR is Required
 - a. Partnership Members can be referred by a physician (Doctor of Medicine, Osteopathy, Podiatric medicine, or Optometry (only for low vision rehabilitation) or non-physician practitioner (Physician Assistant, Clinical Nurse Specialist, ~~or Nurse Practitioner~~ or Dentist) for one consultation visit, through written prescription, for services to be rendered by a qualified Medi-Cal provider or licensed practitioners acting within the scope of their practice. As noted above, no TAR or RAF is required for the initial consultation/ evaluation.
 - b. Following the initial evaluation, the service provider must submit a TAR for the requested services. The TAR should document, at a minimum, the following information:
 - 1) Medical diagnosis necessitating the service with a summary of medical condition
 - 2) Related medical conditions

Policy/Procedure Number: MCUP3114		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Physical, Occupational and Speech Therapies		☒ External Policy ☐ Internal Policy	
Original Date: 06/20/2012		Next Review Date: 09/10/202608/12/2027 Last Review Date: 09/10/202508/12/2026	
Applies to:	☒ Medi-Cal	☐ Employees	

- 3) Functional limitations
- 4) Dates and length of treatment
- 5) Therapeutic goals of treatment and current functional status of the patient with respect to these goals
- 6) Dates of planned progress review
- 7) Specific services to be rendered (e.g. evaluation, treatment, modalities)
- c. Partnership authorizes ancillary services on a case-by-case basis, provided that medical necessity has been demonstrated in the submitted documentation.
- d. The Nurse Coordinators/ Utilization Management (UM) staff review each TAR and consult with the referring physician or ancillary provider as needed to determine the medical necessity of the requested services. If the Nurse Coordinator is unable to approve the requested service based upon information available, the case is submitted to one of Partnership's reviewing physicians for consideration. Determination that a requested service is not medically necessary may only be rendered by a physician.
 - 1) Occupational and physical therapy may be considered medically necessary when:
 - a) There is a reasonable expectation, determined by a physical or occupational therapist and the attending physician, that in a predictable period of time the therapy will achieve measurable improvement in the patient's mobility or activities of daily living.
 - b) Measurable reversal of deterioration from previous levels of cognitive or communication functions.
 - c) The services are used to assess the existence or extent of impairment due to a medical condition.
 - d) A "reasonable expectation" referenced above shall be based upon evidence-based medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate and benefit from the therapy process.
 - e) Any episode of physical or occupational therapy is not medically necessary and will not be approved when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.
 - 2) Speech Therapy services for Members age 21 or over may be considered medically necessary based upon the receipt of appropriate medical documentation demonstrating that the Member and services meet the following criteria:
 - a) Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.
 - b) Appropriate adult candidates for speech therapy must be able to participate in and/or benefit from the therapy process, have adequate attention span, cooperation and endurance to participate, and demonstrate behavior conducive to engaging in the process.
 - c) Speech therapy as conversational therapy/ voice training should be considered prior to any pitch changing surgery for transgender or gender nonconforming beneficiaries as discussed in policy MCUP3125 Gender Dysphoria/Surgical Treatment.
 - d) Speech therapy services are reviewed in accordance with clinical guidelines when considered medically necessary only when there is reasonable expectation that they will achieve significant, measurable improvement in the Member's communication, cognition or swallowing in a reasonable and predictable period of time as determined by the treating therapist and referring provider.
 - e) A "reasonable expectation" referenced above shall be based upon evidence-based medicine. A reasonable expectation shall take into consideration the patient's mental alertness to participate in and benefit from the therapy process.

Policy/Procedure Number: MCUP3114		Lead Department: Health Services	
		Business Unit: Utilization Management	
Policy/Procedure Title: Physical, Occupational and Speech Therapies		☒ External Policy ☐ Internal Policy	
Original Date: 06/20/2012		Next Review Date: 09/10/202608/12/2027	
		Last Review Date: 09/10/202508/12/2026	
Applies to:	☒ Medi-Cal	☐ Employees	

- f) A course of speech therapy shall be determined to be no longer medically necessary when a patient has met established treatment goals or has stabilized and is not expected to continue to make significant gains.
- 3) The following are examples of conditions where therapy may be considered medically necessary based upon the receipt of appropriate medical documentation:
 - a) Musculoskeletal Pathology or Dysfunction, including limitations in joint range of motion and/or mobility, deterioration from previous function of muscle strength and/or decreased endurance, soft tissue dysfunction, alterations in postural control and alignment.
 - b) Neuromuscular Pathology or Dysfunction, including deterioration from previous function of gross and/or fine motor coordination, alterations in tone- increased or decreased, deterioration from previous function of motor planning skills, deterioration from previous function of balance, loss of selective motor control, decrease in bilateral integration.
 - c) Neurocognitive Pathology or Dysfunction, including sensory dysfunctions regarding food textures and oral tactile defensiveness when impacting overall health; deterioration from previous function in cognitive, self-care or adaptive skills.
 - d) Pathology or Dysfunction of the Vascular System, including primary or secondary lymphedema, edema and venous stasis.
 - e) Pathology or Injury to Skin, including burns and/or sores following injury or surgery, open wounds.
 - f) Assessments of Impairment Related to Medical Condition, including appropriate assessments as part of a multidisciplinary or interdisciplinary team of motor skills disorders and physical functions; appropriate individual assessments of post therapy functions and periodic review of appropriate maintenance activities for the patient and family
 - g) Design of Maintenance Activities, including physical exercise, drills, techniques that a patient performs outside of therapy or after any therapy has concluded.
- 4) The following services are generally not considered “medically” necessary or are not covered:
 - a) Recreational therapy
 - b) Activities that provide diversion or general motivation
 - c) Exercise programs for healthy individuals, including development and delivery of exercise programs; assisted walking
 - d) Programs for communication/cognitive deficits from developmental disorders - where deficits do not impact overall health
 - e) Maintenance physical or occupational therapy to preserve the patient's present level of function and prevent regression of that function. Maintenance begins when the therapeutic goals of the treatment plan have been achieved and when no further functional progress is apparent or expected to occur. Maintenance does not require the skills of a qualified provider of physical or occupational therapy services. The patient is responsible for practicing learned drills, techniques and exercises to preserve his or her present level of function and prevent regression of that function. Maintenance includes ongoing supervision of independent exercise programs, supervision/ observation of activities of daily living, and supervision of independent transfer activities.
 - i. For Members residing in a skilled nursing facility, the facility must provide maintenance therapy that is included in the room and board fee and not separately reimbursable.

Policy/Procedure Number: MCUP3114		Lead Department: Health Services	
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Applies to:	☒ Medi-Cal	☐ Employees	

- e. If therapy is required beyond the visits initially approved, a new TAR must be submitted.
- f. The approval of continuation of therapy will be based on documentation of measurable improvement in the patient's condition in a reasonable and predictable period of time, based on the written care plan and the clinical judgment of the treating physical or occupational therapist with the patient's referring physician. Regular evaluation of the patient is required to determine that continuation of therapy is medically appropriate. The medical need for continuation must be documented on the TAR submitted to Partnership.
 - 1) Continued therapy will not be approved once a Member has met established treatment goals, or has stabilized and is not expected to continue to make significant gains, based on the written care plan and the clinical judgment of the treating PT or OT in conjunction with the patient's referring physician.
3. Speech Therapy Related to Hearing Loss for Members Under 21 Years of Age:
 - a. Partnership Members who have a California Children's Services (CCS)-eligible condition are enrolled in the Whole Child Model (WCM) program. The WCM program integrates CCS program-covered services with Members' regular Medi-Cal benefits to provide seamless care for children and youth.
 - 1) Partnership covers the medical condition of hearing loss for hearing tests, evaluations by audiologists, and medical evaluations by head and neck surgeons and physicians in other clinical specialties.
 - 2) Under the WCM program, Partnership also covers speech and language therapy for hearing impaired children who have hearing aids or need to use sign language, but do not have physical impairment of the articulators. For these conditions, the Member should be referred to CCS in the county of residence to determine program eligibility. Once CCS program eligibility is established, all medically necessary covered services, including case management and authorization of services, for CCS-eligible conditions will be provided by Partnership under the WCM program. See policy M CCP2024 Whole Child Model for California Children's Services (CCS).
 - b. Speech Pathologists are reimbursed for services only if the services are performed in response to the written referral of licensed practitioners, acting within the scope of their practice.
 - c. A Member may receive services through the Local Educational Agency (LEA) but is not required to do so prior to receiving therapy benefits under Partnership. If a Member is receiving medically necessary services through the LEA, Partnership will coordinate with the LEA to provide additional services to the extent determined to be medically necessary. For example, if it is determined that the Member medically requires speech therapy three times per week, and he/she receives speech services by the LEA one time per week, Partnership will approve the additional two visits per week if criteria are met.

VII. REFERENCES:

- A. Social Security Act Section 1905(r)
- B. Medi-Cal Provider Manual/ Guidelines: Physical Therapy ([phys](#)); Occupational Therapy ([occu](#)); Speech Therapy ([speech](#)); Medicine: Telehealth ([medne tele](#)), Home Health Agencies ([home hlth](#))
- C. [California Children's Services \(CCS\) Medical Eligibility](#)
- D. [Full-Year Continuing Consolidated Appropriations and Extensions Act, 20265 \(extends Medicare telehealth flexibilities through 2027\)](#)

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

Policy/Procedure Number: MCUP3114		Lead Department: Health Services Business Unit: Utilization Management
Policy/Procedure Title: Physical, Occupational and Speech Therapies		☒ External Policy ☐ Internal Policy
Original Date: 06/20/2012		Next Review Date: 09/10/202608/12/2027 Last Review Date: 09/10/202508/12/2026
Applies to:	☒ Medi-Cal	☐ Employees

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

X. REVISION DATES: 01/20/16; 11/16/16; 11/15/17; *02/13/19; 03/11/20; 06/10/20; 01/13/21; 02/09/22; 02/08/23; 03/13/24; 08/14/24; 09/10/25, 9/0908/12/26

*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

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 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 Partnership.

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

Policy/Procedure Number: MCUP3141				Lead Department: Health Services	
				Business Unit: Utilization Management	
Policy/Procedure Title: Delegation of Inpatient Utilization Management				☒ External Policy ☐ Internal Policy	
Original Date: 06/09/2021		Next Review Date: ~~09/10/2026~~ <u>08/12/2027</u> Last Review Date: ~~09/10/2025~~ <u>08/12/2026</u>			
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage		
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC		
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT	
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC	
	☐ CEO	☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA				Approval Date: ~~09/10/2025~~ <u>08/12/2026</u>	

I. RELATED POLICIES:

- A. MCUG3024 - Inpatient Utilization Management
- B. MCUP3041 - Treatment Authorization Request (TAR) Review Process
- C. MPUP3014 - Emergency Services
- D. MPUP3039 - Direct Members
- E. MCUP3037 - Appeals of Utilization Management/Pharmacy Decisions
- F. CGA024 - Medi-Cal Member Grievance System
- G. CMP36 - Delegation Oversight and Monitoring
- H. CMP02 - Risk Assessment, Audits and Monitoring
- I. CMP38 - Escalation and Corrective Action
- J. ADM47 - Administrative and Financial Sanctions

II. IMPACTED DEPTS:

- A. Health Services
- B. Provider Relations
- C. Finance
- D. Regulatory Affairs/Compliance

III. DEFINITIONS:

- A. Adverse Benefit Determination (ABD) - The definition of an Adverse Benefit Determination encompasses all previously existing elements of an "Action" as defined under federal regulations with the addition of language that clarifies the inclusion of determinations involving medical necessity, appropriateness, setting, covered benefits, and financial liability. An ABD is defined to mean any of the following actions taken by a Managed Care Plan (i.e. Partnership HealthPlan of California):
 - 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. 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. Assigned Risk: In accordance with the Division of Financial Responsibility (DOFR), a determination made by Partnership HealthPlan of California (Partnership) concerning which entity, Partnership or the

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Delegated Entity, will be financially responsible for the inpatient hospital services rendered to the Member under the capitation agreement and applied in accordance with the written understanding between Partnership and the Delegated Entity.

- C. Capitated Hospital Admission: Admission of an assigned Member to a capitated hospital within a Delegated Entity's contracted network. [Also known as capped to capped \(CTC\)](#).
- D. Capitation: Refers to a form of reimbursement between Partnership and the Delegated Entity of a fixed amount per member per month.
- E. Delegated Entity(ies): The hospital that has assumed certain financial responsibilities including Utilization Management (UM), and who has entered into a capitated contractual arrangement with Partnership to perform inpatient services specifically related to fulfilling Partnership's obligations to the Department of Health Care Services (DHCS) under the terms of the DHCS/Medi-Cal contract or those duties Partnership would otherwise perform as defined by the National Committee for Quality Assurance (NCQA).
- F. Delegation Oversight: The process whereby Partnership monitors a Delegated Entity's delegated activities to ensure their compliance with statutes, regulations, policies and contractual obligations, including the Delegation Agreement and/or NCQA standards and DHCS requirements.
- G. Delegation Agreement: A written agreement between Partnership and the Delegated Entity that defines the obligations and responsibilities of the Delegated Entity.
- H. Direct Member: Direct Members are those whose service needs are such that Primary Care Provider (PCP) assignment would be inappropriate. Assignment to Direct Member status is based on the Member's aid code, prime insurance, demographics, or administrative approval based on qualified circumstances. A Referral Authorization Form (RAF) is not required for Direct Members to see PHC network providers and/or certified Medi-Cal providers willing to bill PHC for covered services. However, many specialists will still request a RAF from the PCP to communicate background patient information to the specialist and to maintain good communication with the PCP.
- I. Division of Financial Responsibility (DOFR): DOFR shall be defined as the written understanding between Partnership and the Delegated Entity regarding Assigned Risk.
- J. Emergency Medical Condition: Per DHCS County Organized Health System (COHS) contract Exhibit A, Attachment 1 Definitions, a medical condition which is manifested by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention could result in one or more of the following:
 - 1. Placing the health of the individual (or, the case of a pregnant member, the health of the Member or Member's unborn child) in serious jeopardy
 - 2. Serious impairment to bodily functions
 - 3. Serious dysfunction of any bodily organ or part, or
 - 4. Death
- K. Out-of-Area Admission (OOA): An inpatient hospital admission that occurs at a facility that is not in the Delegated Entity's service area as defined by the contractual agreement between Partnership and the Delegated Entity.
- L. Utilization Management (UM): The process of evaluating the necessity, appropriateness, and efficiency of the use of medical services, procedures and facilities.

IV. ATTACHMENTS:

A. N/A

V. PURPOSE:

To define processes, procedures and respective responsibilities that apply when Partnership HealthPlan of California (Partnership) delegates inpatient utilization management functions to hospitals.

Policy/Procedure Number: MCUP3141		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: Delegation of Inpatient Utilization Management		☒ External Policy ☐ Internal Policy	
Original Date: 06/09/2021		Next Review Date: 09/10/202608/12/2027 Last Review Date: 09/10/202508/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

VI. POLICY / PROCEDURE:

- A. Delegated Entity(ies):
 1. Adventist Health (*Clear Lake, Howard Memorial, Mendocino Coast, St. Helena and Ukiah Valley*)
 2. MarinHealth Medical Center
 3. NorthBay Medical Center/ VacaValley Hospital
 4. Providence (aka St. Joseph Health) Queen of the Valley Medical Center
- B. Preauthorization Process for Elective Admissions to the Delegated Entity
 1. Partnership performs prior authorization review to determine if the proposed services meet medical necessity criteria. Partnership notifies the requesting provider of the determination in writing.
- C. Preauthorization Process for Elective Admissions outside of the Delegated Entity's Contracted Service Area
 1. Partnership receives the Provider's request and forwards it to the Delegated Entity's UM Designee for their review within one (1) business day of receipt.
 2. Delegated Entities are responsible for reviewing authorization requests according to the terms of their DOFR agreement and in accordance with policy MCUP3041 Treatment Authorization Request (TAR) Review Process. This may include, but is not limited to, the following actions:
 - a. Reviewing the medical necessity of the requested elective services
 - 1) The Delegated Entity's Medical Director, or physician designee, must review cases where medical necessity is in question, utilizing nationally recognized criteria approved by Partnership.
 - 2) For any denial or modification of medical necessity (adverse benefit determination), the Provider must be notified in writing or electronically within 24 hours of the decision, using an NCQA/DHCS-approved letter template. A copy of the notification must be sent to Partnership, which will mail the notification to the Member. The notice must include the medical rationale for the determination.
 - b. Determining if the elective procedure(s) can be provided (and redirected) within the Delegated Entity's network or whether they will allow the Member to receive services out-of-network.
 - c. Complying with the following DHCS review and timeliness standards:
 - 1) Rendering a decision within five (5) business days from receipt of a preauthorization request; or
 - 2) 72 hours from receipt of an urgent request
- D. Concurrent Review at Delegated Hospitals
 1. Admission: The Delegated Entity notifies Partnership of any admission to their hospital within one (1) business day.
 - a. Admission notification may be made using Partnership's secure Online Services (OLS) Portal <https://provider.partnershiphp.org/UI/Login.aspx> or by submission of a patient demographic "face sheet" via fax to (707) 863- 4118.
 - b. Upon submission, a Treatment Authorization Request (TAR) number is generated in Partnership's electronic system.
 2. The Delegated Entity is responsible for concurrent review throughout the inpatient stay.
 3. Discharge
 - a. The Delegated Entity must complete the final review and determination of the request.
 - 1) Delegated Entities utilizing Partnership's electronic system must populate the discharge information directly into the system to generate the determination correspondence for the UM review.
 - 2) Delegated Entities not utilizing Partnership's electronic system must generate the determination correspondence for the UM review and notify Partnership by phone or fax to update the status in Partnership's system. A copy of the correspondence must also be received by Partnership.

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Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

- E. Emergency Admissions at Hospitals Outside of the Delegated Entity's Contracted Service Area
1. When Partnership is notified that a capitated Member has been admitted emergently to an out-of-area hospital, Partnership notifies the Delegated Entity of the Member's admission within one (1) business day.
 2. The case is assigned to a Partnership Concurrent Review Nurse to perform an initial clinical review.
 3. Partnership performs concurrent review during the hospital stay or until the Delegated Entity is determined to be financially responsible for the hospital stay. This occurs when Partnership's Chief Medical Officer, or physician designee, determines that the Member is medically stable for transfer to the Delegated Entity's hospital. Upon determination, the Delegated Entity is notified and becomes financially responsible for the continued hospital stay on the next calendar day or in accordance with their contractual agreement with Partnership.
 4. The Delegated Entity may choose to allow continued hospitalization at the current hospital or make arrangements to repatriate the Member to their hospital; however, the financial risk remains with the Delegated Entity. The Delegated Entity must notify Partnership's Nurse Coordinator of the decision, with the outcome documented in Partnership's electronic system.
 5. In the event the out-of-area hospital fails to notify Partnership in a timely manner (that is after the Member becomes medically stable for transfer to the Delegated Entity's hospital), Partnership's Chief Medical Officer, or physician designee, reviews the clinical documentation and determines the date of medical stability. Partnership then notifies the Delegated Entity of the effective date of the determination.
 - a. If Partnership and the Delegated Entity do not agree on the effective date of the Delegated Entity's financial responsibility, both parties agree to negotiate in good faith to resolve the issue or as defined by the contractual arrangement between Partnership and the Delegated Entity.
- F. Other Services/Considerations
1. Provider Education
 - a. Although Partnership will assist the Delegated Entity with Partnership network resources, it is the Delegated Entity's responsibility to keep their network physicians and/or staff informed of the services that are available within the Delegated Entity's network.
 - b. Collaborating with network providers increases the opportunity to keep referrals within the network.
 2. Referrals
 - a. If a Partnership Member is referred by their Primary Care Provider (who is linked with the Delegated Entity) to an out-of-area specialist for ongoing specialty care and as a result, the Member is hospitalized on either an elective or an emergency basis in an out-of-area hospital by the out-of-area specialist, Partnership will assign the financial risk to the Delegated Entity at the time of the hospital admission.
 3. If a Member is transported by ambulance from the Delegated Entity's hospital to an out-of-area hospital because the service is not routinely provided by the Delegated Entity's hospital, the Delegated Entity maintains the financial responsibility.
 4. In the event that an emergency occurs in the Delegated Entity's service area, but the Member is transported to an out-of-area hospital, the financial responsibility remains with the Delegated Entity.
 5. If the Delegated Entity's hospital emergency department is on diversion status (unable to accept patients) and the Member is transported to another hospital, the financial responsibility remains with the Delegated Entity.
- G. Member Removal from Capitation
1. Certain Partnership Members may be removed from capitation status based on special service needs e.g. Member's medical condition, prime insurance, demographics or administrative eligibility status.
 2. In order for Partnership to consider a Member's removal from capitation, the Delegated Entity must securely submit a request with supporting clinical documentation and a detailed description of the

Policy/Procedure Number: MCUP3141		Lead Department: Health Services Business Unit: Utilization Management	
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Original Date: 06/09/2021		Next Review Date: 09/10/202608/12/2027 Last Review Date: 09/10/202508/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

circumstances that necessitate removal. Reference should be made to Partnership's policy MPUP3039 Direct Members to determine under what Direct Member status category the request for removal from capitation status is being made and that specific status should be indicated in the letter of request. Requests may be addressed to the Senior Director of Care Management and the Associate Director, UM Regulations at Partnership.

3. The Member will remain under the Delegate's capitation agreement pending written outcome of the review determination.
 4. The request and clinical documentation will be reviewed by a Partnership Medical Director and the requesting Delegate will be notified of the determination in writing.
 5. If it is determined by Partnership's Medical Director that the Member should be placed in a Direct Member status, the effective date of the Direct Member status will be at the discretion of the Medical Director, based on each Member's individual circumstances and reviewed on a case-by-case basis.
- H. Provider/Member Appeals and Member Complaints/Grievances
1. Partnership assumes responsibility for processing all Provider and Member appeals, complaints and grievances on behalf of the delegated entities.
 2. Delegated Entities must comply with the Appeal/Complaint/Grievance processes by providing all written relevant clinical documentation, review determination rationale and any other available documents pertinent to the subject of the dispute in accordance with regulatory requirements.
 3. If the Appeal/ Complaint/ Grievance review results in the overturning of the Delegated Entity's previous determination, the Delegated Entity must abide by Partnership's determination and remains financially responsible for the disputed services.
- I. Regulatory Compliance and Oversight
1. Delegated Entities are required to meet UM standards as set forth NCQA and DHCS.
 2. Delegated Entities must comply with all oversight activities, which may include, but not be limited to, the following:
 - a. Monthly reporting of all inpatient acute admissions to the Delegated Entity's network hospitals. (If the Delegated Entity is using Partnership's electronic system, this report can be generated by Partnership.)
 - b. Participation in a Compliance audit at least annually to include (at a minimum) Partnership review of the Delegated Entity's UM policies, procedures, and decisions.
 3. Delegated Entity agrees to comply with all requirements set forth in the Delegation Agreement.

VII. REFERENCES:

- A. DHCS Contract Exhibit A, Attachment III Section 2.3 Utilization Management Program and Exhibit A, Attachment 1, Definitions
- B. National Committee for Quality Assurance (NCQA) Guidelines ~~(Effective July 1, 2025)~~ UM Standards
- C. DHCS All Plan Letter [\(APL\) 21-011 Revised](#) Grievance and Appeals Requirements, Notice and "Your Rights" Templates (08/31/2022)

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

X. REVISION DATES: 06/08/22; 08/09/23; 08/14/24; 09/10/25; 08/12/26

Policy/Procedure Number: MCUP3141		Lead Department: Health Services	
		Business Unit: Utilization Management	
Policy/Procedure Title: Delegation of Inpatient Utilization Management		☒ External Policy ☐ Internal Policy	
Original Date: 06/09/2021		Next Review Date: 09/10/202608/12/2027 Last Review Date: 09/10/202508/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☐ Partnership Advantage

PREVIOUSLY APPLIED TO:

Medi-Cal (UP100333; MCUP3033: 01/10/1995 to 06/09/2021)

01/10/95; 10/10/97 (name change only); 12/15/99; 03/22/00 by Commission; 12/20/00; 09/19/01; 10/16/02; 06/16/04; 09/21/05; 10/19/05, 10/18/06; 10/17/07; 10/15/08; 11/18/09; 05/18/11; 02/20/13; 01/21/15; 01/20/16; 01/18/17; *02/14/18; 02/13/19; 08/12/20; ARCHIVED 06/09/2021

*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.

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 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 Partnership.

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

Guideline/Procedure Title: MPUG3010 (previously MCUG3010, UG100310)			Lead Department: Health Services	
			Business Unit: Utilization Management	
Guideline/Procedure Title: Chiropractic Services			☒ External Policy ☐ Internal Policy	
Original Date: 02/21/1995		Next Review Date: 08/13/2026 Last Review Date: 08/13/2025		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO ☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: 08/13/2025	

I. RELATED POLICIES:

- A. MCUP3124 – Referral to Specialists (RAF) Policy
- B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- C. MCCP2022 – Early & Periodic Screening, Diagnostic and Treatment (EPSDT) Services

II. IMPACTED DEPTS:

- A. Health Services
- B. Member Services
- C. Claims

III. DEFINITIONS:

- A. EPSDT: Early and Periodic Screening, Diagnostic and Treatment Supplemental Services is a federally mandated Medicaid/ Medi-Cal benefit for Medi-Cal members under age 21 for medically necessary treatment services needed to correct or ameliorate a defect, physical illness, mental illness or a condition, even if the service or item is not otherwise included in the State's Medicaid Plan. [Source: Title 42 US code Section 1396(a)(43) and 1396d(r)]. (California refers to the EPSDT benefit as Medi-Cal for Kids & Teens.)
- B. Partnership Advantage: Effective January 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 Members-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 January 1, 2028 and subject to CMS and DHCS approval.

IV. ATTACHMENTS:

- A. N/A

V. PURPOSE:

This guideline describes the conditions under which chiropractic services are a covered benefit.

VI. GUIDELINE / PROCEDURE:

- A. Chiropractic services are a Partnership HealthPlan of California benefit for members who meet medical

Guideline/Procedure Number: MPUG3010 (previously MCUG3010, UG100310)		Lead Department: Health Services Business Unit: Utilization Management	
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Original Date: 02/21/1995		Next Review Date: 08/13/2026 Last Review Date: 08/13/2025	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

necessity guidelines.

1. For Partnership Medi-Cal Members: Refer to the Medi-Cal Provider Manual/ Guidelines section on Chiropractic Services ([chiro](#)).
2. For Partnership Advantage EnrolleesMembers: Refer to the [Medicare Benefit Policy Manual 100-02](#) Chapter 15, Section 30.5 and Section 240.

B. Authorizations

1. Members age 21 and over who are capitated or assigned to a primary care provider (PCP) require a referral authorization form (RAF) from their PCP for chiropractic services.
 - a. No Treatment Authorization Request (TAR) is required for up to 2 visits per month. Additional monthly visits require prior authorization with justification of medical necessity.
 - b. For Partnership Advantage Members, procedures, or Current Procedural Terminology (CPT) codes submitted by a licensed Chiropractor which relate to manual manipulation of the spine to correct a spinal subluxation, will be reimbursed at the Medicare rate. Other CPT billing codes submitted by a Chiropractor listed in the Medi-Cal Provider Manual/ Guidelines section on Chiropractic Services, will be reimbursed at the Medi-Cal rate.
2. Members under age 21 require prior authorization with justification of medical necessity for chiropractic services. A TAR must be submitted and EPSDT criteria will be considered when evaluating the request.
3. Except as noted in VI.B.4. below, only Partnership-credentialed and Partnership-contracted chiropractors will be paid for chiropractic services.
4. Chiropractic services provided by Indian Health Services (IHS) providers to American Indian/Alaskan native members, irrespective of contracting or in-network status, are reimbursable consistent with the Department of Health Care Services (DHCS) fee-for-service provider manual.
5. Initial assessments without spinal manipulation may be billed using CPT code 99202. Chiropractic service CPT codes 98940 through 98942 may be used for chiropractic services as noted:
 - a. 98940: Chiropractic Manipulative Treatment (CMT); spinal, one or two regions
 - b. 98941: Spinal, three to four regions
 - c. 98942: Spinal, five regions
6. Therapeutic modalities (such as massage, ice/cold packs, education, ultrasound) performed with chiropractic manipulation are not billable separately; the chiropractic service codes are considered bundled payments that include all associated adjunctive therapies performed by the chiropractor.
7. Note that code 98943: CMT, extraspinal, one or more regions, is not covered by Medi-Cal, Medicare or Partnership.

VII. REFERENCES:

- A. Medi-Cal Provider Manual/ Guidelines: Chiropractic Services ([chiro](#))
- B. Title 22 California Code of Regulations (CCR) Sections [51304a](#), [51308](#)
- C. Title 42 US Code Section [1396\(a\)\(43\)](#) and [1396d\(r\)](#)
- D. DHCS FFS Provider Manual – Chiropractic Services
- E. DHCS FFS Provider Manual – Tribal Federally Qualified Health Centers (Tribal FQHCs)
- F. Welfare and Institutions (W&I) Code Section [14131.10\(b\)\(1\)\(C\)](#)
- G. [Medicare Benefit Policy Manual 100-02](#) Chapter 15, Section 30.5 and Section 240.

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

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

Guideline/Procedure Number: MPUG3010 (previously MCUG3010, UG100310)		Lead Department: Health Services Business Unit: Utilization Management	
Guideline/Procedure Title: Chiropractic Services		☒ External Policy ☐ Internal Policy	
Original Date: 02/21/1995		Next Review Date: ~~08/13/2026~~ 08/12/2027 Last Review Date: ~~08/13/2025~~ 08/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

X. REVISION DATES: 3/28/95, 4/28/00; 9/19/01; 10/16/02; 9/15/04; 9/21/05; 10/17/07; 10/15/08; 1/18/12; 5/21/14; 9/17/14; 02/18/15; 05/20/15; 05/18/16; 06/21/17; *08/08/18; 08/14/19; 02/12/20; 11/11/20; 10/13/21; 05/11/22; 04/12/23; 04/10/24; 09/11/24; (MPUG3010) 08/13/25; 08/12/26

*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

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 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 Partnership.

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

Policy/Procedure Number: MPUP3042 (previously MCUP3042, UP100342)			Lead Department: Health Services	
			Business Unit: Utilization Management	
Policy/Procedure Title: Technology Assessment			☒ External Policy ☐ Internal Policy	
Original Date: 04/14/1999		Next Review Date: ~~09/10/2026~~ 08/12/2027 Last Review Date: ~~09/10/2025~~ 08/12/2026		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO	☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~09/10/2025~~ 08/12/2026	

I. RELATED POLICIES:

- A. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- B. MPRP4001 – Pharmacy and Therapeutics (P&T) Committee
- C. MPQP1003 – Physician Advisory Committee (PAC)
- D. MPQP1002 – Quality/Utilization Advisory Committee
- E. MPUP3138 – External Independent Medical Review

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims
- C. Member Services

III. DEFINITIONS:

- A. Biomarker Test: A diagnostic test, single or multigene, of an individual's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide treatment.
- B. Partnership Advantage: Effective January 1, 202~~8~~7, 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~~Members 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 January 1, 2028 and subject to CMS and DHCS approval.
- C. The following definitions apply to entirely new technologies or new applications of existing technologies

INTERVENTION	Lab or animal studies completed	Human studies completed	FDA or regulatory approval	Medicare benefit	State Medi-Cal benefit	Partnership benefit
Experimental (preclinical trials)	No	No	No	No	No	No
Cont'd below						

Policy/Procedure Number: MPUP3042 (previously MCUP3042, UP100342)		Lead Department: Health Services Business Unit: Utilization Management	
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Original Date: 04/14/1999		Next Review Date: <u>09/10/2026</u> Last Review Date: <u>08/12/2027</u>	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

INTERVENTION	Lab or animal studies completed	Human studies completed	FDA or regulatory approval	Medicare benefit	State Medi-Cal benefit	Partnership benefit
<i>Cont'd</i> Investigational (clinical trials in progress)	Yes	No	No	No	No	If all 6 criteria are met
New technology (clinical trial results available)	Yes	Yes	Yes or No	No	No	Case-by case review OR Consider addition as a Partnership benefit
New benefit	Yes	Yes	Yes	Yes	Yes	Yes

IV. ATTACHMENTS:

A. [Review of New Medical Technology Form](#)

V. PURPOSE:

To define the process utilized by Partnership HealthPlan of California (Partnership) to evaluate new technologies/investigational services and interventions, including medical and behavioral health procedures, pharmaceuticals and devices as well as changes in the application of existing technologies or adding new benefits for Members.

VI. POLICY / PROCEDURE:

A. Investigational Interventions:

1. Partnership Medi-Cal Members:

- a. Department of Health Care Services (DHCS) policy (Title 22, California Code of Regulations [CCR] Section [51303\(h\)](#) for approval of investigational services (interventions) states that all six of the following criteria must be fully met:
 - 1) Conventional therapy will not adequately treat the intended patient's condition.
 - 2) Conventional therapy will not prevent progressive disability or premature death.
 - 3) The provider of the proposed service has a record of safety and success with the investigational service that is equivalent or superior to that of other providers.
 - 4) The investigational service is the lowest cost item or service that meets the patient's medical needs and is less costly than all conventional alternatives.
 - 5) The service is not being performed as part of research study protocol.
 - 6) There is a reasonable expectation that the investigational service will significantly prolong the intended patient's life and will maintain or restore a range of physical and social function suited to the activities of daily living.

2. Partnership Advantage Enrollees:

- a. Centers for Medicare & Medicaid Services (CMS) National Coverage Determination ([NCD](#)) [policy 310.1](#) for Routine Costs in Clinical Trials states the following:
 - 1) Covered Services:
 - a) Items or services that are typically provided absent a clinical trial (e.g. conventional care)

Policy/Procedure Number: MPUP3042 (previously MCUP3042, UP100342)		Lead Department: Health Services Business Unit: Utilization Management	
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Original Date: 04/14/1999		Next Review Date: <u>09/10/202608/12/2027</u> Last Review Date: <u>09/10/202508/12/2026</u>	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

- b) Items or services required solely for the provision of the investigational item or service (e.g. administration of a non-covered chemotherapeutic agent), the clinically appropriate monitoring of the effects of the item or service, or the prevention of complications; AND
 - c) Items or services needed for reasonable and necessary care arising from the provision of an investigational item or service - in particular, for the diagnosis or treatment of complications.
 - 2) Non-covered Items and Services:
 - a) The investigational item or service itself, unless otherwise covered outside of the clinical trial
 - b) Items and services provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient (e.g., monthly CT scans for a condition usually requiring only a single scan)
 - c) Items and services customarily provided by the research sponsors free-of-charge for any enrollee in the trial
 - 3. Investigational interventions will not be authorized in the inpatient setting if there is no indication for acute care treatment.
 - 4. After collection of all materials necessary to evaluate whether these criteria are met, the Chief Medical Officer (CMO) or Physician Designee will review the request. If all criteria are judged to be met, the investigational service will be approved.
 - 5. If criteria are not met, the case may be sent for independent medical review by a relevant specialist in the area of the intervention. If, in the opinion of the specialist, criteria have been met, the procedure will be approved.
 - B. Coverage for Cancer Clinical Trials
 - 1. Partnership follows state and federal guidelines as follows:
 - a. Partnership Medi-Cal Members: [DHCS guidelines](#)
 - b. Partnership Advantage Enrollees: CMS guidelines including [NCD policy 310.1](#) for Routine Costs in Clinical Trials.
 - 2. Partnership covers routine patient care costs for eligible Members and Enrollees who are in any one of the four clinical trial phases as long as the following are met:
 - a. The treating physician recommends participation in the trial
 - b. Participation in the trial MUST have meaningful potential to benefit the Member
 - c. The trial must NOT exclusively be to test toxicity, but must have a therapeutic intent
 - d. Trial will NOT occur in the inpatient setting if there is no indication for acute care treatment
 - 3. Trials that qualify for approval include:
 - a. Those involving a drug exempt under federal regulation from a new drug application OR
 - b. The cancer clinical trial is approved by one of the following:
 - 1) The National Institute of Health
 - 2) The Food and Drug Administration (FDA) in the form of an investigational new drug application,
 - 3) The United States Department of Defense
 - 4) The United States Department of Veterans Affairs
 - 4. Per Health and Safety Code (HSC) § [1370.6](#), Partnership does not limit, prohibit, or modify a Member's rights to cancer biomarker testing as part of an approved clinical trial and no prior authorization is required for either of the following*:
 - a. Biomarker testing for a Member with advanced or metastatic stage 3 or 4 cancer
 - b. Biomarker testing for cancer progression or recurrence in a Member with advanced or metastatic stage 3 or 4 cancer
- *If the biomarker test is not associated with an FDA-approved cancer therapy for advanced or*

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Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

metastatic stage 3 or 4 cancer, Partnership may still require prior authorization for such testing.

C. New technologies physician request and authorization process

1. Case-by-case review: If Partnership receives a physician's request to provide benefits of a new intervention for a specific Member the process is as follows:
 - a. A Treatment Authorization Request (TAR) must be submitted to Partnership describing the intervention and containing medical justification for its use. Pertinent patient medical records must be included.
 - b. The CMO or Physician Designee will ask the provider for background information including copies of clinical studies regarding the intervention. Partnership staff will perform a literature search for peer reviewed studies or recommendations from professional societies regarding the use, efficacy, and safety of the proposed service. In addition, Partnership will consider determinations of regulatory authorities (e.g. CMS or FDA) concerning the intervention.
 - c. The CMO or Physician Designee may request input from a relevant specialist prior to presenting the request to the various committees such as the Pharmacy & Therapeutics (P&T) Committee or Physician Advisory Committee (PAC). This specialist must have expertise in the technology under review.
 - d. All behavioral health technologies will include input from an appropriate behavioral health specialist.
 - e. When clinically indicated, a case may be sent for external review to a contracted independent medical review organization. (See policy MPUG3138 External Independent Medical Review.)
 - f. Based on input from the Utilization Management Department, P&T Committee, PAC or relevant specialist, the CMO or Physician Designee renders a determination.
 - g. All records concerning the review are retained by Partnership's Health Services department.
 - h. Determination criteria used by the relevant specialist(s), P&T Committee, PAC, and the CMO or Physician Designee must include all six criteria specified in VI.A.1. a. – f. above when reviewers consider the following:
 - 1) Sufficient objective information regarding the safety, efficacy, and indications for the intervention which support its use.
 - 2) The proposed intervention is likely to lead to a better outcome than conventional interventions currently available.
 - 3) The provider has a record of safety and success with the proposed service which is equivalent or superior to that of other providers of the intervention.
 - 4) The practitioner proposing to provide the intervention is willing to accept the payment rate offered by Partnership.
 - 5) The intervention is not provided as part of a research study protocol.
 - i. Evaluations of new and existing medications are managed by the process described in the Pharmacy & Therapeutics (P&T) Committee policy MPRP4001.

D. Addition of a new benefit:

1. A request to add a new Partnership benefit may be submitted by a provider, Member or Partnership staff. In such instance the following steps occur:
 - a. The request is sent to the CMO or Physician Designee, which includes a statement explaining why the requested service should be added as a Partnership benefit, identification of the Partnership Member to benefit from the service, and all pertinent supporting clinical information. The Chief Health Services Officer will also review the request and offer feedback.
 - b. Partnership will perform a literature search regarding the use, efficacy and safety of the intervention and may also use the services of an external technology assessment organization such as [ECRI Institute](#) or others. As needed, materials collected relating to the request may be forwarded by the CMO or Physician Designee to an appropriate relevant specialist (or to an

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Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

ad hoc physician committee) to review the material and to advise Partnership regarding the use of the new technology. The reviewer or review committee is asked to recommend whether the intervention be added as a Partnership benefit and to delineate criteria used to evaluate the use of the new technology. The CMO may also opt to bring the proposal to the Quality/Utilization Advisory Committee (QUAC) or PAC for feedback on the proposal.

- c. Partnership also has an operational workgroup for review of potential new benefits called the Benefit Review and Evaluation Workgroup (BREW). BREW is comprised of the Chief Medical Officer, the Chief Health Services Officer, the Chief Operating Officer and representatives from these departments: Regulatory Affairs, Provider Relations, Member Services, Finance, Claims, and Information Technology. BREW investigates and considers the medical, financial and operational issues surrounding proposed benefit changes. BREW findings are summarized and presented to the Partnership Executive Committee which will determine next steps. All medical criteria changes follow the process described in VI.D.1.a. and b. above. The Executive Committee may refer a recommendation to the Board (Partnership Commission) for addition of a new benefit class. The Executive Committee may also request input from the Physician Advisory Committee (PAC) prior to rendering a decision. The Executive Committee may approve coverage of single CPT codes (“minor changes”) that it deems are within the general scope of medical services generally covered by Partnership. The Executive Committee will also determine operational changes required such as information technology (IT) and claims configuration and/or financial considerations such as recommending Medi-Cal coverage of new technologies to the California Department of Health Care Services (DHCS).
2. Notification of New Benefit Addition: Once approved by the PAC and the Board (Partnership Commission) as applicable, information regarding the new benefit may be disseminated as necessary in the following manner:
 - a. Primary Care Providers (PCPs) and relevant specialists are notified electronically by “Important Provider Notice (IPN).”
 - b. Internal notification is sent to Partnership department leadership so that policies and procedures may be created and information gathered to inform utilization management determinations, benefit interpretations, care coordination decisions, and the design of health educational materials.
 - c. Partnership Members are notified of benefit additions via the Member Newsletter, updates to the Member Handbooks and the [Partnership website](#).

VII. REFERENCES:

- A. Title 22, California Code of Regulations (CCR) Section [51303](#)
- B. Medi-Cal Provider Manual/ Guidelines: Chemotherapy: An Overview ([chemo an over](#))
- C. DHCS All Plan Letter ([APL](#)) [22-010](#) Cancer Biomarker Testing (06/22/2022)
- D. Health and Safety Code (HSC) § [1370.6](#)
- E. ECRI (founded as Emergency Care Research Institute) <https://home.ecri.org/>
- ~~F. National Committee for Quality Assurance (NCQA) Guidelines (Effective July 1, 2025) UM 10 Evaluation of New Technology Elements A & B~~
- ~~G.F. Medicare National Coverage Determinations (NCD) [Manual 100-03: Chapter 1, Part 4, Section 310.1](#) Clinical Trials: Routine Costs in Clinical Trials. Implementation date 05/27/2024 or any subsequent updates published by CMS.~~
- ~~H.G. [Noridian Jurisdiction E Medicare Part B Clinical Trials](#) guidance. Last updated 03/17/2026.~~

VIII. DISTRIBUTION:

- A. Partnership Department Directors
- B. Partnership Provider Manual

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Original Date: 04/14/1999		Next Review Date: ~~09/10/2026~~ 08/12/2027 Last Review Date: ~~09/10/2025~~ 08/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

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

X. REVISION DATES: 06/21/00; 12/19/01; 10/16/02, 10/20/04; 10/19/05; 10/18/06; 10/17/07; 05/21/08; 07/15/09; 05/18/11; 02/20/13; 01/20/16; 10/19/16; 10/18/17; *06/13/18; 08/14/19; 08/12/20; 08/11/21; 08/10/22; 08/09/23; 08/14/24; (MPUP3042) 09/10/25; 08/12/26

*Through 2017, dates 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

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 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 Partnership.

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

Policy/Procedure Number: MPUP3138 (previously MCUP3138)			Lead Department: Health Services	
			Business Unit: Utilization Management	
Policy/Procedure Title: External Independent Medical Review			☒ External Policy ☐ Internal Policy	
Original Date: 06/13/2018		Next Review Date: ~~09/10/2027~~ 08/12/2026 Last Review Date: ~~09/10/2026~~ 08/12/2026		
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage	
Reviewing Entities:	☒ IQI	☐ P & T	☒ QUAC	
	☐ OPERATIONS	☐ EXECUTIVE	☐ COMPLIANCE	☐ DEPARTMENT
Approving Entities:	☐ BOARD	☐ COMPLIANCE	☐ FINANCE	☒ PAC
	☐ CEO ☐ COO	☐ CREDENTIALS	☐ DEPT. DIRECTOR/OFFICER	
Approval Signature: Robert Moore, MD, MPH, MBA			Approval Date: ~~09/10/2025~~ 08/12/2026	

I. RELATED POLICIES:

- A. MPUP3042 – Technology Assessment
- B. MCUP3041 – Treatment Authorization Request (TAR) Review Process
- C. MCUP3037 – Appeals of Utilization Management/ Pharmacy Decisions
- D. MCRP4068 – Medical Benefit Medication TAR Policy

II. IMPACTED DEPTS:

- A. Health Services
- B. Claims
- C. Member Services

III. DEFINITIONS:

- A. Independent Medical Review process: Process in which an expert independent medical professional is selected to review a specific health service request and provide a fair and objective opinion based on his/her designated specialty.
- B. Independent Medical Review Organization (IMRO): A third-party medical review resource which provides objective, unbiased medical determinations to support effective decision making based only on medical evidence.
- C. Independent Review Entity (IRE): Specific to Partnership Advantage Members, an IRE refers to an independent organization contracted by the Centers for Medicare & Medicaid Services (CMS) to review Medicare Advantage (Part C) or Prescription Drug (Part D) plan decisions in the second level of appeal.
- D. Life Threatening: Defined as a disease or condition where the likelihood of death is high unless the course of the disease is interrupted OR diseases or conditions with potentially fatal outcomes where the end point of the clinical intervention is survival.
- E. Partnership Advantage: Effective January 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 ~~Members-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 January 1, 2028 and subject to CMS and DHCS approval.
- F. Seriously Debilitating: Defined as diseases or conditions causing major irreversible morbidity.

IV. ATTACHMENTS:

- A. N/A

Policy/Procedure Number: MPUP3138 (previously MCUP3138)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: External Independent Medical Review		☒ External Policy ☐ Internal Policy	
Original Date: 06/13/2018		Next Review Date: ~~08/14/2027~~ 08/12/2027 Last Review Date: ~~08/14/2026~~ 08/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

V. PURPOSE:

To describe the process used by Partnership HealthPlan of California (Partnership) to provide a comprehensive and fair evaluation of health service requests. The external independent medical review process may be applied in circumstances for which nationally recognized evidenced-based criteria or Partnership medical policy does not provide ample guidance or where the Chief Medical Officer (CMO) or Physician Designee desires an additional opinion from an actively practicing, board-certified physician of like or similar specialty.

VI. POLICY / PROCEDURE:

- A. Partnership contracts with Independent Medical Review Organizations (IMROs) to ensure qualified case-matched independent specialists are available to review health service requests as expeditiously as possible in deference to the Member's health condition. In addition to an IMRO, Partnership may also use qualified case-matched independent specialists to review on a case-by-case basis. An IMRO or qualified case-matched independent specialist may be used at the discretion of the CMO or Physician Designee for circumstances including, but not limited to the following:
 1. Assessment of health treatment efficacy and/or scope of application
 2. Service requests deemed Experimental or Investigational
 3. In the instance of an appeal (Note: For Partnership Advantage Members, the designated IRE would be used as described in III.C. above)
 4. Denial of an Experimental or Investigational therapy when a Member has a life threatening or seriously debilitating condition.
 5. Denial, modification or delay of health care services based in whole or part on the determination that the service requested is not medically necessary. The Member's contracted treating physician must certify that the condition has not responded to standard therapies AND must make written recommendation that another drug, device, procedure or therapy would be MORE beneficial than those that are standard.
 6. Existing technology/pharmacology used differently
- B. With the exception of Experimental or Investigational Therapy, determinations to deny, delay or modify health care services based on a benefit exclusion, are not eligible for an independent medical review under this policy.
- C. Partnership does not reward practitioners or other individuals for issuing denials of coverage. There are no financial incentives for Utilization Management (UM) decision makers to deny care, and Partnership does not encourage decisions which would result in under-utilization, but rather bases decisions solely on the appropriateness of care or service and the existence of coverage.
- D. The IMRO conducting the independent medical review is contracted directly by Partnership. The cost of the independent medical review is the responsibility of the health plan. The Member or Provider requesting an independent medical review on the Member's behalf shall NOT be charged an application or processing fee.
- E. Process for Referral to Independent Medical Review
 1. Partnership's CMO or Physician Designee will work with the Utilization Management (UM) Department to assemble and submit all necessary information to the contracted IMRO, IRE, or qualified case-matched independent specialist.
 2. The UM staff will submit a completed file for review by the Independent Medical Reviewer which will include, but is not limited to:
 - a. Internal patient identifier for the purpose of the review
 - b. Requested service/procedure to include specific CPT/HCPCS code(s)
 - c. Member diagnosis (Using current ICD Code sets)
 - d. All information provided relevant to the service requested
 - e. All information submitted by the practitioner in support of the requested service

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Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

- f. Pertinent medical history
 - g. Treatment or clinical data
 - h. Date response needed
 - i. Specific questions concerning treatment requiring clarification
3. The UM staff maintain contact with the IMRO and ensure timely resolution of the submitted case.
 4. Upon receipt of the independent review, Partnership's CMO or Physician Designee will determine coverage of the requested service.
 5. After the coverage decision has been reached and all parties notified, Partnership's CMO or Physician Designee- will submit a copy of the case, including the final resolution, to UM department staff.
 6. UM department staff uploads a summary of the case and all supporting documentation into the UM Department documentation system as an attachment to the Member's Treatment Authorization Request (TAR) file for which the review was completed.
 7. UM staff maintain tracking/monitoring of all cases submitted to the IMRO.
 8. IMRO information is available to the Partnership Quality/Utilization Advisory Committee (Q/UAC) upon request.
 9. The CMO or Physician Designee is responsible for ensuring the timely processing and final resolution of the requested service. When independent medical review is sought, it must also occur in this time frame.
- F. Time Frames
1. Standard Review: The IMRO shall review all relevant information and make a written determination within five (5) business days of receipt of the request in order to allow for timely resolution of non-urgent requests.
 2. Expedited Review:
 - a. An expedited independent medical review is initiated under the following conditions:
 - 1) The CMO or Physician Designee, or treating physician determines there is an imminent and serious threat to the health of the Member including, but not limited to, severe pain, the potential loss of life, limb or major bodily function, and or the immediate and serious deterioration of the health of the Member.
 - 2) The Member's physician has determined that the proposed therapy would be significantly less effective if not promptly initiated.
 - b. The IMRO shall make their determination within 24 hours of the receipt of the request and provide supporting documentation to allow for a timely review within seventy-two (72) hours of date of receipt at Partnership. Partnership may extend the IMRO's determination deadline for an additional 24 hours in extraordinary circumstances or for good cause, which is in the best interest of the Member and still allows for a timely review or appeal resolution within seventy-two (72) hours of date of receipt.
 3. Retrospective Review: In the case of a retrospective review, the IMRO shall review all relevant information and make a written determination within five (5) to seven (7) business days of receipt of the request to allow for timely review decision within 30 business days of the date of receipt at Partnership.
 4. In all cases, Partnership will provide the Member and the Member's treating practitioner with the analysis and determination as well as a description of the qualifications of the medical professionals who reviewed the case. As part of the grievance process, Partnership provides a Member with a written determination to uphold a denial, delay or modification based on either medical necessity or the experimental or investigational nature of the request, and advises the Member of appeal rights and process.

Policy/Procedure Number: MPUP3138 (previously MCUP3138)		Lead Department: Health Services Business Unit: Utilization Management	
Policy/Procedure Title: External Independent Medical Review		☒ External Policy ☐ Internal Policy	
Original Date: 06/13/2018		Next Review Date: ~~08/14/2027~~ 08/12/2027 Last Review Date: ~~08/14/2026~~ 08/12/2026	
Applies to:	☐ Employees	☒ Medi-Cal	☒ Partnership Advantage

VII. REFERENCES:

- A. California Health and Safety Code, Division 2, Chapter 2.2 Health Care Service Plans, Article 5.55 Appeals Seeking Independent Medical Reviews Section [1374.30 - .36](#)
- B. Title 28 California Code of Regulations (CCR), Division 1, Chapter 2, Article 8 Section [1300.70.4](#) and [1300.74.30](#)
- C. In compliance with the California Department of Health Care Services (DHCS) contract
- D. [Title 22](#) California Code of Regulations (CCR)
- E. National Committee for Quality Assurance (NCQA) Guidelines (~~Effective July 1, 2025~~)—UM 4 Appropriate Professionals Element F—~~and UM 10 Evaluation of New Technology Elements A & B~~
- F. Medicare [Parts C & D Enrollee Grievances, Organization/Coverage Determinations, and Appeals Guidance](#) (11/18/2024)

VIII. DISTRIBUTION:

- A. Partnership Provider Manual
- B. Partnership Department Directors

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Chief Health Services Officer, Chief Medical Officer or Physician Designee

X. REVISION DATES:

08/14/19; 08/12/20; 08/11/21; 08/10/22; 08/09/23; 08/14/24; (MPUP3138) 09/10/25; ~~09/09~~ 08/12/26

PREVIOUSLY APPLIED TO:

N/A

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 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 Partnership.

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
Meeting Minutes**

COMMITTEE	Pharmacy and Therapeutics Committee Meeting (P&T)		
DATE / TIME:	Thursday, July 09, 2026 / 7:30am – 10:00am PT		
Practicing Members Present: Michael Majeski, PharmD Jay Shubrook, DO Lilia Vargas-Toledo, RN	PHC Members Present: <i>Deputy Chief Medical Officer, Committee Chair:</i> Kermit Jones, MD <i>Medical Directors:</i> Jeffery Ribordy, MD, MPH Mark Glickstein, MD Matthew Morris, MD Colleen Townsend, MD Mark Netherda, MD		Invited Guests Present: Donell Colvin, CPhT Yasmin Bains, DO, MSc Victoria Guan, Pharmacy Student (UCSF) (SFP) <i>Department AA:</i> Jacquelyn Brackett <i>IT Ops & Systems:</i> Jose Puga John Lemoine
Practicing Members Absent: Kirsten Balano, PharmD Phillip Nguyen, PharmD, BCACP, BCGCP	PHC Members Absent: Robert Moore, MD, MPH, MBA Dave Katz, MD Bradley Cox, DO Richard Matthews, MD Lisa Ward, MD Marshall Kubota, MD Bettina Spiller, MD Jeffrey DeVido, MD Teresa Frankovich, MD Aaron Thornton, MD Michael George, MD Kathleen Vo, PharmD Lisa Rowand, PharmD		

AGENDA ITEM	DISCUSSION / CONCLUSIONS	SPEAKER, APPROVED ACTION ITEMS	EFFECTIVE DATE
<u>Opening Comments</u>	- o Introductions - o Housekeeping (Announcement: Meeting is being recorded) - o Conflict of Interest statement reminder	<i>Presented by Stan Leung, PharmD</i>	
<u>I. Approval of minutes</u>	Quorum: Yes 3 out of 5 members attended Minutes: Approved	<i>Presented by Stan Leung, PharmD</i>	N/A
<u>II. Standing Agenda</u>			
1. PHC Update	<u>PHC Updates provided by Dr. Jones:</u> As you are aware, Dr. Moore, the CMO, will be returning next week. Some of the big issues that we are dealing with is the UIS carve out from the state level and how at the plan level, we have been working with our sister plans to try to figure out how to keep them in the Medi-Cal managed plan benefit that it looks like we are going to talk about this a little bit more at our executive meeting today. That is not going to happen. So that's still something that we're kind of working through. As you know, we will be working with pharmacy as well to see how that affects us from the pharmacy and the Medi-Cal Rx standpoint. In terms of updates with respect to DSNP program, we are still in the process of working with the delegate to determine what specific things will be delegated and then what plans or rather policies that they're going to be handling and writing in conjunction with us. From the UM standpoint, we are in the process of also increasing our internal and external UM relationships to facilitate the processing of the TARs as well. Finally, we are going through the process of our joint leadership initiatives with some of the other healthcare systems that we're working with to try to ensure that from a quality standpoint, we're improving those as well. So those are all the organizational updates I have for now. We did get our preliminary HEDIS scores back, but I want to wait until we get the final scores to share that with the rest of the committee.	<i>Presented by Kermit Jones, MD JD</i>	N/A

2. Additional Updates	<u>Pharmacy and Medi-Cal Rx Updates:</u> There are two updates which pertain to Medi-Cal Rx. The first is with the provider enrollment requirement. As a reminder, the provider enrollment requirement is where Medi-Cal Rx will require providers to enroll in Medi-Cal with their type one NPI for their prescriptions and even their prior authorizations to pay. Please keep in mind that enrollment with or under the organization NPI, which is usually the type two NPI will not meet this requirement. Originally Medi-Cal was going to go through a phased approach of enforcement beginning this July, but they have now since postponed this to a future to be determined date. I think it's important to kind of take the opportunity for this extension for non-enrolled prescribers to submit their applications as soon as possible. Currently Medi-Cal is providing the managed care plans with a monthly list of non-enrolled providers, and we are using this list to work with the provider relations and the regional directors to reach out to the organizations and reach out to those non-enrolled prescribers to urge them to submit their applications to PAVE as soon as possible. The processing time for Medi-Cal to receive the application and complete the processing for enrollment takes about 90 days. When this requirement is enforced, submitting the application for DHCS to receive the application will not fulfill this requirement. So really the main takeaway is for prescribers to submit their application as soon as possible to prevent any disruptions at the pharmacy because this impacts all prescriptions that are associated with non-enrolled NPIs, so not only new prescriptions but all refills will be impacted as well. The second update pertains to the PAD policy change, the physician administered drug policy change. And what this policy does is essentially carve out certain physician administered drugs out of the Medi-Cal Rx pharmacy benefit and back into the managed plan's medical benefit. So essentially this carves out or eliminates or potentially eliminates pharmacies from providing home infusions for these PAD drugs, which could cause a significant impact to prescribers and patients in terms of access for these PADs. We've heard in previous meetings that certain smaller practices that does buy or does rely on infusion pharmacies provide these drugs don't really have the infrastructure to sustain and have a bill buy and bill process for these drugs,	<i>Presented by Stan Leung, PharmD</i>	N/A

3. DUR Update	so they really rely on the infusion pharmacies to service patients for some of these infusion drugs. Originally, Medi-Cal was going to implement this policy in the first quarter of 2027, but they have now postponed this until 2028. I think they recognize that there are still a lot of items that need to be worked through and clarified, in particular are the drugs that they are going to carve out from the pharmacy benefit, the reimbursement methodology that they're going to use to pay the managed care plans to pay for these drugs, and then third, the exception process. So those are our three big items that still need quite a bit of work through and clarification and they're extending the timeline to implementation to work with the managed care plans, work with the prescribers and pharmacies to ensure that they create policies that will have an effective way of providing timely as well as appropriate level of care access for these PAD drugs. Those are the two Medi-Cal Rx updates. Psychotropic Medications in Youth: Monitoring for concomitant use of antipsychotics with antidepressants and mood stabilizers <u>Overview</u> The Department of Health Care Services (DHCS) requires managed care plans to monitor the appropriate use of psychiatric drugs in members under the age of 18. This includes evaluating whether overutilization of psychotropic drugs occurred among our youth and foster care population. The monitored medication classes include antipsychotics, mood stabilizers, and anti-depressants. In response, Partnership HealthPlan of California (PHC) implemented a process to identify potential psychotropic medication overutilization and to notify the prescribers when concerns are identified. <u>Method</u> A biannual retrospective review of pharmacy claims was conducted to identify members under 18 years of age who filled prescriptions for more than one antipsychotic medication. For members with fills for two or more antipsychotics medications, additional claims analysis was	<i>Presented by Stan Leung, PharmD</i>	N/A

4. Review of Member	conducted to assess concurrent use of mood stabilizers, antidepressants, stimulants, benzodiazepines, and sedatives. Members who received three or more psychotropic medications, including at least two antipsychotics, underwent further review to confirm prescriber specialty and evaluate the appropriateness of the overall regimen. Cases with potential concerns were escalated to PHC medical directors with pediatric and psychiatric expertise to determine whether follow-up or intervention was needed. PHC also monitored whether youth in foster care were more or less likely than non-foster care youth to be identified with potential overutilization of psychotropic medications. <u>Results</u> PHC reviewed Medi-Cal Rx pharmacy claims for antipsychotic medications used among members under age 18 to identify potential psychotropic medication overutilization. <u>Summary</u> Pharmacy claims review (9/1/25 to 2/28/26: Period 1) • Overall rate: 2.8% (74 of 2,668 total youth population) • Non-foster care vs. foster care rate: 3.0% (56 of 2,067 non-foster care youth) vs 2.1% (18 of 601 foster care youth) As a comparison, claims review (3/1/25–8/31/25: Period 2) Overall rate: 3.1% (75 of 2,402 total youth population) • Non-foster care vs. foster care: 3.1% for both groups (58 of 1,867 non-foster care youth vs 17 of 535 foster care youth) <u>Conclusion</u> The proportion of potential overutilization of psychotropic medications between Non-Foster Youths vs Foster Youths is not statistically different. Also, Period 1 vs Period 2 shows no statistical difference in overutilization between the two periods. One member was referred to PHC’s medical directors for further review, and it was determined that prescriber intervention was not necessary.		

Language for PADs 5. Drug Benefit Review	Dr. Ocampo presented an overview of Partnership’s PAD and Medi-Cal Rx benefit information that appears in the Member Handbook, Member Newsletter and PHC Pharmacy External Webpage. This is a requirement for NCQA that Partnership annually review any member facing language about partnerships coverage of physician administered drugs. Dr. Ocampo requested feedback and recommendations from the committee to help finalize the drug benefit information and confirm that it is understandable for our members. Language approved by the committee as presented, without any recommended modifications. The classes for this quarter’s review are: - o Dermatological, Anorectal, Mouth – Throat, Dental, Eye - Ear - o Endocrine and Metabolic Agents - o Gastrointestinal Agents - o Miscellaneous Products All actions at right were approved by the committee as presented, unless otherwise noted as “<i>approved as modified.</i>” All changes will be effective 10/01/2026 unless otherwise noted. Class Reviews: - o Dermatological, Anorectal, Mouth – Throat, Dental, Eye - Ear • Updates to the following were presented, with approved action shown at right. ▪ capsaicin 8% patch, per square centimeter (Qutenza™) ▪ aflibercept, 1 mg (Eylea™) ▪ aflibercept-ayyh (pavblu), biosimilar, 1 mg (Pavblu™) ▪ aflibercept-abzv (enzeevu), biosimilar, 1 mg (Enzeevu™) ▪ aflibercept-mrbb (ahzantive), biosimilar, 1 mg (Ahzantive™)	Presented by Andrea Ocampo, PharmD Presented by Susan Becker, PharmD, BCPS, Erin Montegary, PharmD and Angela Keough, PharmD Presented by Angela Keough, PharmD and Susan Becker, PharmD, BCPS <table><tr><th colspan="2">Dermatological, Anorectal, Mouth – Throat, Dental, Eye - Ear Class Review, Approved Actions:</th></tr><tr><th>HCPCS</th><th>Drug</th></tr><tr><th colspan="2">New TAR Criteria (see attached criteria for details)</th></tr><tr><td>J7336</td><td>Capsaicin 8% patch, per square centimeter (Qutenza™)</td></tr><tr><th colspan="2">TAR Criteria Updates (see attached criteria for details)</th></tr><tr><td>J0178</td><td>Injection, aflibercept, 1 mg (Eylea™)</td></tr><tr><td>Q5147</td><td>Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg (Pavblu™)</td></tr></table>	Dermatological, Anorectal, Mouth – Throat, Dental, Eye - Ear Class Review, Approved Actions:		HCPCS	Drug	New TAR Criteria (see attached criteria for details)		J7336	Capsaicin 8% patch, per square centimeter (Qutenza™)	TAR Criteria Updates (see attached criteria for details)		J0178	Injection, aflibercept, 1 mg (Eylea™)	Q5147	Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg (Pavblu™)	N/A 10/1/2026
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O Endocrine and Metabolic Agents • Updates to the following were presented, with approved action shown at right. ▪ pegzilarginase-nbln (Loargys™) ▪ lanreotide, 1 mg (Somatuline Depot™) ▪ lanreotide, (cipl), 1 mg (Cipla 505(b)(2) lanreotide ▪ multiple enzyme replacement drugs listed in criteria	Presented by Erin Montegary, PharmD <table><tr><td colspan="2">Endocrine and Metabolic Agents Class Review, Approved Actions:</td></tr><tr><td>HPCPS</td><td>Drug</td></tr><tr><td colspan="2">New TAR Criteria (see attached criteria for details)</td></tr><tr><td>J3590 (NOC)</td><td>Injection, pegzilarginase-nbln (Loargys™)</td></tr></table>	Endocrine and Metabolic Agents Class Review, Approved Actions:		HPCPS	Drug	New TAR Criteria (see attached criteria for details)		J3590 (NOC)	Injection, pegzilarginase-nbln (Loargys™)	10/1/2026																									
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- teplizumab-mzwv, 5 mcg (TzielTM) - Discussion brought forth by Dr. Glickstein to the committee members regarding defining "Diabetologist" and Prescriber Restrictions as well as discussion with Dr. Shubrook and committee members to updated covered use section to extend timeframe of Stage 3 Type 1 diagnosis within 12 weeks versus 6 weeks previously stated. The changes have been made to the drug specific criteria (see attached criteria, *Approved as Modified*).
- zoledronic acid, 1 mg (Reclast; ZometaTM)
- betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg (Celestone SoluspanTM)

O Gastrointestinal Agents

- Updates to the following were presented, with approved action shown at right.
 - infliximab, excludes biosimilar, 10 mg (RemicadeTM) and multiple biosimilar codes
 - ustekinumab, for intravenous injection, 1 mg (StelaraTM) and multiple biosimilars – discussion brought forth by Dr. Andrea Ocampo regarding Stelara criteria, age limit updated to 2 years of age and older for diagnosis of Crohns disease. The change has been made to the drug specific criteria (see attached criteria, *Approved as Modified*).
 - vedolizumab, Intravenous, 1 Mg (EntyvioTM)

TAR Criteria Updates (see attached criteria for details)

J1930	Injection, lanreotide, 1 mg (Somatuline Depot TM)
J1932	Injection, lanreotide, (cipl), 1 mg (Cipla 505(b)(2) lanreotide)
Multiple HCPCS codes *see attached criteria*	Multiple HCPCS codes under Enzyme Replacement Drugs criteria
J9381	Injection, teplizumab-mzwv, 5 mcg (Tziel TM) (<i>Approved as Modified</i>)

Updates to Claim Limits &/or Requirements *No TAR Required*

J3489	Injection, zoledronic acid, 1 mg (Reclast; Zometa TM) – removal of frequency limits, daily limits (5 units) remains

Removal of Claim Limits &/or Requirements

J0702	Injection, betamethasone acetate 3 mg and betamethasone sodium phosphate 3 mg (Celestone Soluspan TM)

Presented by Erin Montegary, PharmD

Gastrointestinal Agents Class Review, Approved Actions:

HCPCS	Drug
TAR Criteria Updates (see attached criteria for details)	
J1745	Injection, infliximab, excludes biosimilar, 10 mg (Remicade TM) and Biosimilars
J3358	Ustekinumab, for intravenous injection, 1 mg (Stelara TM) and Biosimilars (<i>Approved as Modified</i>)
J3380	Injection, Vedolizumab, Intravenous, 1 Mg (Entyvio TM)

10/1/2026

o Miscellaneous Products

- Updates to the following were presented, with approved action shown at right.
 - inebilizumab-cdon, 1 mg (Uplizna™)
 - efgartigimod alfa-fcab, 2mg (Vyvgart™)
 - efgartigimod alfa, 2 mg and hyaluronidase-qvfc (Vyvgart Hytrulo™)
 - rozanolixizumab-noli, 1 mg (Rystiggo™)
 - nipocalimab-aahu, 3 mg (Imaavy™)
 - anifrolumab-fnia, 1 mg (Saphnelo™)
 - belimumab, 10 mg (Benlysta IV™)
 - candida albicans skin test (Candin™)
 - hyaluronidase, recombinant, 1 usp unit (Hylenex™)
 - hyaluronidase, up to 150 units (Amphadase™)
 - sodium thiosulfate (hope), 100 mg
- Updated Configuration in Partnership's internal Amysis system to remove denial code EX: 86 (Not Covered Benefit) to allow claims to pay with an Approved TAR for drugs listed below:
 - hyaluronidase, recombinant, 1 usp unit (Hylenex™)
 - hyaluronidase, up to 150 units (Amphadase™)
 - sodium thiosulfate (hope), 100 mg

In addition to the scheduled class reviews, PHC presented the following:

- o Updates to Antineoplastic & Adjunctive Agents:
- cyclophosphamide, 5 mg (Frindovyx™)
 - cyclophosphamide (sandoz), 5 mg

Presented by Susan Becker, PharmD, BCPS

Miscellaneous Products Class Review, Approved Actions:

HCPCS	Drug
TAR Criteria Updates (see attached criteria for details)	
J1823	Injection, inebilizumab-cdon, 1 mg (Uplizna™)
J9332	Injection, efgartigimod alfa-fcab, 2mg (Vyvgart™)
J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc (Vyvgart Hytrulo™)
J9333	Injection, rozanolixizumab-noli, 1 mg (Rystiggo™)
J9256	Injection, nipocalimab-aahu, 3 mg (Imaavy™)
J0491	Injection, anifrolumab-fnia, 1 mg (Saphnelo™)
J0490	Injection, belimumab, 10 mg (Benlysta IV™)

Updates to Claim Limits &/or Requirements (Configuration update; see details at right.)

J3473	Injection, hyaluronidase, recombinant, 1 usp unit (Hylenex™)
J3470	Injection, hyaluronidase, up to 150 units (Amphadase™)
J0209	Injection, sodium thiosulfate (hope), 100 mg

Addition of Claim Limits &/or Requirements

J3590 (NOC)	Unclassified biologics: candida albicans skin test (Candin™) ***QL: 1 unit per date of service***

10/1/2026

Presented by Erin Montegary, Pharm D

Ad hoc Updates

HCPCS	HCPCS Description (brand)	Approved Action
J9072	Injection, cyclophosphamide, 5 mg (Frindovyx™)	Addition of TAR requirement
J9074	Injection, cyclophosphamide (sandoz), 5 mg	Addition of TAR requirement

10/1/2026

	o New HCPCS code review – listed at right, listed in two sections: • First time HCPCS code for drug (other than unclassified code) • HCPCS code changed but no change in coverage requirements for the drug itself. • Codes were announced as benefits by DHCS on 6/29/2026, with an effective date of 7/1/2026.	Presented by Erin Montegary, PharmD NTR = No TAR Required <table><tr><th colspan="3">New HCPCS codes (no prior code or was previously unclassified)</th></tr><tr><th>HCPCS</th><th>HCPCS Description</th><th>Requirements</th></tr><tr><td>J0528</td><td>Injection, fosfomycin disodium, 20 mg (Contepo™)</td><td>TAR</td></tr><tr><td>J2361</td><td>Injection, depemokimab-ulaa, 1 mg (Exdensur™)</td><td>TAR</td></tr><tr><td>J9062</td><td>Injection, amivantamab 5 mg and hyaluronidase-lpuj (Rybrevant Faspro™)</td><td>TAR</td></tr><tr><td>J9053</td><td>Injection, belantamab mafodotin-blmf, 0.1 mg (Blenrep™)</td><td>TAR</td></tr><tr><td>C9310</td><td>Injection, leucovorin calcium (avyxa), 1 mg</td><td>TAR</td></tr><tr><td>J2374</td><td>Apraclonidine hydrochloride ophthalmic, 1% solution, 0.1 ml (Iopidine 1%™)</td><td>Covered with no limits</td></tr><tr><td>J2789</td><td>Riboflavin 5'- phosphate, ophthalmic solution (epioxa hd/epioxa), up to 2 ml (Epioxa/Epioxa HD™)</td><td>TAR</td></tr><tr><td>Q5168</td><td>Injection, ranibizumableyk (nufymco), biosimilar, 0.1 mg (Nufymco™)</td><td>TAR</td></tr><tr><td>Q5170</td><td>Injection, afliberceptboav (eydenzelt), biosimilar, 1 mg</td><td>TAR</td></tr><tr><td>Q5165</td><td>Injection, denosumabmobz (oziltus), biosimilar, 1 mg (Oziltus™)</td><td>TAR</td></tr><tr><td>Q5166</td><td>Injection, denosumabdesu (osvyrti/jubereq), biosimilar, 1 mg (Osvyrti/Jubereq™)</td><td>TAR</td></tr><tr><td>Q5167</td><td>Injection, denosumabqbde (enoby/xtrenbo), biosimilar, 1 mg (Enoby/Xtrenbo™)</td><td>TAR</td></tr><tr><td>Q5171</td><td>Injection, denosumabmobz (boncresa), biosimilar, 1 mg (Boncresa™)</td><td>TAR</td></tr><tr><td>Q5164</td><td>Injection, ustekinumabhmny (starjemza), biosimilar, 1 mg (Starjemza™)</td><td>TAR</td></tr><tr><td>J1289</td><td>Injection, narsoplimabwuug, 1 mg (Yartemlea™)</td><td>TAR</td></tr><tr><td>J3386</td><td>Injection, etuvetidigene autotemcel, per treatment (Waskyra™)</td><td>TAR</td></tr><tr><td>J7176</td><td>Injection, human fibrinogen - chmt (fesilty), 1 mg (Fesilty™)</td><td>TAR</td></tr></table>	New HCPCS codes (no prior code or was previously unclassified)			HCPCS	HCPCS Description	Requirements	J0528	Injection, fosfomycin disodium, 20 mg (Contepo™)	TAR	J2361	Injection, depemokimab-ulaa, 1 mg (Exdensur™)	TAR	J9062	Injection, amivantamab 5 mg and hyaluronidase-lpuj (Rybrevant Faspro™)	TAR	J9053	Injection, belantamab mafodotin-blmf, 0.1 mg (Blenrep™)	TAR	C9310	Injection, leucovorin calcium (avyxa), 1 mg	TAR	J2374	Apraclonidine hydrochloride ophthalmic, 1% solution, 0.1 ml (Iopidine 1%™)	Covered with no limits	J2789	Riboflavin 5'- phosphate, ophthalmic solution (epioxa hd/epioxa), up to 2 ml (Epioxa/Epioxa HD™)	TAR	Q5168	Injection, ranibizumableyk (nufymco), biosimilar, 0.1 mg (Nufymco™)	TAR	Q5170	Injection, afliberceptboav (eydenzelt), biosimilar, 1 mg	TAR	Q5165	Injection, denosumabmobz (oziltus), biosimilar, 1 mg (Oziltus™)	TAR	Q5166	Injection, denosumabdesu (osvyrti/jubereq), biosimilar, 1 mg (Osvyrti/Jubereq™)	TAR	Q5167	Injection, denosumabqbde (enoby/xtrenbo), biosimilar, 1 mg (Enoby/Xtrenbo™)	TAR	Q5171	Injection, denosumabmobz (boncresa), biosimilar, 1 mg (Boncresa™)	TAR	Q5164	Injection, ustekinumabhmny (starjemza), biosimilar, 1 mg (Starjemza™)	TAR	J1289	Injection, narsoplimabwuug, 1 mg (Yartemlea™)	TAR	J3386	Injection, etuvetidigene autotemcel, per treatment (Waskyra™)	TAR	J7176	Injection, human fibrinogen - chmt (fesilty), 1 mg (Fesilty™)	TAR	7/1/2026
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o Consent items not needing Committee vote: These are codes where configuration changes have been decided internally for processing efficiency and they mirror the State’s billing requirements, and that change is not a negative change. Changes to billing requirements shown on the right. No consent agenda items were presented for this P&T meeting.																																										

N/A

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PA Criteria	Criteria Details
Covered Uses	FDA approved indications per product (not all biosimilars are approved for all conditions): 1) Diabetic macular edema (DME) 2) Diabetic retinopathy in patients with DME (DR w/ DME); or proliferative DR without DME (PDR, +/- DME) 3) Neovascular (wet) age-related macular degeneration (AMD) 4) Macular edema following retinal vein occlusion (RVO) 5) Retinopathy of prematurity (ROP)
Exclusion Criteria	Members with active ocular or periocular infection
Required Medical Information	<u>Diagnosis of AMD, macular edema following RVO, DME/DR+DME, or PDR:</u> 1) Clinic notes to confirm the diagnosis submitted 2) Baseline visual acuity score 3) If the eye is previously untreated with a vascular endothelial growth factor (VEGF) inhibitor, documentation of trial and failure to, or reason(s) why preferred VEGF inhibitor, bevacizumab, cannot be used (ophthalmic use of bevacizumab does not require a TAR) <u>Diagnosis of ROP:</u> 1) Must have a or b: a. Gestational age of $\leq$ 32 weeks b. Maximum birth weight of $\leq$ 1500 g (3.3 lb) 2) Must have diagnosis of a, b or c: a. ROP Zone I stage 1+, 2+, 3, & 3+ b. ROP Zone II Stage 2+, 3+ c. AP-ROP (aggressive posterior ROP) 3) Documentation of trial and failure to, or reason(s) why preferred VEGF inhibitor, bevacizumab, cannot be used (ophthalmic use of bevacizumab does not require a TAR)
Age Restriction	• DME, DR w/ DME, AMD, macular edema w/RVO: 18 years and older. • ROP: $\leq$ 52 weeks chronological age
Prescriber Restriction	Must be prescribed or recommended by an ophthalmologist
Coverage Duration	• AMD, DME, DR w/ DME, & RVO: Limited to a maximum of 13 injections per 12 months (per eye). • ROP: 1 dose per affected eye per request
Other Requirements & Information	<u>Renewal or retreatment requests:</u> <u>AMD, DME, DR w/ DME, PDR, & RVO:</u> Renewal will be based on documentation of benefit from therapy (may be indicated on the TAR unless clinic notes are specifically requested). Baseline and updated vision status maybe requested with evidence of: 1) Improvement or stabilization compared to baseline OR 2) Decrease in rate of vision loss compared to baseline

	<u>ROP:</u> 1) Current gestational age 2) Continues to be positive for diagnosis of a, b or c: a. ROP Zone I stage 1+, 2+, 3, & 3+ b. ROP Zone II Stage 2+, 3+ c. AP-ROP (aggressive posterior ROP) 3) Has had ≤ 2 prior treatments with aflibercept Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
Eylea™	J0178	Injection, aflibercept, 1 mg	AMD (all): 2mg every 4 weeks for 3 doses followed by 2 mg every 8 weeks (may be used monthly) DME & DR w/ DME, PDR (all): 2mg every 4 weeks for 5 doses followed by 2mg every 8 weeks (may be used monthly) RVO (all): 2mg every 4 weeks ROP (J0178 only): 0.4 mg into the affected eye, may repeat after a minimum interval of 10 days.
Opuviz™	Q5153	Injection, aflibercept-yszy (opuviz), biosimilar, 1 mg	
Pavblu™	Q5147	Injection, aflibercept-ayyh (pavblu), biosimilar, 1 mg	
Enzeevu™	Q5149	Injection, aflibercept-abzv (enzeevu), biosimilar, 1 mg	
Ahzantive™	Q5150	Injection, aflibercept-mrbb (ahzantive), biosimilar, 1 mg	
Yesafili™	Q5155	Injection, aflibercept-jbvf (yesafili), biosimilar, 1 mg	
Eydenzelt™	Q5170	Injection, aflibercept-boav (eydenzelt), biosimilar, 1 mg	

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	1) Diabetic macular edema (DME) 2) Diabetic retinopathy in patients with DME (DR w/ DME); or proliferative DR without DME (PDR, +/- DME) 3) Neovascular (wet) age-related macular degeneration (nAMD) 4) Macular Edema Following Retinal Vein Occlusion (RVO)
Exclusion Criteria	Members with active ocular or periocular infection
Required Medical Information	<u>Diagnosis of nAMD, DME, or RVO:</u> 1) Clinic notes to confirm the diagnosis submitted 2) Baseline visual acuity score 3) Trial and failure to both of the following. a. Afibercept 2mg (Eylea™) or aflibercept biosimilar, AND b. faricimab (Vabysmo™) 4) For members with stable/controlled disease on Eylea 2mg, documentation of medical need for an extended frequency product is required <u>Diagnosis of PDR:</u> 1) Clinic notes to confirm the diagnosis submitted 2) Baseline visual acuity score 3) Trial and failure to both of the following. a. Afibercept 2mg (Eylea™) or aflibercept biosimilar, AND a. One additional preferred agent such as ranibizumab-nuna (Byooviz™), ranibizumab (Lucentis™), ranibizumab-eqrn (Cimerli™), or off-label bevacizumab (Avastin™) or faricimab (Vabysmo™) 4) For members with stable/controlled disease on Eylea 2mg, documentation of medical need for an extended frequency product is required
Age Restriction	18 years and older
Prescriber Restriction	Must be prescribed or recommended by an ophthalmologist
Coverage Duration	Limit to maximum of 13 injections per eye over 12 months months
Other Requirements	<u>Renewal or retreatment requests:</u> Renewal will be based on documentation of benefit from therapy (may be indicated on the TAR unless clinic notes are specifically requested). Baseline and updated vision status maybe requested with evidence of: 1) Improvement or stabilization compared to baseline OR 2) Decrease in rate of vision loss compared to baseline Requests for off-label use: See PHC criteria document, <i>Case-by-Case TAR Requirements and Considerations</i>.

Medical Billing:

Dose limits & billing requirements (approved TAR is required):

HCPCS	Description	Dosing, Units
J0177	Intravitreal injection, aflibercept hd, 1mg	AMD and DME: 8mg every 4 weeks (+/- 7 days) for 3 doses followed by 8 mg every 8-20 weeks (+/- 1 week). Dose may be extended to every 20 weeks dosing schedule after completing 1 year of successful treatment. DR: 8mg every 4 weeks (+/- 7 days) for 3 doses followed by 8 mg every 8-12 weeks (+/- 1 week) RVO: 8mg every 4 weeks (+/- 7 days) for 3-5 doses followed by 8 mg every 8 weeks (+/- 1 week) Note: Some patients did not maintain a response with extended dosing intervals after success with the 3 to 5 initial monthly doses; these patients may benefit from resuming every-4-week (approximately every 21 to 35 days) dosing.

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PA Criteria	Criteria Details
Covered Uses	1) Moderately to severely active ulcerative colitis (UC) 2) Moderately to severely active Crohn’s disease (CD) Note: please see Requirements for Subcutaneous Guselkumab (Tremfya) for criteria for plaque psoriasis, psoriatic arthritis, and maintenance dosing for UC and CD.
Exclusion Criteria	• Active, serious infection, latent (untreated) tuberculosis • Combination with another monoclonal antibody/biologic therapy
Required Medical Information	1) Specialist’s clinic notes documenting disease course with evidence of active disease &/or inflammation as appropriate by diagnosis (imaging, labs, or other findings as indicated). 2) Treatment plan. 3) Disease Activity Score. 4) Awareness of immune-suppression risks specific to latent TB infection, and order exists for TST (Tuberculin Skin Test/PPD) or Interferon Gamma Release Assay (eg, Quanti FERON-TB Gold test). 5) Documentation of trial and failure to both of the following (a AND b) a. TNF inhibitor (TNFi): adalimumab, infliximab (Inflectra™-preferred PA group 1) (Avsola™, Renflexis™-PA group 2), certolizumab (CD indication only) or subcutaneous golimumab (UC indication only) b. Ustekinumab. 6) Reasons why Subcutaneous Guselkumab (Tremfya) cannot be used for induction dosing.
Age Restriction	18 years and older
Prescriber Restriction	Prescribed or in consultation with a gastroenterologist
Coverage Duration	Initial (induction dosing): 3 doses (8 weeks)
Other Requirements & Information	Following IV induction this medication is typically self-administered by the member or a caregiver at home. See the additional TAR requirements in the document titled <i>Standard Requirements for Self-Administered Drugs</i>. Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J1628	Injection, Guselkumab, 1 mg (intravenous product only)	Intravenous: - CD Induction: 200 mg at week 0, 4, and 8 OR 400mg at week 0, 4, and 8, transitioning to subcutaneous at week 12 or 16. - UC Induction: 200 mg at week 0, 4, and 8, transitioning to subcutaneous at week 12 or 16.

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PA Criteria	Criteria Details
Covered Uses	1) Moderate to severe plaque psoriasis (PSO) 2) Active psoriatic arthritis (PsA) 3) Moderately to severely active ulcerative colitis (UC) 4) Moderately to severely active Crohn’s disease (CD) Note: please see Requirements for Intravenous Guselkumab (Tremfya) for criteria for IV induction dosing for Crohn’s Disease and Ulcerative Colitis.
Exclusion Criteria	• Active, serious infection, latent (untreated) tuberculosis • Combination with another monoclonal antibody/biologic therapy
Required Medical Information	For all indications: 1) Specialist’s clinic notes documenting disease course with evidence of active disease &/or inflammation as appropriate by diagnosis (imaging, labs, or other findings as indicated). 2) Treatment plan. 3) Disease Activity Score. 4) Awareness of immune-suppression risks specific to latent TB infection, and order exists for TST (Tuberculin Skin Test/PPD) or Interferon Gamma Release Assay (eg, Quanti FERON-TB Gold test). 5) Reason(s) why the member is unable to obtain from a pharmacy for self-administration. 6) Current weight is ≥40kg Active PSO: 1) Documented therapeutic failure after a minimum 3-month trial of (or contraindication to) a TNFi: adalimumab (Humira), etanercept (Enbrel), or certolizumab (Cimzia). Note that at least one of (a, b, or c) is required for TNFi approval: a. Documentation of ≥ 10% BSA affected OR b. Documentation of <10% BSA affecting sensitive areas (palms of hands, soles of feet, head/neck, genitalia), OR c. Therapeutic failure after a 3-month trial of 2 or more non-biologic therapies (unless contraindicated): i. Methotrexate ii. Cyclosporine iii. Acitretin (TAR required) iv. Phototherapy in conjunction with methoxsalen (TAR required) Active PsA: 1) Rheumatology clinic notes to confirm diagnosis of PsA AND 2) Severe psoriatic arthritis with erosive disease and functional limitation or 3) Moderate to severe axial involvement or 4) Documented therapeutic failure after a minimum of a 3-month trial of (or contraindication to) at least one each from a (DMARD) and b (TNFi): a. Methotrexate, or other oral DMARD if member is unable to take methotrexate, AND b. TNFi: Adalimumab (Humira), etanercept (Enbrel), subcutaneous

	golimumab (Simponi), or certolizumab (Cimzia). Moderately to severely active UC or CD (induction or maintenance dosing) 1) Documentation of trial and failure to both of the following (a AND b) a. TNF inhibitor (TNFi): adalimumab, infliximab (Inflectra™-preferred PA group 1) (Avsola™, Renflexis™-PA group 2), certolizumab (CD indication only) or subcutaneous golimumab (UC indication only) b. Ustekinumab.
Age Restriction	PSO & PSA: 6 years and older UC & CD: 18 years and older
Prescriber Restriction	PSO: Dermatologist PsA: Rheumatologist (prescribed or recommend by); a dermatologist may continue treatment that was initiated based on a rheumatologist's recommendation. UC & CD: Gastroenterologist
Coverage Duration	Case-dependent (medical office single dose requested vs outpatient hospital with multiple doses requested). Limited to the number of doses needed until the member is able to resume self-administration at home.
Other Requirements & Information	This medication is typically self-administered by the member or a caregiver at home. See the additional TAR requirements in the document titled <i>Standard Requirements for Self-Administered Drugs</i>. Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J1628	Injection, Guselkumab, 1 mg (subcutaneous product only)	Subcutaneous • PSO & PsA, 100 mg at week 0, 4 and then every 8 weeks. • CD & UC Induction: 400mg on weeks 0, 4, and 8. • CD & UC Maintenance:100 mg at week 16 and every 8 weeks thereafter OR 200mg at week 12 and every 4 weeks thereafter.

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PA Criteria	Criteria Details
Covered Uses	The treatment of wounds in patients 6 months of age and older with dystrophic epidermolysis bullosa with mutation(s) in the <i>collagen type VII alpha 1 chain (COL7A1) gene</i>
Exclusion Criteria	Use outside FDA approved indication
Required Medical Information	1) Diagnosis of DEB with genetic testing confirming mutations(s) in the COLA7A1 gene 2) Presence of open DEB skin wounds 3) Medical reasons why the member or a caregiver is unable to self-administer at home Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist’s evaluation of the case prior to both denials and approvals (ie denials for medical necessity)
Age Restriction	None
Prescriber Restriction	Dermatologist
Coverage Duration	Case-dependent (medical office single dose requested vs outpatient hospital with multiple doses requested). Limited to the number of doses needed until the member is able to resume self-administration at home.
Other Requirements & Information	Renewal requests: clinic notes documenting benefit from treatment This medication is typically self-administered by the member or a caregiver at home. See the additional TAR requirements in the document titled <i>Standard Requirements for Self-Administered Drugs</i>.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3401	Beremagene geperpavec-svdt for topical administration, containing nominal 5 x 10 ⁹ pfu/ml vector genomes, per 0.1 ml	Maximum weekly volume: 6mo to <3 years: 0.8ml ≥3 years: 1.6ml

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PA Criteria	Criteria Details
Covered Uses	Geographic atrophy (GA) secondary to age-related macular degeneration (AMD)
Exclusion Criteria	- Choroidal neovascularization (CNV) in either eye - GA is secondary to any conditions other than AMD (for example, Stargardt disease, cone rod dystrophy, toxic maculopathies) - Ocular or periocular infection - Active intraocular inflammation - GA lesions are exclusively subfoveal (also called foveal)
Required Medical Information	- Diagnosis of GA secondary to AMD - Best corrected visual acuity (BCVA) $\geq$ 24 ETDRS letters (20/320 Snellen equivalent or better) - GA lesion size $\geq$2.5 and $\leq$17.5 mm² with at least 1 lesion $\geq$1.25 mm² - Presence of non-subfoveal lesions (also called extrafoveal lesions, or lesions that are not affecting the foveal center point)
Age Restriction	60 years and older
Prescriber Restriction	Ophthalmologist
Coverage Duration	Initial and renewal: 12 months
Other Requirements & Information	Renewal criteria: documentation of a positive clinical response to therapy which may include a reduction or stabilization in the rate of vision decline, or stabilization or reduction in total area of GA lesions. Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.

Medical Billing:
Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J2781	Injection, pegcetacoplan, intravitreal, 1 mg	15 mg (0.1 mL) into affected eye(s) once every 25 to 60 days

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Geographic atrophy (GA) secondary to age-related macular degeneration (AMD)
Exclusion Criteria	- Choroidal neovascularization (CNV) in either eye - GA is secondary to any conditions other than AMD (for example, Stargardt disease, cone rod dystrophy, toxic maculopathies) - Ocular or periocular infection - Active intraocular inflammation - GA lesions are exclusively subfoveal (also called foveal)
Required Medical Information	- Diagnosis of GA, secondary to AMD - Best corrected visual acuity (BCVA) between 20/25 and 20/320 - GA lesion size ≥ 2.5 and ≤ 17.5 mm² with at least 1 lesion ≥ 1.25 mm² - Presence of non-subfoveal lesions (also called extrafoveal lesions, or lesions that are not affecting the foveal center point)
Age Restriction	50 years or older
Prescriber Restriction	Ophthalmologist
Coverage Duration	Initial and renewal: 12 months
Other Requirements & Information	Renewal criteria: documentation of a positive clinical response to therapy which may include a reduction or stabilization in the rate of vision decline, or stabilization or reduction in total area of GA lesions. Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J2782	Injection, avacincaptad pegol, 0.1 mg	2 mg (0.1 mL) into affected eye(s) once monthly (~every 21 to 35 days)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Treatment of elevated intraocular pressure (IOP) in patients with open-angle glaucoma (OAG) or ocular hypertension (OHT)
Exclusion Criteria	• Ocular or periocular infections • Corneal endothelial dystrophy • Prior corneal transplantation • Concurrent use (within the prior 6 months) of Durysta in the same eye
Required Medical Information	1) Baseline IOP 2) Trial and failure to a topical prostaglandin in combination with at least one other topical agent from the following classes OR medical reasons why topical therapy cannot be used. Failure as evidenced by uncontrolled IOP despite adequate trial. a. Beta-blockers b. Alpha-2 agonists c. Carbonic anhydrase inhibitor d. Prostaglandin analog e. Cholinergic agents f. Rho kinase inhibitors 3) Trial and failure or reasons why selective laser trabeculoplasty (SLT) cannot be used
Age Restriction	18 years or older
Prescriber Restriction	Must be prescribed by an ophthalmologist
Coverage Duration	12 months: One implant per eye per year
Other Requirements & Information	Renewal requests will require clinic notes documenting all of the following (1-5) 1) IOP was controlled following initial administration of iDose TR 2) Medical necessity of re-administration at the time of TAR submission, such as, documented loss of IOP control 3) Current/Prior iDose TR implant has not dislocated from implantation site 4) There is no ocular or periocular infection 5) The member has not experienced central corneal endothelial cell loss of 10% or greater from pre-administration baseline (adjusted for age-related 1% loss per year and for a 10% loss following an anterior segment surgical procedure [e.g., cataract surgery]) Requests for off-label use: See PHC criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J7355	Injection, travoprost, intracameral implant , 1 microgram (iDOSE TR™)	75mcg (1 implant) one time per eye

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	- Neuropathic pain associated with postherpetic neuralgia (PHN) - Neuropathic pain associated with diabetic peripheral neuropathy (DPN) of the feet
Exclusion Criteria	None
Required Medical Information	<u>Requirements for PHN</u> - Clinic notes documenting focal neuropathic or neuralgic pain persisting for ≥ 3 months in the same dermatomal distribution as a preceding episode of acute herpes zoster - Trial and failure of a ≥ 30-day trial while at an effective target dose of at least TWO of the following oral options (a, b, c, or d): - Amitriptyline or Nortriptyline at a dose of ≥ 50mg/day - Gabapentin ≥ 900mg/day or Pregabalin ≥ 300mg/day - Duloxetine ≥ 60mg/day or Venlafaxine ≥ 150mg/day - Oxcarbazepine ≥ 900mg/day or Carbamazepine ≥ 600mg/day <i>Note: if the target dose cannot be reached due to tolerability, a ≥ 30-day trial of the maximum tolerated dose is accepted</i> <u>Requirements for DPN</u> - Clinic notes documenting a diagnosis of pain associated with diabetic peripheral neuropathy of the feet - For patients on metformin, vitamin B12 deficiency has been ruled out - Trial and failure of a ≥ 30-day trial while at an effective target dose of at least ONE of the following oral options (a, b, or c): - Amitriptyline ≥ 100mg/day or other tricyclic antidepressant at comparable dose - Gabapentin ≥ 900mg/day or Pregabalin ≥ 300mg/day - Duloxetine ≥ 60mg/day or Venlafaxine ≥ 150mg/day <i>Note: if the target dose cannot be reached due to tolerability, a ≥ 30-day trial of the maximum tolerated dose is accepted</i>
Age Restriction	18 years and older
Prescriber Restriction	None
Coverage Duration	12 months
Other Requirements & Information	<u>First Renewal Requirements:</u> Updated clinic notes documenting member has experienced an improvement in their neuropathic pain and is tolerating Qutenza Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i>

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J7336	Capsaicin 8% patch, per square centimeter	The recommended dose of QUTENZA for neuropathic pain associated with postherpetic neuralgia is a single, 60-minute application of up to four topical systems The recommended dose of QUTENZA for neuropathic pain associated with diabetic peripheral neuropathy is a single, 30-minute application on the feet of up to four topical systems Treatment with QUTENZA may be repeated every three months or as warranted by the return of pain (not more frequently than every three months) One patch is 280cm² (280 HCPCS units), maximum dosing allows up to 4 patches (1120 HCPCS units) every 3 months for an annual maximum of 4480 HCPCS units

cUnless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer.

PA Criteria	Criteria Details
Covered Uses	Acromegaly, carcinoid syndrome, and Gastroenteropancreatic neuroendocrine tumors (GEP-NETs)
Exclusion Criteria	None
Required Medical Information	1) Acromegaly, carcinoid syndrome: Requires clinical notes confirming diagnosis. 2) Gastroenteropancreatic neuroendocrine tumors (GEP-NETs): Clinical notes and imaging (MRI or multiphase CT AND somatostatin receptor-based imaging) confirming diagnosis of loco regional advanced and/or metastatic neuroendocrine tumor(s) of the GI tract, lung, or thymus.
Age Restriction	18 years and older
Prescriber Restriction	Oncologist, gastroenterologist or endocrinologist
Coverage Duration	Up to 12 months
Other Requirements & Information	Records from member’s prescriber must show prior use and failure (or contraindication) of both octreotide acetate (immediate-release) AND octreotide LAR Depot. Requests for off-label use: See PHC criteria document <i>Case-by-Case TAR Requirements and Considerations</i> .

Medical Billing:

Dose limits & billing requirements (approved TAR is required)

Product	HCPCS	Description	Dosing, Units
Somatuline™ Depot Injection 60 mg/0.2 ml 90 mg/0.3 ml 120 mg/0.5 ml	J1930	Injection, lanreotide, 1 mg	1 billing unit = 1 mg <u>Acromegaly:</u> Recommended starting dose is 90 mg by deep subcutaneous injection every 4 weeks for 3 months, adjusted thereafter based on GH and/or IGF-1 levels: • GH >1 to ≤ 2.5 ng/mL, IGF-1 normal and clinical symptoms controlled: maintain Somatuline Depot dose at 90 mg every 4 weeks • GH > 2.5 ng/mL, IGF-1 elevated and/or clinical symptoms uncontrolled, increase Somatuline Depot dose to 120 mg every 4 weeks • GH ≤ 1 ng/mL, IGF-1 normal and clinical symptoms controlled: reduce Somatuline Depot dose to 60 mg every 4 weeks <u>Carcinoid Syndrome and GEP-NETs:</u> • 120 mg every 4 weeks
Lanreotide Acetate (depot) 120 mg/0.5 ml	J1932	Injection, lanreotide, (Cipla), 1 mg	

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details	
Covered Uses	Aldurazyme™	Mucopolysaccharidosis I (MPS I) types: (1) Hurler, (2) Hurler-Scheie, and (3) Moderate to severe Scheie form.
	Brineura™	CLN2 Tripeptidyl Peptidase 1 (TPP1) Deficiency (aka Late Infantile Neuronal ceroid lipofuscinosis)
	Cerezyme™, Vpriv™	Gaucher Disease Type 1 (Cerezyme may be used off-label for Type 3)
	Eleprase™	Hunter syndrome (mucopolysaccharidosis II, MPS II
	Fabrazyme™	Fabry Disease
	Lumizyme,™ Nexviazyme™	Pompe Disease
	Mepsevii™	Mucopolysaccharidosis VII (MPS VII, Sly Syndrome)
	Naglazyme™	Mucopolysaccharidosis VI (Maroteaux-Lamy syndrome)
	Vimizim™	Mucopolysaccharidosis IV (Morquio Syndrome)
	Xenpozyme™	Acid sphingomyelinase deficiency (Niemann-Pick disease)
Exclusion Criteria	None	
Required Medical Information	For all products – Clinic notes which include: • Documentation of the FDA approved indication • Subjective findings (complaints) • Objective finding (Enzyme levels, DNA mutation analysis, medical history, physical exam, member weight) • Complications (eg, bony changes or kidney failure) • Quality of life issues (eg, severe, unremitting pain or extreme fatigue) • Treatment plan: Identify the licensed practitioner who will administer the infusion and coordinate care, genetic evaluation & counseling information for the patient and family members. • Goals: Include specific information about the desired outcome, for example: slow progression, allow regular attendance at work or school, or to significantly improve quality of life. • Requests for Nexviazyme™ for members <30 kg require medical justification for inability to use PHC’s preferred enzyme replacement therapy (ERT) for Pompe disease, Lumizyme™, which has the same mechanism of action as Nexviazyme™. Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist’s evaluation of the case prior to both denials and approvals.	
Age Restriction	Vpriv™: ≥ 4 yrs Brineura™: 3-18 yrs Nexviazyme™: ≥ 1 yr Fabrazyme™: ≥ 2 yrs Elaprase™: ≥ 5 yrs; 16 months to <5 years-limited data available	
Prescriber Restriction	Neurologist, endocrinologist, cardiologist, hepatologist, pulmonologist, genetic disease or other specialist familiar with treating lysosomal storage disorders.	
Coverage Duration	Initial & Renewal: 6 months	

Other Requirements & Information	Renewal TARs must include follow-up information such as any significant changes in physical findings, laboratory parameters, symptoms and/or quality of life. Requests for off-label use: See PHC criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Dose greater than that recommended by the manufacture will require documentation of the medical necessity of the requested dose. Maximum recommended doses:

HCPCS	Description	Dosing, Package size
J0180	Injection, agalsidase beta, 1 mg (Fabrazyme™)	1 mg/kg every 2 weeks, 5 mg & 35 mg SDV
J0221	Injection, alglucosidase alfa, 10 mg (Lumizyme™)	20 mg/kg every 2 weeks, 50 mg SDV
J0219	Injection, avalglucosidase alfa-ngpt, 4 mg (Nexviazyme™)	ABW < 30 KG: 40 mg/kg q 2 weeks; ABV ≥30 kg: 20 mg/kg q 2 weeks, 100 mg SDV
J0567	Injection, cerliponase alfa, 1 mg (Brineura™)	300 mg every other week (via aseptic intraventricular infusion into CSF), 150 mg/5mL kit (2 vials)
J1322	Injection, elosulfase alfa, 1 mg (Vimizim™)	2 mg/kg once weekly, 1 mg/mL, 5 mL SDV
J1458	Injection, galsulfase, 1 mg (Naglazyme™)	1 mg/kg once weekly, 5 mg/5 mL SDV
J1743	Injection, idursulfase, 1 mg (Eleprase™)	0.5 mg/kg once weekly, 2 mg/ml, 3ml SDV
J1786	Injection, imiglucerase, 10 units (Cerezyme™)	Individualized based on response. Some pts need more frequent dosing (up to TIW) while others can be dosed every other week. Doses range from 2.5 u/kg TIW to 60 u/kg QOW. State Medical maximum daily dose is 818 billed units (8,180 dose units), without documentation that weight is over 300 lbs, 400 unit SDV
J1931	Injection, laronidase, 0.1 mg (Aldurazyme™)	0.58 mg/kg once weekly, 2.9 mg/5 ml SDV
J0218	Injection, olipudase alfa-rpcp, 1 mg (Xenpozyme™)	Dose is titrated over the course of 14 weeks for adults and 16 weeks in pediatric patients up to a recommended maintenance dose of 3 mg/kg given q 2 weeks, 4 mg or 20 mg SDV.
J3385	Velaglucerase Alfa inj, 100 units (Vpriv™)	60 units/kg every other week, 400 unit SDV
J3397	Injection, vestronidase alfa-vjbk, 1 mg (Mepsevii™)	4 mg/kg every 2 weeks, 2 mg/ml 5 ml vials

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PA Criteria	Criteria Details
Covered Uses	For the treatment of hyperargininemia in adult pediatric patients ≥2 years of age with arginase 1 deficiency (ARG1-D), in conjunction with dietary protein restriction
Exclusion Criteria	• Symptomatic hyperammonemia (ammonia ≥100 μM requiring acute care or hospitalization) within 6 weeks before first Loargys dose • Extreme mobility impairment (i.e. unable to complete assessment) • Prior liver or hematopoietic transplant
Required Medical Information	1. Documented diagnosis of ARG1-D: biochemical evidence of the disease with one of the following: a. Plasma amino acid panel showing persistently elevated plasma arginine (pArg) levels (mean of all screening values with pArg ≥250 μmol/L) b. Molecular genetic test identifying biallelic pathogenic variants in ARG1, OR c. RBC arginase activity assay showing diminished erythrocyte ARG1 activity 2. Impairment on any secondary functional mobility assessment 3. Documentation that patient will use the drug in conjunction with a protein-restricted diet 4. Documentation of recent weight to confirm dose requested 5. Dose requested is to start at 0.1 mg/kg once weekly (dose adjustments not to exceed 0.2 mg/kg once weekly) Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist’s evaluation of the case prior to both denials and approvals.
Age Restriction	2 years of age and older
Prescriber Restriction	Metabolic (genetic) specialist or neurologist experienced in urea cycle disorders (UCDs)
Coverage Duration	• Initial approval of 6 months in order to verify response to treatment (reduction in pArg) • Continued approval can be granted in 12-month cycles with documented response (pARG levels below the upper limit of normal)
Other Requirements & Information	Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i> . .

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
Loargys	J3590 (NOC)	Unclassified biologics: pegzilarginase-nbln	0.1-0.2 mg/kg injected intravenously once weekly. After 8 weeks on once-weekly IV dosing, can switch to once-weeklySUBQ under healthcare professional supervision.

Requirements for Teplizumab-mzwv (TzielTM)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	- Delay onset of Stage 3 type 1 diabetes (T1D) in adults and pediatric patients 1 year an older with Stage 2 T1D - Delay decline in insulin production in pediatric patients (ages 8-17) who have been diagnosed with stage 3 T1D within the last 16 weeks
Exclusion Criteria	Stage 3 T1D: Diagnosis of stage 3 T1D longer than 16 weeks ago.
Required Medical Information	Diagnosis of Stage 2 type 1 diabetes confirmed by all of the following: - Documentation of at least 2 of the following type 1 diabetes-related autoantibodies within the last 6 months. Any positive test should have repeat confirmatory testing completed: - Islet cell autoantibody (ICA) - Glutamic acid decarboxylase 65 (GAD) autoantibody - Zinc transporter 8 autoantibody (ZnT8A) - Insulinoma-associated antigen 2 autoantibody (IA-2A) - Insulin autoantibody (IAA) - Documentation of dysglycemia without overt hyperglycemia within the preceding 2 months defined as one of the following: - Fasting plasma glucose level 100-125 mg/dL; OR - Two-hour postprandial plasma glucose 140-199 mg/dL; OR - Postprandial glucose level at 30, 60 or 90 minutes $\geq$ 200 mg/ dL; OR - A1C 5.7-6.4% - Documentation type 2 diabetes has been ruled out based on clinical history. - Body surface area (BSA) needed for dosing. - Administering facility must be able to accommodate 14 consecutive calendar days of administration. Diagnosis of Stage 3 type 1 diabetes confirmed by all of the following: - Documentation of at least 1 of the following type 1 diabetes-related autoantibodies within the last 6 months. Any positive test should have repeat confirmatory testing completed: - Islet cell autoantibody (ICA) - Glutamic acid decarboxylase 65 (GAD) autoantibody - Zinc transporter 8 autoantibody (ZnT8A) - Insulinoma-associated antigen 2 autoantibody (IA-2A) - Insulin autoantibody (IAA) - Residual β-cell function, defined as a peak stimulated C-peptide level $\geq$0.2 pmol/mL on a mixed-meal stimulation test - Stage 3 type 1 diabetes diagnosed within the last 16 weeks - Documentation type 2 diabetes has been ruled out based on clinical history. - Body surface area (BSA) needed for dosing. Administering facility must be able to accommodate 12 consecutive calendar days of administration every 6 months for 2 courses.
Age Restriction	Stage 2 T1D: 1 year and older Stage 3 T1D: ages 8-17 years
Prescriber	Board certified endocrinologist is preferred, requests from other prescribers will

Requirements for Teplizumab-mzwv

(Tzield™)

Restriction	be evaluated on a case-by-case basis. <i>Prescribers other than board certified endocrinologists should indicate any formal training in diabetes management they have completed on the request and must attest that they will follow all laboratory and infection evaluation and vaccination requirements as specified in the FDA approved label prior to initiating Tzield and during treatment.</i>
Coverage Duration	Stage 2 T1D: 14-day treatment course only, once per lifetime. Stage 3 T1D: Two 12-day treatment courses once every 6 months only, once per lifetime.
Other Requirements	Note, prior to initiating therapy, provider must have awareness of the following: 1) Completion of age-appropriate vaccinations. 2) No evidence of active serious infections (i.e. Epstein-Barr virus or cytomegalovirus infection). 3) Adequate hepatic function at baseline (i.e. ALT/AST, bilirubin) 4) Adequate hematologic function at baseline (i.e. platelets, hemoglobin, absolute neutrophil count, lymphocytes). 5) Member is not pregnant. Note that each 2 ml single dose vial (SDV) contains 2,000 mcg (2 mg), equivalent to 400 HCPCS billing units per vial. Vials are diluted to 100 mcg/ml and must be administered within 4 hours of being diluted, with remainder discarded (see Partnership Drug Waste policy for billing waste with JW modifier. TARs must include both the dose and anticipated waste amounts. Waste units must be billed separately from the administered dose units, using the JW modifier as stated in Policy MPRP4062, Drug Wastage Payments. The number of units on the authorized TAR will be sufficient for both dose and waste claims. 1 vial per day is sufficient for all doses up to a BSA of 1.94 m². Requests for more than 1 vial (400 billing units) per day must include the member’s current BSA.

Requirements for Teplizumab-mzwv (Tzield™)

Medical Billing:

Dose limits & billing requirements (approved TAR is required):

HCPCS	Description	Dosing, Units
J9381	Injection, teplizumab-mzwv, 5 mcg	A single vial (2 ml=2,000 mcg) is 400 HCPCS units (5 mcg/unit). For BSA ≤ 1.94 m², maximum reimbursement is for 1 vial, 400 units (includes dose + waste). Stage 2 T1D: Administer once daily for 14 consecutive days. <u>Day 1</u>: 65 mcg/m² body surface area (BSA) IV once daily <u>Day 2</u>: 125 mcg/m² BSA <u>Day 3</u>: 250 mcg/m² BSA <u>Day 4</u>: 500 mcg/m² BSA <u>Day 5 to day 14</u>: 1,030 mcg/m² BSA once daily If a planned infusion dose is missed, resume dosing by administering all remaining doses on consecutive days to complete the 14-day treatment course. Stage 3 T1D: Administer once daily for 12 consecutive days once every 6 months for 2 courses. <u>Day 1</u>: 106 mcg/m² body surface area (BSA) <u>Day 2</u>: 425 mcg/m² BSA <u>Day 3-12</u>: 850 mcg/m² BSA

cUnless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Ankylosing spondylitis (AS), Crohn’s disease (CD), Plaque psoriasis (PP), Psoriatic arthritis (PsA), Rheumatoid arthritis (RA), and Ulcerative colitis (UC). In addition, infliximab biosimilars are coverable with an approved TAR for the off-label indication of non-radiographic axial spondyloarthritis (nr-axSpA). Please note-use of biosimilars are preferred: Avsola, Inflectra, and Renfлексis Non-preferred brand: Remicade.
Exclusion Criteria	Doses greater than 5 mg/kg in patients with moderate or severe heart failure (NYHA Class III/IV).
Required Medical Information	All indications: • Specialist’s clinic notes documenting disease course (activity, progression, severity), with evidence of active disease &/or inflammation as appropriate by diagnosis (imaging, labs, or other findings as indicated) • Previous therapies tried and failed • Current evaluation (lab and imaging reports as appropriate for indication) • Treatment plan • Awareness of immune-suppression risks specific to latent TB infection, and order exists for TST (Tuberculin Skin Test/PPD) or Interferon Gamma Release Assay (eg, Quanti FERON-TB Gold test) • Member’s weight (dosing is weight-based, thus needed to confirm dose & billing units as part of TAR review process). • Documentation of trial and failure of at least 1 subcutaneously injected TNF inhibitor; which product would depend on the indication and recommendations from professional treatment guidelines &/or FDA approved indications. Other TNF inhibitors include: subcutaneously injected adalimumab, etanercept, golimumab, and certolizumab pegol. • Documentation of trail and failure with preferred biosimilars to infliximab: Inflectra, Avsola or Renfлексis . • CD/UC only: Please note, infliximab is now available in a subcutaneous formulation (Zymfentra) and consideration for transitioning to this SUBQ formulation is recommended for convenience of self-administration and lower level of care. Zymfentra is FDA-approved for treating CD and UC. • If requesting use of brand Remicade, please submit additional information regarding reason(s) why preferred biosimilars cannot be used. In addition, nr-axSpA, AS, CD, PsA, RA, and UC require a Disease Activity Score with TAR submission
Age Restriction	For UC/CD: 6 years and older. For all other indications: 18 years or older
Prescriber Restriction	1) AS, RA, nr-axSpA: Rheumatologist 2) PsA: Dermatologist or Rheumatologist 3) HS, PP: Dermatologist 4) CD, UC: Gastroenterologist
Coverage Duration	Initial: up to 6 months (3 months for PP). Renewal: 12 months, with documentation of efficacy

Other Requirements & Information	For PP: Diagnosis of chronic plaque psoriasis (at least 1 year) in adults who are candidates for systemic therapy or phototherapy, and when other systemic therapies are less appropriate. Items (1), (2) and (3) must be met: (1) Patient has documented severe disease greater than 10% BSA affected OR b) less than10% BSA affected with involvement of sensitive areas that significantly impact quality of life (palms of hands, soles of feet, head/neck, genitalia), OR (c) overlapping confirmed diagnosis of psoriatic arthritis AND (2) Patient has documented therapeutic failure of three months’ trial, or inability to use, at least two non-biologic therapies: Methotrexate, Cyclosporin, Acitretin (Soriatane), Phototherapy w/ Methoxsalen (Oxsoralen); (3) Member has a documented history of an adequate (3 month) trial and failure/inadequate response (or contraindication) to both adalimumab AND etanercept. Renewal: submit clinical documentation that supports a decrease or stabilization in percent of body surface area involvement when compared to baseline. Requests for off-label use: See PHC criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.

Medical Billing: Dose limits & billing requirements, with an approved TAR:		
HCPCS	Description	Dosing, Units
J1745	Infliximab inj., excludes biosimilar, (Remicade), 10 mg	<u>CD, UC, PsA, PA, RA:</u> Initiate at Weeks 0, 2 & 6; followed by every 8 weeks.
Q5121	Injection, infliximab-axxq, biosimilar, (avsola), 10 mg	
Q5103	Injection, infliximab-dyyb, biosimilar, (inflectra), 10 mg	<u>AS, nr-axSpA:</u> Same induction regimen as above, but maintenance is every 6 weeks (6-8 weeks per UpToDate). <u>AS, nr-axSpA, PsA, PP, UC:</u> 5 mg/kg <u>CD:</u> 5 mg/kg per dose (adults can be increased to 10 mg/kg)
Q5104	Injection, infliximab-abda, biosimilar, (renflexis), 10 mg	<u>RA:</u> Induction & maintenance is 3 mg/kg, but can be adjusted up to 10 mg/kg

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PA Criteria	Criteria Details
Covered Uses	IV induction dosage (single dose) for the treatment of moderately to severely active Crohn’s disease (CD) or ulcerative colitis (UC). Please note the following are preferred brands: Stelara, Steqeyma, Wezlana, and Pyzchiva. Non-preferred brands: Imuldosa, Yesintek, Selarsdi, Otulfi, and Starjemza.
Exclusion Criteria	• Active, serious infection, latent (untreated) tuberculosis • Combination with another monoclonal antibody/biologic therapy
Required Medical Information	1) Specialist’s clinic notes documenting disease course with evidence of active disease &/or inflammation as appropriate by diagnosis (imaging, labs, or other findings as indicated). 2) Treatment plan (Note: the single induction dose is recommended to be followed by 90 mg subcutaneous dose 8 weeks after induction dose, and every 8 weeks thereafter). 3) Disease Activity Score or patient specific symptoms/treatment history to confirm moderately to severely active disease. 4) Awareness of immune-suppression risks specific to latent TB infection, and order exists for TST (Tuberculin Skin Test/PPD) or Interferon Gamma Release Assay (eg, Quanti FERON-TB Gold test). 5) If requesting use of Imuldosa, Yesintek, Selarsdi, Otulfi, or Starjemza, please submit additional information regarding reason(s) why preferred options cannot be used.
Age Restriction	Crohn’s Disease: ≥2 years Ulcerative Colitis: ≥18 years
Prescriber Restriction	Prescribed or in consultation with a gastroenterologist
Coverage Duration	Single fill/date of service. FDA indicated dosing is for a single IV dose for induction, followed by subcutaneous dosing thereafter.
Other Requirements & Information	Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i> .

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units								
J3358	Ustekinumab, for IV injections, 1 mg (only indicated for Crohn’s or UC induction)	<table><tr><th>Member Weight</th><th>Recommended Dose</th></tr><tr><td>≤55 kg</td><td>260 mg IV x 1</td></tr><tr><td>54-85 kg</td><td>390 mg IV x 1</td></tr><tr><td>≥86 kg</td><td>520 mg IV x 1</td></tr></table> <i>With transition to subcutaneous dosing after the initial IV induction dose</i>	Member Weight	Recommended Dose	≤55 kg	260 mg IV x 1	54-85 kg	390 mg IV x 1	≥86 kg	520 mg IV x 1
Member Weight	Recommended Dose									
≤55 kg	260 mg IV x 1									
54-85 kg	390 mg IV x 1									
≥86 kg	520 mg IV x 1									
Q5138	Injection, ustekinumab-auub (Wezlana), biosimilar, intravenous, 1 mg (only indicated for Crohn’s or UC induction)									
Q9997	Injection, ustekinumab-ttwe (Pyzchiva), intravenous, 1 mg (only indicated for Crohn’s or UC induction)									
Q9998	Injection, ustekinumab-aekn (Selarsdi), 1 mg (only indicated for Crohn’s or UC induction)									
Q9999	Injection, ustekinumab-aauz (otulfi), biosimilar, 1 mg									
Q5100	Injection, ustekinumab-kfce (yesintek), biosimilar, 1 mg									
Q5098	Injection, ustekinumab-srlf (imuldosa), biosimilar, 1 mg									
Q5099	Injection, ustekinumab-stba (steqeyma), biosimilar, 1 mg									
Q5164	Injection, ustekinumab-hmny (starjemza), biosimilar, 1 mg									

cUnless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	1) Crohn’s disease (CD) 2) Ulcerative colitis (UC)
Exclusion Criteria	- Active, serious infection, latent (untreated) tuberculosis - Combination with another monoclonal antibody/biologic therapy.
Required Medical Information	For all indications: - Specialist’s clinic notes documenting disease course with evidence of active disease &/or inflammation as appropriate by diagnosis (imaging, labs, or other findings as indicated). - Treatment plan which includes plan for transitioning to Entyvio Pen for subcutaneous injection following first two to three doses of IV vedolizumab for induction only. - Disease Activity Score or patient specific symptoms/treatment history to confirm moderately to severely active disease. - Awareness of immune-suppression risks specific to latent TB infection, and order exists for TST (Tuberculin Skin Test/PPD) or Interferon Gamma Release Assay (eg, Quanti FERON-TB Gold test). - Documentation of trial and failure at least 1 of the following - TNF inhibitor (TNFi): adalimumab, infliximab, certolizumab (CD indication only) or subcutaneous golimumab (UC indication only) - Ustekinumab
Age Restriction	18 yrs and older
Prescriber Restriction	Prescribed or in consultation with a gastroenterologist
Coverage Duration	Initial: up to 3 doses for IV induction dose only Renewal: Requires medical justification for inability to transition to subcutaneous product (Entyvio Pen) .
Other Requirements & Information	Requests for off-label use: See PHC criteria document <i>Case-by-Case TAR Requirements and Considerations</i> .

Medical Billing:
Dose limits & billing requirements, with an approved TAR:

HCP	CS	Description	Dosing, Units
J3380		Injection, vedolizumab, 1 mg	300 mg at week 0, 2, 6 then every 8 weeks. Partnership requires transition to subcutaneous pen after initial induction dose

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	• Neuromyelitis optica spectrum disorder (NMOSD) in adults who are anti-aquaporin-4 (AQP4) IgG antibody positive. • Immunoglobulin G4-related disease (IgG4-RD) • Generalized myasthenia gravis (gMG) in adult patients who are anti-acetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibody positive
Exclusion Criteria	• History of a life-threatening infusion reaction to inebilizumab; active hepatitis B infection; tuberculosis (TB) disease (active TB) or untreated TB infection (latent TB). • NMOSD: Use along with IV eculizumab (Soliris™) or SUBQ satralizumab (Enspryng™) • NMOSD negative AQP4-IgG • IgG4-RD: Use along with rituximab • gMG: LRP4 antibody positive or triple seronegative • gMG: Concurrent use with other systemic biologic agents for refractory gMG (such as Complement Inhibitors, Neonatal Fc Receptor Antagonists, or anti-CD20 monoclonal antibodies)
Required Medical Information	All requests should include documentation that member has been screened for hepatitis B virus (HBsAg and anti-HBc measurements) and active tuberculosis prior to treatment initiation. Submit the following per indication: <u>Requests for neuromyelitis optica spectrum disorder (NMOSD) (AQP4 IgG positive) required documentation of ALL of the following:</u> 1) At least one of the following: a. Optic neuritis b. Acute myelitis c. Area postrema syndrome: Episode of otherwise unexplained hiccups or nausea and vomiting d. Acute brainstem syndrome (acute inflammatory demyelination of the primary medulla) e. Symptomatic narcolepsy or acute diencephalic clinical syndrome with NMOSD-typical diencephalic MRI lesions f. Symptomatic cerebral syndrome with NMOSD-typical brain lesions 2) Seropositive for AQP4-IgG antibodies 3) Baseline Expanded Disability Status Scale (EDSS) score 4) Provider to submit reason(s) why satralizumab (Enspryng™) cannot be used, as the lower- level of care agent. <u>Requests for Immunoglobulin G4-related disease (IgG4-RD) require documentation of ALL the following:</u> 1) Diagnosis of IgG4-RD including documentation to show BOTH of the following: a. Clinical or radiologic evidence of tumor-like swelling of organs

	involved. b. Biopsy of the involved organs that demonstrates ALL of the following: i. Lymphoplasmacytic infiltrate enriched in IgG4-positive plasma cells ii. Storiform fibrosis (typified by a cartwheel appearance of the arranged fibroblasts and inflammatory cells) iii. Obliterative phlebitis 2) Other conditions (eg. malignancy, infection, other autoimmune disorders etc) have been ruled out. 3) IgG4-RD affecting 2 or more of the following organ/sites at any time: a. Pancreas b. Bile ducts/biliary tree c. Orbits d. Lungs e. Kidneys f. Lacrimal glands g. Major salivary glands h. Retroperitoneum i. Aorta j. Pachymeninges k. Thyroids glands 4) Member is experiencing (or recently experienced) an IgG4-RD flare that requires initiation or continuation of glucocorticoid treatment and/or recurrent disease. a. Flare is defined as new or worsening clinical features of IgG4-RD for which no clear alternative diagnosis exists. 5) Refractory to or unable to use glucocorticoids (including glucocorticoid dependence). a. Refractory to glucocorticoids is defined as inability to experience symptom relief, reduction in mass/organ size, improvement in organ function, or adequate decreases in serum IgG4 concentrations from glucocorticoids alone. b. This includes patients who are glucocorticoid-dependent (i.e. unable to reduce glucocorticoid dose to <5 mg/day) without causing disease flare or worsening of symptoms. 6) Trial and failure, or contraindication to, rituximab (biosimilar preferred).or explanation from the provider as to why rituximab is not appropriate. Generalized Myasthenia Gravis (gMG): 1) Positive immunologic binding assay to confirm MG due to the presence of AChR or MuSK antibodies 2) Avoidance of drugs that may exacerbate MG if possible, such as but not limited to: Beta blockers, hydroxychloroquine, gabapentin, lithium 3) Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 6 with at least 50% of the score coming from non-ocular symptoms at baseline 4) Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV 5) Documentation to indicated trial and failure (insufficient response) or reason(s) for contraindication to ALL of the following: a. Pyridostigmine AND b. Moderate to high dose glucocorticoids (onset 2-3 weeks and

	b. Hereditary demyelinating neuropathy c. Prominent sphincter disturbance d. Diagnosis of multifocal motor neuropathy (MMN) e. IgM monoclonal gammopathy with high titer antibodies to myelinassociated glycoprotein (MAG) f. Other causes for a demyelinating neuropathy including POEMS syndrome, osteosclerotic myeloma, and diabetic and nondiabetic lumbosacral radiculoplexus neuropathy; peripheral nervous system lymphoma and amyloidosis may occasionally have demyelinating features 4) Inflammatory Neuropathy Cause and Treatment (INCAT) score, Inflammatory Rasch-built Overall Disability Scale (I-RODS) or similar measurement of impairment 5) Documentation of failure to respond to glucocorticoids (oral or injectable) or reason(s) why glucocorticoids cannot be used such as but not limited to: a. Contraindication b. Severe disability c. Pure motor phenotype d. Fast progressive disease 6) Documentation of inadequate response, significant intolerance, or contraindication to intravenous immunoglobulin (IVIG) or subcutaneous immunoglobulin (SCIG) 7) Documentation of trial and failure, intolerance or reason(s) why self-administered efgartigimod alfa and hyaluronidase-qvfc PFS (Vyvgart Hytrulo PFS™) cannot be used				
Age Restriction	18 years and older				
Prescriber Restriction	Neurology				
Coverage Duration	MG: Initial: 6 months CIDP: Initial: 3 months Renewals (MG & CIDP): 12 months				
Other Requirements & Information	Renewal Requests: MG: - Clinical notes with current: MG-ADL and MGFA classification. Renewal Requests: CIDP: - Inflammatory Neuropathy Cause and Treatment (INCAT) score, Inflammatory Rasch-built Overall Disability Scale (I-RODS) or similar measurement of impairment. - If symptoms do not improve or continue to progress after an initial two-to-three-month treatment trial, the patient should be reevaluated to verify the diagnosis of CIDP. Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i>. <table border="1"> <thead> <tr> <th colspan="2">EAN/PNS 2021 CIDP Guidelines Diagnostic Criteria</th></tr> </thead> <tbody> <tr> <td>Typical CIDP</td><td> 1. Progressive or relapsing, symmetric, proximal and distal muscle weakness of upper and lower limbs, and sensory involvement of at least two limbs 2. Developing over at least 8 weeks 3. Absent or reduced tendon reflexes in all limbs </td></tr> </tbody> </table>	EAN/PNS 2021 CIDP Guidelines Diagnostic Criteria		Typical CIDP	1. Progressive or relapsing, symmetric, proximal and distal muscle weakness of upper and lower limbs, and sensory involvement of at least two limbs 2. Developing over at least 8 weeks 3. Absent or reduced tendon reflexes in all limbs
EAN/PNS 2021 CIDP Guidelines Diagnostic Criteria					
Typical CIDP	1. Progressive or relapsing, symmetric, proximal and distal muscle weakness of upper and lower limbs, and sensory involvement of at least two limbs 2. Developing over at least 8 weeks 3. Absent or reduced tendon reflexes in all limbs				

		4. At least two motor nerves must have abnormalities which fulfil the motor conduction criteria. If criteria are fulfilled in only one nerve, the diagnosis is possible typical CIDP. See Box: Motor Nerve Conduction Criteria below. 5. Sensory conduction abnormalities must be present in at least two nerves. See Box: Sensory Nerve Conduction Criteria below. Note: In patients suspected of having typical CIDP because they fulfil clinical criteria but not minimal electrodiagnostic criteria, the diagnosis of possible typical CIDP may be made if there is objective improvement following treatment with IVIg, corticosteroids or plasma exchange AND if at least one additional supportive criterion (2-5) is fulfilled. See Box: Supportive Criterion below.	
	Distal CIDP	1. Progressive or relapsing, symmetric, distal sensory loss and muscle weakness predominantly in lower limbs 2. Developing over at least 8 weeks 3. Absent or reduced tendon reflexes in affected limbs (tendon reflexes may be normal in unaffected limbs). 6. Motor conduction criteria fulfilment is required in at least two upper limb nerves to confirm the clinical diagnosis of distal CIDP. The distal negative peak CMAP amplitude should be at least 1 mV. When criteria are fulfilled in two lower limb but not upper limb nerves or if criteria are fulfilled in only one upper limb nerve, the maximum diagnostic certainty is possible distal CIDP. See Box: Motor Nerve Conduction Criteria below. 4. Sensory conduction abnormalities must be present in at least two nerves. See Box: Sensory Nerve Conduction Criteria below.	
	Multifocal CIDP	1. Progressive or relapsing, sensory loss and muscle weakness in a multifocal pattern, usually asymmetric, upper limb predominant, in more than one limb 2. Developing over at least 8 weeks 3. Absent or reduced tendon reflexes in affected limbs (tendon reflexes may be normal in unaffected limbs). 7. Motor conduction criteria fulfilment is required in at least two nerves in total in more than one limb. When criteria are fulfilled in only one nerve, the maximum diagnostic certainty is possible multifocal CIDP. See Box: Motor Nerve Conduction Criteria below. 4. Sensory conduction abnormalities must be present in at least two nerves of the affected limbs for the diagnosis of multifocal CIDP. See Box: Sensory Nerve Conduction Criteria below.	
	Focal CIDP	1. Progressive or relapsing, sensory loss and muscle weakness in only one limb. 2. Developing over at least 8 weeks. 3. Absent or reduced tendon reflexes in affected limbs (tendon reflexes may be normal in unaffected limbs). 8. Motor conduction criteria fulfilment is required in at least two nerves in total in more than one limb to confirm the clinical	

		diagnosis of multifocal CIDP and in at least two nerves in one limb for the diagnosis of focal CIDP. When criteria are fulfilled in only one nerve, the maximum diagnostic certainty is possible multifocal or possible focal CIDP. See Box: Motor Nerve Conduction Criteria below. 4. Sensory conduction abnormalities must be present in at least two nerves of the affected limb for the diagnosis of focal CIDP and in one nerve of the affected limb for the diagnosis of possible focal CIDP. See Box: Sensory Nerve Conduction Criteria below.	
	Motor CIDP (and motor-predominant)	1. Progressive or relapsing, symmetric, proximal and distal muscle weakness of upper and lower limbs, without sensory involvement. 2. Developing over at least 8 weeks 3. Absent or reduced tendon reflexes in all limbs 9. Motor CIDP must fulfil motor conduction criteria in at least two nerves and sensory conduction must be normal in all of at least four nerves (median, ulnar, radial, and sural) to confirm the clinical diagnosis of motor CIDP. If criteria are fulfilled in only one motor nerve, the diagnosis is possible motor CIDP. See Box: Motor Nerve Conduction Criteria below. Note: Motor CIDP with sensory conduction abnormalities in two nerves is diagnosed as motor-predominant CIDP.	
	Sensory CIDP (and sensory predominant)	1. Progressive or relapsing, symmetric sensory involvement of at least two limbs, without motor involvement. 2. Developing over at least 8 weeks 3. Absent or reduced tendon reflexes in all limbs 4. Sensory CIDP must fulfil sensory conduction criteria and motor conduction must be normal in all of at least four nerves (median, ulnar, peroneal, and tibial) to confirm the clinical diagnosis. The maximum diagnostic certainty is possible sensory CIDP. See Box: Sensory Nerve Conduction Criteria below. Note: Sensory CIDP with motor conduction criteria fulfilled in one nerve is diagnosed as possible sensory-predominant CIDP. If motor conduction criteria are fulfilled in two nerves, the diagnostic certainty increases to sensory-predominant CIDP.	
	Motor Nerve Conduction Criteria:	One of the following strongly supports demyelination (if the criteria only applies to 1 nerve, it is weakly supportive): 1. Motor distal latency prolongation $\geq 50\%$ above ULN in two nerves (excluding median neuropathy at the wrist from carpal tunnel syndrome), or 2. Reduction of motor conduction velocity $\geq 30\%$ below LLN in two nerves, or 3. Prolongation of F-wave latency $\geq 20\%$ above ULN in two nerves ($\geq 50\%$ if amplitude of distal negative peak CMAP $< 80\%$ of LLN), or 4. Absence of F-waves in two nerves (if these nerves have distal negative peak CMAP amplitudes $\geq 20\%$ of LLN) + ≥ 1 other demyelinating parameters in ≥ 1 other nerve, or	

		5. Motor conduction block: $\geq 30\%$ reduction of the proximal relative to distal negative peak CMAP amplitude, excluding the tibial nerve, and distal negative peak CMAP amplitude $\geq 20\%$ of LLN in two nerves; or in one nerve + ≥ 1 other demyelinating parameters except absence of F-waves in ≥ 1 other nerve, or 6. Abnormal temporal dispersion: $>30\%$ duration increase between the proximal and distal negative peak CMAP (at least 100% in the tibial nerve) in ≥ 2 nerves, or 7. Distal CMAP duration (interval between onset of the first negative peak and return to baseline of the last negative peak) prolongation in ≥ 1 nerveb + ≥ 1 other demyelinating parameters in ≥ 1 other nerve (LFF 2 Hz) median > 8.4 ms, ulnar > 9.6 ms, peroneal > 8.8 ms, tibial > 9.2 ms (LFF 5 Hz) median > 8.0 ms, ulnar > 8.6 ms, peroneal > 8.5 ms, tibial > 8.3 ms (LFF 10 Hz) median > 7.8 ms, ulnar > 8.5 ms, peroneal > 8.3 ms, tibial > 8.2 ms (LFF 20 Hz) median > 7.4 ms, ulnar > 7.8 ms, peroneal > 8.1 ms, tibial > 8.0 ms	
	Sensory Nerve Conduction Criteria	1. For a diagnosis of CIPD: Sensory conduction abnormalities (prolonged distal latency, or reduced SNAP amplitude, or slowed conduction velocity outside of normal limits) in two nerves. 2. For a diagnosis of “possible CIPD”: - sensory nerve conduction velocity $<80\%$ of LLN (for SNAP amplitude $>80\%$ of LLN) or $<70\%$ of LLN (for SNAP amplitude $<80\%$ of LLN) in at least two nerves (median, ulnar, radial, sural nerve), OR - Sural sparing pattern (abnormal median or radial sensory nerve action potential [SNAP amplitude] with normal sural nerve SNAP amplitude) (excluding carpal tunnel syndrome).	
	Supportive Criterion	1. Objective response to treatment with immunomodulatory agents (IVIg, plasma exchange, corticosteroids). The changes required to define improvement have not been adequately validated. The following which have been used in clinical trials can serve as a guide: - I-RODS: + ≥ 4 centile points - INCAT disability scale: $- \geq 1$ point - mISS: $- \geq 2$ points - MRC sum score (0-60): + ≥ 2 to 4 points* - Grip strength: Martin Vigorimeter: + ≥ 8 to 14 kPa* OR Jamar hand grip dynamometer: + $\geq 10\%^{**}$ 2. Imaging: only recommended when diagnosis is “possible CIPD”: before concluding that ultrasound or MRI abnormalities are supportive of CIPD, there should be no laboratory/clinical features that suggest other diseases that mimic CIPD (these are listed). - Ultrasound showing nerve enlargement of at least two sites in proximal median nerve segments	

		and/or the brachial plexus b. MRI showing enlargement and/or increased signal intensity of nerve root(s) on T2 weighted MRI sequences (DIXON/STIR, coronal + sagittal planes) 3. CSF evaluation: only recommended when diagnosis is “possible CIDP”: sensitivity of CSF protein elevation for CIDP was 68% using cut-offs of ≥ 0.5 g/L under the age of 50 years and > 0.6 g/L over the age of 60 years. 4. Nerve Biopsy: only recommended when CIDP is suspected but cannot be confirmed with other tests. Factors probably supporting the diagnosis of CIDP may be: - thinly myelinated axons and small onion bulbs. - thinly myelinated or demyelinated internodes in teased fibers. - perivascular macrophage clusters. - supportive features of demyelination on electron microscopy	

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
Vyvgart	J9332	Injection, efgartigimod alfa-fcab, 2 mg	10 mg/kg IV once weekly for 4 weeks. Subsequent cycles are repeated at least 28 days from the start of the previous cycle. Members weighing more than 120 kg: Maximum dose is 1.2 g IV.
Vyvgart Hytrulo	J9334	Injection, efgartigimod alfa, 2 mg and hyaluronidase-qvfc	MG: 1,008 mg efgartigimod alfa/ 11,200 units hyaluronidase once weekly for 4 weeks. Subsequent cycles are repeated at least 28 days from the start of the previous cycle. CIDP: 1,008 mg efgartigimod alfa/ 11,200 units hyaluronidase once weekly

Vyvgart Hytrulo PFS is a self-administered product and will fall under Partnership’s Standard Requirements for Self-Administered Drugs

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	Generalized myasthenia gravis (MG) in adults who are anti-acetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibody positive.
Exclusion Criteria	- Myasthenia gravis LRP4 antibody positive or triple seronegative - Concurrent use with other systemic biologic agents for refractory gMG (such as Complement Inhibitors, Neonatal Fc Receptor Antagonists, or anti-CD19 monoclonal antibodies)
Required Medical Information	- Positive immunologic binding assay to confirm MG due to the presence of AChR or MuSK antibodies - Avoidance of drugs that may exacerbate MG if possible such as but not limited to: Beta blockers, hydroxychloroquine, gabapentin, lithium - Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 6 at baseline - Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV - Documentation to indicated trial and failure (insufficient response) or reason(s) for contraindication to ALL of the following: - Pyridostigmine AND - Moderate to high dose glucocorticoids (onset 2-3 weeks and peaks 5.5 months), tapered to the lowest effective dose AND - Oral glucocorticoid sparing immunomodulator, such as: azathioprine, cyclosporine, tacrolimus or mycophenolate, (prior use of rituximab may also meet this requirement for MuSK+ disease) AND - Efgartigimod alfa and hyaluronidase-qvfc PFS (Vyvgart Hytrulo PFSTM) (preferred), or Efgartigimod alfa-fcab (VyvgartTM) or efgartigimod alfa, 2 mg and hyaluronidase-qvfc (Vyvgart HytruloTM)
Age Restriction	18 years and older
Prescriber Restriction	Neurology
Coverage Duration	Initial: 6 months Renewal: 12 months
Other Requirements & Information	Renewal Requests: - Clinical notes with current: - MG-ADL - MGFA classification Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J9333	Injection, rozanolixizumab-noli, 1 mg	Weight based dosing: • Less than 50kg: 420mg • 50kg to less than 100kg: 560mg • 100kg and above: 850mg Dose given by subcutaneous infusion once weekly for 6 weeks. Subsequent cycles are repeated at least 63 days from the start of the previous cycle.

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment. Unless otherwise specified, brand names are shown for reference only and the criteria apply to the generic drug ingredient regardless of manufacturer or labeler.

PA Criteria	Criteria Details
Covered Uses	Generalized myasthenia gravis (MG) in patients who are anti-acetylcholine receptor (AChR) or anti-muscle specific tyrosine kinase (MuSK) antibody positive.
Exclusion Criteria	- Myasthenia gravis LRP4 antibody positive or triple seronegative - Concurrent use with other systemic biologic agents for refractory gMG (such as Complement Inhibitors, Neonatal Fc Receptor Antagonists, or anti-CD19 monoclonal antibodies)
Required Medical Information	- Positive immunologic binding assay to confirm MG due to the presence of AChR or MuSK antibodies - Avoidance of drugs that may exacerbate MG if possible, such as but not limited to: Beta blockers, hydroxychloroquine, gabapentin, lithium - Myasthenia Gravis Activities of Daily Living (MG-ADL) score ≥ 6 at baseline - Myasthenia Gravis Foundation of America (MGFA) clinical classification of Class II to IV - Current weight - Documentation to indicated trial and failure (insufficient response) or reason(s) for contraindication to ALL of the following: - Pyridostigmine AND - Moderate to high dose glucocorticoids (onset 2-3 weeks and peaks 5.5 months), tapered to the lowest effective dose AND - Oral glucocorticoid sparing immunomodulator, such as: azathioprine, cyclosporine, tacrolimus or mycophenolate, (prior use of rituximab may also meet this requirement for MuSK+ disease) AND - Efgartigimod alfa and hyaluronidase-qvfc PFS (Vyvgart Hytrulo PFSTM) (preferred) or Efgartigimod alfa-fcab (VyvgartTM) or efgartigimod alfa and hyaluronidase-qvfc (Vyvgart HytruloTM).
Age Restriction	12 years and older
Prescriber Restriction	Neurology
Coverage Duration	Initial: 6 months Renewal: 12 months
Other Requirements & Information	Renewal Requests: - Clinical notes with current: - MG-ADL - MGFA classification Requests for off-label use: See Partnership criteria document <i>Case-by-Case TAR Requirements and Considerations</i>.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J9256	Injection, nipocalimab-aahu, 3 mg (Imaavy)	30mg/kg as a single dose, followed 2 weeks later by 15mg/kg given every 2 weeks thereafter.

Requirements for Anifrolumab-fnia Intravenous Injection (Saphnelo™)

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details		
Covered Uses	Moderate to severe systemic lupus erythematosus in adults who are receiving standard therapy. Standard therapy would include medications such as NSAIDs, corticosteroids, antimalarials (eg, chloroquine, hydroxychloroquine) and immunosuppressives (eg, cyclophosphamide, azathioprine, mycophenolate or methotrexate).		
Exclusion Criteria	- Severe active lupus nephritis - Severe active central nervous system lupus		
Required Medical Information	- Positive anti-nuclear antibody test with titer of $\geq 1:80$ HEp2 or equivalent positive test - Current standard treatment being used - Comprehensive metabolic panel (CMP-14), urinalysis, or kidney biopsy to rule out active lupus nephritis - Lab reports to indicate active inflammation: - CBC to indicate low hematocrit, hemoglobin, WBC and platelets - High erythrocyte sedimentation rate (ESR) - High C-Reactive Protein (CRP) - Positive anti-double-stranded DNA (anti-dsDNA) antibodies - Low levels of (complement proteins) C3 <60 and/or C4 <15 - Documentation of failure with or reason(s) why subcutaneous self-administered Saphnelo Pen Auto-injector or Saphnelo Prefilled Syringe cannot be used - Documentation of failure with or reason(s) why subcutaneous belimumab (Benlysta™) cannot be used.		
Age Restriction	18 years and older		
Prescriber Restriction	Rheumatologist		
Coverage Duration	Initial: 6 months Renewal: 12 months		
Other Requirements & Information	Renewal Requests: Clinic notes which document benefit from treatment with and tolerance to anifrolumab- fnia (Saphnelo™). Requests for off-label use: See PHC criteria document <i>Case-by-Case TAR Requirements and Considerations</i>		
Medical Billing: Dose limits & billing requirements (approved TAR is required)			
HCP	HCPCS	Description	Dosing, Units
	J0491	Injection, anifrolumab-fnia, 1 mg	300 mg IV q4weeks

Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	- Active, autoantibody- positive, systemic lupus erythematosus (SLE) in combination with standard therapy (≥ 5 yrs) - Active lupus nephritis who are receiving standard therapy Standard therapy would include medications such as NSAIDs, corticosteroids, antimalarials (eg, chloroquine, hydroxychloroquine) and immunosuppressives (eg, cyclophosphamide, azathioprine, mycophenolate or methotrexate).
Exclusion Criteria	- Severe active CNS lupus - Use in combination with other biologics, including B- cell targeted therapies or IV cyclophosphamide
Required Medical Information	<u>Active, autoantibody- positive, systemic lupus erythematosus (SLE):</u> - Positive anti-nuclear antibody test with titer of $\geq 1:80$ HEp2 or equivalent positive test - Age must be ≥ 5 yrs - Current standard treatment being used - Member weight - Lab reports, including references ranges, to indicate active inflammation: - CBC to indicate low hematocrit, hemoglobin, WBC and platelets - Creatinine - High erythrocyte sedimentation rate (ESR) - High C-Reactive Protein (CRP) - Positive anti-double-stranded DNA (anti-dsDNA) antibodies - Low levels of (complement proteins) C3 <60 and/or C4 <15 - Reason(s) why less invasive treatment option Benlysta subcutaneous (SC) pens or prefilled syringes cannot be considered. - Anticipated length of time required for IV administration prior to transitioning to SC administration. <u>Active lupus nephritis:</u> - Kidney biopsy results confirm active lupus nephritis and to stage the severity - Current standard treatment being used - Urinalysis to indicate proteinuria - Comprehensive metabolic panel (CMP-14) to indicate status of kidney - Member weight - Reason(s) why less invasive treatment option Benlysta subcutaneous (SC) pens or prefilled syringes cannot be considered. - Anticipated length of time required for IV administration prior to transitioning to SC administration. a.
Age Restriction	Vials (IV): 5 yrs and older
Prescriber Restriction	Rheumatologist or Nephrologist
Coverage Duration	<u>For IV administration (for ages 5-17 yrs):</u> Initial: 6 months Renewal: 12 months Adults (18 yrs and older): TBD, case-dependent

Other Requirements & Information	<u>Renewal Requests:</u> Clinic notes which document benefit from treatment with and tolerance to belimumab (Benlysta™). <u>Requests for off-label use:</u> See PHC criteria document <i>Case-by-Case TAR Requirements and Considerations</i>

Medical Billing: Dose limits & billing requirements (approved TAR is required)		
HCPCS	Description	Dosing, Units
J0490	Injection, belimumab, 10 mg	<u>Lupus nephritis:</u> 10 mg/kg IV at 2-week intervals for the first 3 doses, and at 4-week intervals thereafter. <u>Switching from IV to SC:</u> - Administer the first subcutaneous dose of 200 mg 1 to 2 weeks after the last IV dose. - Patients may switch to subcutaneous therapy after completion of 2 IV doses. <u>Systemic lupus erythematosus:</u> 10 mg/kg IV at 2-week intervals for the first 3 doses, and at 4-week intervals thereafter. <u>Switching from IV to SC:</u> - Administer the first subcutaneous dose 1 to 4 weeks after the last IV dose. <u>Billing Unit Equivalence:</u> 1 billing unit is 10 mg. Doses are calculated as 10 mg/kg. Determine the correct number of billing units by dividing the administered dose in milligrams by 10. Example: 80 kg member receives 800 mg dose. 800 mg ÷ 10 mg per unit = 80 code units.

PARTNERSHIP HEALTHPLAN OF CALIFORNIA MEETING SUMMARY

(Confidential – Protected by CA. Evidence Code 1157)

*=by phone conference

Committee: Credentials Committee
 Date: May 13, 2026 7:00 A.M.
 Members Present: Steven Gwiazdowski, MD; David Gorchoff, MD*; Michele Herman, MD; Bradley Sandler, MD* ;
 by phone conference* Brian Montenegro, MD; Craig Rhoades, PA-C*

PHC Staff: Mark Netherda, MD* Medical Director Quality Improvement, Credentials Chair; Marshall Kubota,
 by phone conference* MD*; PHC Associate Medical Director; Robert Moore, MD*, MPH, MBA, PHC Chief Medical
 Officer; Jeffery Ribordy, MD* Regional Medical Director; Lisa Ward, MD* Regional Medical
 Director; Matthew Morris, MD* Regional Medical Director; Priscila Ayala, Director of Network
 Services; Danika Ahedo, Supervisor of Credentialing; J'aime Seale, Credentialing Team Lead;
 Nolan Smith, Credentialing Specialist II; Morgan Brambley, Credentialing Specialist I; Amanda
 Arguello, Lead Trainer Network Services

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
I. Meeting called to order.	I. Mark Netherda, MD Medical Director of Quality Improvement and Credentials Meeting Chair called the meeting to order at 7:00AM. Credentials Committee roll call taken by Mark Netherda, MD. The Credentials Chair reminded everyone that all items discussed are confidential.			5/13/2026
a. Voting member reminder.	a. Partnership Credentials Chair Mark Netherda, MD reminded The Credentials Committee of who the voting members are. Voting is restricted to Non-Partnership Committee staff. Mark Netherda, MD reminded the committee that all information discussed is confidential in nature.			5/13/2026
II. Review and approval of the April 8, 2026 Credentials Meeting Summary.	II. The Credentials Committee meeting Summary for the April 8, 2026 Credentials Meeting was reviewed by the Committee.	II. The April 8, 2026 Credentials Meeting Summary was reviewed. A motion for approval of the Summary was made. First motion approved by Steven Gwiazdowski, MD and the second motion approved by Michele Herman, MD. Meeting Summary' motions approved by		5/13/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
		committee unanimously, with no objections.		
III. Old Business.	III. Old Business	III. Old Business		
a. Update for practitioner <i>Information Only</i>	a. Mark Netherda, MD Committee Chair updated the Credentials Committee on new information received for the practitioner. The provider was previously deferred to March, April and May 2026 Credentials meetings by Dr. Netherda due to further information needed to clarify the sanctions imposed by the California, Washington and Arizona Nursing Boards. The information received was determined beyond Medical Director review. Network Services and Legal Departments will need to determine how to move forward to disconnect from the practitioner. Determination pending further information and recommendations from Network Services and Legal Departments.	a. <i>Information Only</i>	6/10/2026	
b. Update for practitioner <i>Information Only</i>	b. Mark Netherda, MD Committee Chair updated the Credentials Committee on new information received for the practitioner. During the April 8, 2026 meeting, the Credentials Committee approved the provider pending an updated and signed MPCR17-A Primary Care and Urgent Care Provider Procedures Form. The provider returned the requested information on 5/5/2026. Medical Director review determined the form held insufficient information and errors. Dr. Netherda explained to the Credentials Committee that Credentialing Staff sent a letter and correspondence to the	b. <i>Information Only</i>	6/10/2026	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	provider notating the changes required for the provider, along with notifying the provider that due to Partnership's 120-day compliance their initial process may need to start again if the corrections to the form are not received.			
IV. New Business	IV. New Business	IV. New Business		
a. Review and Approval of Routine Practitioner List.	a. Mark Netherda, MD referred the Credentials Committee to review the routine list of practitioners.	a. The Committee reviewed the Routine Practitioner List. A motion to approve the Routine Practitioner List was made. First motion approved by Brian Montenegro, MD and the second motion approved by Bradley Sandler, MD. Routine Practitioner List motions approved by committee unanimously with no objections.		5/13/2026
b. MPCR200 Clean/Routine Practitioners and Ancillary Practitioners	b. Mark Netherda, MD directed the Credentials Committee to the MPCR200 Clean/Routine Practitioners and Ancillary Practitioners list. These practitioners are approved by Dr. Netherda Pre-Credentials Committee meeting.	b. The Credentials Committee reviewed the MPCR200 Clean/Routine list. A motion to approve the MPCR200 Clean/Routine Practitioners and Ancillary Practitioners list was made. First motion approved by Bradley Sandler, MD and the second motion approved by Steven Gwiazdowski, MD. MPCR200 Clean Routine Practitioners motions approved by committee unanimously with no objections.		5/13/2026
c. Review and Approval of Revised Policies.	c. Review and Approval of the Revised Policies presented to the Credentials Committee by Danika Ahedo, Supervisor of Credentialing. Danika explained the following policies: • MPCR13D - Registered Pharmacists for AB1114 Credentialing changes are consent calendar. • MPCR602 - Reporting Actions to Authorities changes are consent	c. The Committee reviewed the Revised Policies. A motion to approve the revised policies was made. First motion approved by Bradley Sandler, MD and the second motion approved by Michele Herman, MD. Revised Policies motions approved by committee unanimously with no objections.		5/13/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	calendar. • MPCR17 - Standards for Contracted Primary and Urgent Care Providers contained changes to the procedure section language. • MPCR17-A form title changed from Primary Care and Urgent Care Provider Form to Primary Care and Urgent Provider Procedures form. The MPCR17-A form also contains an additional section to add additional information. • MPCR102 Provider Directory Accuracy also contacted consent calendar update and HOA NCQA additions.			
V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List. a. Review and Approval of Ongoing Monitoring of Sanctions Report.	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List. a. Review and Approval of Ongoing Monitoring of Sanctions Report. The Credentials Committee was asked to review and approve the Ongoing Monitoring of Sanctions Report.	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List. a. The Credentials Committee members reviewed the report. A motion for approval of the Ongoing Monitoring of Sanctions Report was made. First motion approved by Steven Gwiazdowski, MD and the second motion approved by Bradley Sandler, MD. Ongoing Monitoring of Sanctions Report motions approved by committee unanimously with no objections.		5/13/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
b. Practitioner Monitoring List.	b. The Credentials Committee was asked to review the Practitioner Monitoring list. Mark Netherda, MD reminded the committee that the credentialing department monitors these boards for any actions regarding our providers.	b. <i>Informational only.</i>		5/13/2026
VI. Review and Approval of Consent Calendar Items. a. Report of Long-Term Care Facility, Hospital, and Ancillary provider list. b. Annual Delegation Audits	VI. Review and Approval of Consent Calendar Items. a. Mark Netherda, MD asked the Credentials Committee members to review the report of Long-Term Care Facility, Hospital, and Ancillary provider list. b. Mark Netherda, MD presented the Annual Delegation Audits for: • Carelon Behavioral Health • Dignity Health Medical Foundation • Lucile Packard Children's Hospital • UC Davis Health The audits included Partnerships review and evaluation of the credentialing information integrity results.	VI. Review and Approval of Consent Calendar Items. a/b. The Credentials Committee members reviewed the list of Consent Calendar Items. A motion for approval was made for the Report of Long-Term Care Facility, Hospital and Ancillary provider list and Annual Delegation Audits. First motion approved by Steven Gwiazdowski, MD and the second motion approved by Bradley Sandler, MD. Consent Calendar Items approved by committee unanimously with no objections.		5/13/2026
VII. Meeting Adjourned.	VII. Meeting adjourned.			5/13/2026

Credentials Meeting Summary for 5/13/2026 respectfully prepared and submitted by J'aime Seale, Network Services Credentialing Lead

Chairman Signature of Approval _____

Mark Netherda, MD Credentials Meeting Chair



Date 5/13/2026

May 2026 Routine Practitioner List

App. Type	Full Name	NPI Number	Provider Typ	Name/Street	County Name	Specialty Description	Board Name	Initial Cert Date	Board Certi	Hospital Ne	Staff Cat	Description
I	Norwood, Ricky R.,FNP-BC	1730214511	SPEC	Active Life Wound Clinic	Yolo	Family Nurse Practitioner	American Nurses Credentialing Center	08/29/2006	Yes	None		
I	Martin, Adrianna E.,Doula	1386225837	SPEC	Adrianna Martin Doula	Mendocino	Doula	None		No	None		
I	Swietanski, Jadie J.,FNP-BC	1215723507	PCP	Adventist Health	Butte	Family Nurse Practitioner	American Nurses Credentialing Center	08/23/2024	Yes	None		
I	Couch, Kelly D.,CADC_CAS	1740779198	W&R	Aegis Treatment Centers, LLC - Redding	Shasta	Wellness and Recovery	California Consortium of Addiction Programs Profe	02/11/2010	Yes	None		
I	Longee, Joilyn SUDRC I	1518810837	W&R	Aegis Treatment Centers, LLC - Redding	Shasta	Wellness and Recovery	California Substance Use Disorder	02/26/2026	Yes	None		
I	Kennedy, Kellie R.,LMFT	1942602701	W&R	Aldea Children and Family Services	Solano	Wellness and Recovery	None		No	None		
I	Vanegas, Amy RADT	1043794985	W&R	Aldea Children and Family Services	Solano	Wellness and Recovery	California Consortium of Addiction Programs Profe	12/12/2025	Yes	None		
I	Mendiola, Monica A.,PA	1619598489	BOTH	Alexander Valley Health Center	Sonoma	Physician Assistant	None		No	None		
I	Shiba, David A.,MD	1255389300	SPEC	Ampla Health Oroville Medical	Butte	Hematology and Oncology	None		No	Admitting A	None	
I	Bailey, Paul W.,FNP-C	1467130435	PCP	Anderson Walk In Medical Clinic	Shasta	Family Nurse Practitioner	American Academy of Nurse Practitioners Certifica	08/26/2024	Yes	None		
I	Willey, Andrea MD	1952317455	SPEC	Andrea Willey, MD, PMC	Sacramento	Dermatology	ABMS of Dermatology	08/13/2007	Yes	Admitting A	None	
I	Laba, Tobias G.,SUDRC I	1477498962	W&R	Archway Recovery Services	Napa	Wellness and Recovery	California Substance Use Disorder	03/24/2026	Yes	None		
I	Murphy, Melissa RADT	1316894942	W&R	Archway Recovery Services	Napa	Wellness and Recovery	California Consortium of Addiction Programs Profe	10/31/2025	Yes	None		
I	Bradshaw, John RADT	1518844547	W&R	Archway Recovery Services IOP W & R	Solano	Wellness and Recovery	California Consortium of Addiction Programs Profe	09/20/2023	Yes	None		
I	Draper, Michelle CADC I	1427996800	W&R	Archway Recovery Services IOP W & R	Solano	Wellness and Recovery	California Consortium of Addiction Programs Profe	04/23/2025	Yes	None		
I	Burton, Dominica BCBA	1982179891	BHP	Autism Intervention Professionals	Solano	BCBA	Behavior Analyst Certification Board	02/03/2023	Yes	None		
I	Duncan, Taylor BCBA	1174103089	BHP	Autism Intervention Professionals	Solano	BCBA	Behavior Analyst Certification Board	02/23/2024	Yes	None		
I	Lee, Derek BCBA	1538738992	BHP	Autism Intervention Professionals	Solano	BCBA	Behavior Analyst Certification Board	03/05/2025	Yes	None		
I	McCauley, Megan BCBA	1023510559	BHP	Autism Intervention Professionals	Solano	BCBA	Behavior Analyst Certification Board	05/31/2019	Yes	None		
I	Otto, Robert BCBA	1508636655	BHP	Autism Intervention Professionals	Solano	BCBA	Behavior Analyst Certification Board	04/22/2025	Yes	None		
I	Wittwer, Summer BCBA	1932731304	BHP	Autism Intervention Professionals	Solano	BCBA	Behavior Analyst Certification Board	04/03/2024	Yes	None		
I	Lacey, Savauna BCBA	1053881656	BHP	Autism Learning Partners	Solano	BCBA	Behavior Analyst Certification Board	07/23/2021	Yes	None		
I	Jetty, Silpa S.,MD	1164050266	SPEC	Bay Area Surgical Specialists - Infectious Disease	Solano	Infectious Disease	ABMS of Internal Medicine	10/30/2025	Yes	Admitting A	None	
I	Buchanan, Kathrynne BCBA	1104371939	BHP	BM Behavioral Center, LLC	Solano	BCBA	Behavior Analyst Certification Board	02/28/2015	Yes	None		
I	Carrillo-Gomez, Maleni BCBA	1639723257	BHP	BM Behavioral Center, LLC	Solano	BCBA	Behavior Analyst Certification Board	07/15/2024	Yes	None		
I	Rose-Heron, Yakima E.,BCBA	1316505415	BHP	BM Behavioral Center, LLC	Solano	BCBA	Behavior Analyst Certification Board	12/15/2022	Yes	None		
I	Lewis, Kayla Doula	1437948452	SPEC	Brave & Beautiful Births	Solano	Doula	None		No	None		
I	Blalack, Julia BCBA	1063057891	BHP	Burnett Therapeutic Services, Inc.	Napa	BCBA	Behavior Analyst Certification Board	07/30/2025	Yes	None		
I	Li, Catherine BCBA	1508225251	BHP	Burnett Therapeutic Services, Inc.	Napa	BCBA	Behavior Analyst Certification Board	11/30/2018	Yes	None		
I	Marin-Curd, Lynel BCBA	1992321004	BHP	Burnett Therapeutic Services, Inc.	Napa	BCBA	Behavior Analyst Certification Board	09/12/2025	Yes	None		
I	Maximous, Marisa BCBA	1023764156	BHP	Burnett Therapeutic Services, Inc.	Napa	BCBA	Behavior Analyst Certification Board	03/26/2026	Yes	None		
I	Pierre, Lavonda BCBA	1396398590	BHP	Burnett Therapeutic Services, Inc.	Napa	BCBA	Behavior Analyst Certification Board	01/17/2023	Yes	None		
I	Wallace, Kiblena BCBA	1760904817	BHP	Burnett Therapeutic Services, Inc.	Napa	BCBA	Behavior Analyst Certification Board	05/06/2020	Yes	None		
I	Worthington, Randy L.,DC	1902880610	SPEC	Burney Alternative Health Center	Shasta	Chiropractic	None		No	None		
I	Lloyd, Nathan BCBA	1659755031	BHP	California Psychcare, Inc dba 360 Behavioral Health	Sacramento	BCBA	Behavior Analyst Certification Board	02/28/2014	Yes	None		
I	Bae, Hannah BCBA	1346889235	BHP	California Sprout MC 1 LLC dba Tilly	Solano	BCBA	Behavior Analyst Certification Board	11/30/2019	Yes	None		
I	Roberts, Keyon BCBA	1891153680	BHP	California Sprout MC 1 LLC dba Tilly	Solano	BCBA	Behavior Analyst Certification Board	05/31/2015	Yes	None		
I	Sandoval, Christina BCBA	1871017624	BHP	California Sprout MC 1 LLC dba Tilly	Solano	BCBA	Behavior Analyst Certification Board	02/29/2016	Yes	None		
I	Reid, Melina D., FNP	1366025850	SPEC	Capital OB/GYN, Inc.	Yolo	Family Nurse Practitioner	American Nurses Credentialing Center	03/25/2021	Yes	None		
I	Cabrera, Danielle BCBA	1861952749	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analyst Certification Board	10/18/2025	Yes	None		
I	Clark, Kayla BCBA	1114634128	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analyst Certification Board	09/09/2025	Yes	None		
I	Cochran, Kimberly BCBA	1699443861	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analyst Certification Board	01/06/2025	Yes	None		
I	Johnson, Taylor BCBA	1932908282	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analyst Certification Board	03/01/2025	Yes	None		
I	Provencher, Kallie BCBA	1447856950	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analyst Certification Board	10/26/2020	Yes	None		
I	Ramirez, Riley BCBA	1356983993	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analyst Certification Board	03/13/2026	Yes	None		
I	Russell, Brandy BCBA	1235791419	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analyst Certification Board	04/21/2025	Yes	None		
I	Stellhorn, Emily BCBA	1003446246	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analyst Certification Board	10/15/2025	Yes	None		
I	Sulek, Bridget BCBA	1922762137	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analyst Certification Board	02/11/2025	Yes	None		
I	Kanani, Babak MD	1023323813	PCP	Chapa-De Indian Health (Auburn)	Placer	Internal Medicine	ABMS of Internal Medicine	08/16/2010	Yes	Admitting A	None	
I	Wlasjuk, Lidya H., MD	1003175910	PCP	Chapa-De Indian Health (Grass Valley)	Nevada	Family Medicine	ABMS of Family Medicine	07/22/2015	Yes	Admitting A	None	
I	Blumstein, Brynne BCBA	1598170854	BHP	Children's Developmental Milestones, Inc	Solano	Board Certified Behavior An:	Behavior Analyst Certification Board	09/30/2013	Yes	None		
I	Friedman, Kimberly BCBA	1659712198	BHP	Children's Developmental Milestones, Inc	Solano	Board Certified Behavior An:	Behavior Analyst Certification Board	05/31/2013	Yes	None		
I	Johnson, Amanda BCBA	1689983678	BHP	Children's Developmental Milestones, Inc	Solano	Board Certified Behavior An:	Behavior Analyst Certification Board	10/09/2020	Yes	None		
I	Moore, Ashlee BCBA	1558769992	BHP	Children's Developmental Milestones, Inc	Solano	Board Certified Behavior An:	Behavior Analyst Certification Board	09/30/2012	Yes	None		
I	Okusanya, Oluwaseyi PA-C	1306481221	PCP	Chukwuemeka Ndulue, M.D. - Pediatrics	Yuba	Physician Assistant Certifie	National Commission on Certification of Physician	10/23/2025	Yes	None		
I	Barrs, Marni M.,CNM	1184651713	PCP	CommuniCare Ole - Davis Community Clinic	Yolo	Certified Nurse Midwife	American Midwifery Certification Board	01/01/1997	Yes	None		
I	Storey, Keri B.,CNM	1295225084	SPEC	CommuniCare Ole - Davis Community Clinic	Yolo	Certified Nurse Midwife	American Midwifery Certification Board	02/01/2018	Yes	None		
I	Hunt, Anne L.,FNP-BC	1780382085	SPEC	Davis Urgent Care Inc.	Yolo	Family Nurse Practitioner	American Nurses Credentialing Center	02/22/2023	Yes	None		
I	McKinney-Brooks, Victoria K.,PA-C	1154000537	SPEC	Davis Urgent Care Inc.	Yolo	Physician Assistant Certifie	National Commission on Certification of Physician	10/04/2023	Yes	None		
I	Hunter, Amber L.,FNP-C	1851168579	PCP	Dignity Health - Mercy Lake Shastina Comm Clinic	Siskiyou	Family Nurse Practitioner	American Academy of Nurse Practitioners Certifica	10/20/2023	Yes	None		
I	Rao, Vijay P.,MD	1982725180	SPEC	Dignity Health dba Mercy Oncology Center	Shasta	Hematology	ABMS of Internal Medicine	10/24/2019	Yes	Mercy Medi Active		
I	Durant, Jayne FNP-C	1083304851	PCP	Dignity Health Women's Health Services Clinic - PCP/SPEC	Tehama	Family Nurse Practitioner	American Academy of Nurse Practitioners Certifica	04/25/2023	Yes	None		
I	Miller, Susan K.,FNP-C	1134560691	PCP	Dignity Health Women's Health Services Clinic - PCP/SPEC	Tehama	Family Nurse Practitioner	American Academy of Nurse Practitioners Certifica	09/10/2014	Yes	None		
I	Davis, Jason RADT	1821892761	W&R	Drug Abuse Alternatives Center	Sonoma	Wellness and Recovery	California Consortium of Addiction Programs Profe	03/11/2025	Yes	None		
I	Lu, Chuan J.,LVN	1134939325	W&R	Drug Abuse Alternatives Center	Sonoma	Licensed Vocational Nurse	None		No	None		
I	Perez, Sara D.,LVN	1033007497	W&R	Drug Abuse Alternatives Center	Sonoma	Licensed Vocational Nurse	None		No	None		
I	Shields, Sharon M.,SUDCC II	1265859763	W&R	Drug Abuse Alternatives Center	Sonoma	Substance Use Disorder	California Substance Use Disorder	05/28/2025	Yes	None		
I	Grier, Barnett J., Jr., MD	1932233665	PCP	Eastern PLumas Health Care Portola Medical Clinic	Plumas	Family Medicine	Meets MPCR#17, Previously Board Certified in FM,	10/30/1977	No	Admitting A	None	
I	Farquharson, Patrice PA-C	1275373409	PCP	Elica Health Centers - North Highlands	Placer	Physician Assistant Certifie	National Commission on Certification of Physician	04/23/2024	Yes	None		
I	Tinapay, Jeoffrey FNP-C	1497267587	PCP	Elica Health Centers - North Highlands	Placer	Family Nurse Practitioner	American Academy of Nurse Practitioners Certifica	09/26/2017	Yes	None		
I	Katikireddy, Chandra K.,MD	1649318023	SPEC	Enloe Cardiology Services & Structural Heart & Valve Center	Butte	Advanced Heart Failure and	ABMS of Internal Medicine	11/03/2014	Yes	Admitting A	None	
I	Scharf, Joshua L.,MD	1861539470	SPEC	Enloe Ear, Nose & Throat Clinic	Butte	Otolaryngology, Head, and N	ABMS of Otolaryngology-Head and Neck Surgery	06/01/2008	Yes	Enloe Medi Provisional		
I	Iyengar, Sreesh G.,MD	1699069146	SPEC	Enloe Health and Wellness Nephrology	Butte	Internal Medicine	ABMS of Internal Medicine	08/08/2014	Yes	Enloe Medi Temporary		
I	Murphy, Serena M.,MD	1295198893	SPEC	Enloe Surgical Oncology	Butte	Colon and Rectal Surgery	ABMS of Colon and Rectal Surgery	09/28/2024	Yes	Admitting A	None	
I	Simmons, Tristan P.,DO	1033564380	SPEC	Generations Urgent Care PC	Shasta	Emergency Medicine	ABMS of Emergency Medicine	04/05/2021	Yes	Mercy Medi Active		
I	Lopez Guerrero, Paola BCBA	1528563046	BHP	Grow With Me - Creciendo Juntos	Solano	BCBA	Behavior Analyst Certification Board	02/28/2018	Yes	None		
I	Grant, Harlee Doula	1992666176	SPEC	Harlee Grant	Humboldt	Doula	None		No	None		
I	Majer, Martin MD	1376749234	SPEC	Interventioanl Radiation Oncology of California Inc	Solano	Medical Oncology	ABMS of Internal Medicine	11/13/2007	Yes	Admitting A	None	
I	Elshanskaia, Lulija Doula	1053281097	SPEC	Lulija Elshanskaia Slavic Doula	Placer	Doula	None		Not Applic	None		
I	Aldrich, Jade G.,Doula	1770370751	SPEC	Jade Golden Doula Services	Mendocino	Doula	None		Not Applic	None		
I	Anderson, Lydia BCBA	1306384847	BHP	Kadiant, LLC	Placer	BCBA	Behavior Analyst Certification Board	05/31/2016	Yes	None		
I	Duong, Yasmine BCBA	1629572326	BHP	Kadiant, LLC	Solano	BCBA	Behavior Analyst Certification Board	09/06/2025	Yes	None		
I	Fitzsimmons, Emily BCBA	1578066650	BHP	Kadiant, LLC	Solano	BCBA	Behavior Analyst Certification Board	11/30/2019	Yes	None		

May 2026 Routine Practitioner List

App. Type	Full Name	NPI Number	Provider Typ	Name/Street	County Name	Specialty Description	Board Name	Initial Cert Date	Board Certi	Hospital Ne	Staff Cat	Description
I	Fuerte, Margaret BCBA	1831690114	BHP	Kadiant, LLC	Placer	BCBA	Behavior Analyst Certification Board	08/31/2019	Yes	None		
I	Garcia, Lauren BCBA	1790286995	BHP	Kadiant, LLC	Solano	BCBA	Behavior Analyst Certification Board	06/05/2025	Yes	None		
I	Alvarez, Karina BCBA	1639790322	BHP	Kadiant, LLC	Stanislaus	BCBA	Behavior Analyst Certification Board	12/29/2021	Yes	None		
I	Barrios, Tiana BCBA	1821597030	BHP	Kadiant, LLC	Stanislaus	BCBA	Behavior Analyst Certification Board	10/31/2020	Yes	None		
I	Bullington, Jennifer BCBA	1386114361	BHP	Kadiant, LLC	Stanislaus	BCBA	Behavior Analyst Certification Board	01/21/2026	Yes	None		
I	Evans, Shahana BCBA	1538763008	BHP	Kadiant, LLC	Stanislaus	BCBA	Behavior Analyst Certification Board	08/07/2024	Yes	None		
I	Gallardo, Alejandra BCBA	1386319085	BHP	Kadiant, LLC	Stanislaus	BCBA	Behavior Analyst Certification Board	03/24/2025	Yes	None		
I	Miles, Kelsey BCBA	1609364751	BHP	Kadiant, LLC	Stanislaus	BCBA	Behavior Analyst Certification Board	01/11/2024	Yes	None		
I	Bradford, Jessica D., MD	1962414599	PCP	Kimaw Medical Center	Humboldt	Internal Medicine	ABMS of Internal Medicine	08/12/2009	Yes	Admitting A	Active	
I	Arellano, Jan Patricia BCBA	1376259689	BHP	Kyo Autism Therapy LLC, fka Gateway Learning Group	Marin	BCBA	Behavior Analyst Certification Board	03/25/2026	Yes	None		
I	Barney, Marysha BCBA	1720511470	BHP	Kyo Autism Therapy LLC, fka Gateway Learning Group	Marin	BCBA	Behavior Analyst Certification Board	02/28/2019	Yes	None		
I	Grant, Elizabeth BCBA	1487252854	BHP	Kyo Autism Therapy LLC, fka Gateway Learning Group	Marin	BCBA	Behavior Analyst Certification Board	07/08/2020	Yes	None		
I	Taylor, Desree BCBA	1205588217	BHP	Kyo Autism Therapy LLC, fka Gateway Learning Group	Marin	BCBA	Behavior Analyst Certification Board	03/10/2026	Yes	None		
I	Valencia, Ana BCBA	1487126074	BHP	Kyo Autism Therapy LLC, fka Gateway Learning Group	Marin	BCBA	Behavior Analyst Certification Board	07/02/2021	Yes	None		
I	Ball, Dorian M., MD	1902555360	PCP	La Clinica	Solano	Family Medicine	ABMS of Family Medicine	11/18/2025	Yes	Admitting A	None	
I	Mukherjee, Moneesha R., MD	1386374700	PCP	La Clinica	Solano	Family Medicine	ABMS of Family Medicine	06/23/2025	Yes	Admitting A	None	
I	Kedlaya, Divakara MD	1134104037	SPEC	Lake County Tribal Health Center	Lake	Neuromuscular Medicine	Previously Board Certified	10/01/2012		Providence	Provisional	
I	Milligan, Nicolas MD	1447612627	PCP	Lassen Indian Health Center	Lassen	Family Medicine	None		No	Admitting A	None	
I	Wong, Curtis S., MD	1114931151	SPEC	Lassen Medical Clinic- Red Bluff	Shasta	Plastic Surgery	ABMS of Plastic Surgery	11/23/1996	Yes	Admitting A	None	
I	Burke, Leta R., Doula	1265381248	SPEC	Leta Burke	Butte	Doula	None		No	None		
I	Jennings, Iyanna Doula	1033927611	SPEC	Loula Perinatal Health Services of California	Solano	Doula	None		No	None		
I	Jones, Jamie Doula	1114814274	SPEC	Loula Perinatal Health Services of California	Solano	Doula	None		No	None		
I	Lewis, Chanel Doula	1053093294	SPEC	Loula Perinatal Health Services of California	Solano	Doula	None		No	None		
I	Meza, Leslie Doula	1285331223	SPEC	Loula Perinatal Health Services of California	Solano	Doula	None		Not Applicable	None		
I	Thompson, Marian Maya Doula	1538880745	SPEC	Loula Perinatal Health Services of California	Solano	Doula	None		No	None		
I	Smith, Vinita D., SUDCC	1083131148	W&R	MedMark Treatment Centers Vallejo	Solano	Wellness and Recovery	California Substance Use Disorder	08/17/2025	Yes	None		
I	Grow, Patricia A., FNP-C	1043416803	PCP	Mendocino Coast Clinic	Mendocino	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification	08/01/2006	Yes	None		
I	Barker, Emily R., PA-C	1215306196	PCP	Mendocino Community Health Clinic: Hillside Health Center	Mendocino	Physician Assistant Certification	National Commission on Certification of Physician	06/11/2015	Yes	None		
I	Behar, Henry J., MD	1053553743	SPEC	Mendocino Community Health Clinic: Hillside Health Center	Mendocino	Obstetrics and Gynecology	ABMS of Obstetrics and Gynecology	11/11/2016	Yes	Adventist - Locum Tenens		
I	Hasan, Noha BCBA	1013763879	BHP	Montera Health California, LLC	Yolo	BCBA	Behavior Analyst Certification Board	04/03/2024		None		
I	Verosky, Victoria BCBA	1023659307	BHP	Montera Health California, LLC	Yolo	BCBA	Behavior Analyst Certification Board	02/25/2023	Yes	None		
I	Lieuallen, Emily DO	1669786174	PCP	MVHC - Burney Health Center	Shasta	Family Medicine	ABMS of Family Medicine	08/06/2013	Yes	Admitting A	None	
I	Echipare, Lorigail T., DO	1558725846	SPEC	Nephrology Associates	Sonoma	Internal Medicine	ABMS of Internal Medicine	08/17/2020	Yes	Providence	Active	
I	Limosnero, Glenn R., LMFT	1952911554	W&R	New Life, LLC	Mendocino	License Marriage and Family	None		No	None		
I	Ahmad, Robina MD	1003265745	SPEC	Noel Serrano, MD	Solano	Family Medicine	ABMS of Family Medicine	07/01/2019	Yes	Santa Rosa	Active	
I	Watts, Sharron Doula	1477442887	SPEC	Nomie's Breath Doula Services	Solano	Doula	None		No	None		
I	Purvis, Barbara J., FNP-C	1194169086	PCP	Northeastern Rural Health Clinics, Inc.	Lassen	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification	06/05/2013	Yes	None		
I	Bobadilla, Melina M., FNP-BC	1295577229	PCP	One Community Health - Infectious Disease and	Yolo	Family Nurse Practitioner	American Nurses Credentialing Center	07/14/2024	Yes	None		
I	Mattathil, Divya FNP-C	1013874817	PCP	One Community Health - Infectious Disease and	Solano	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification	07/11/2025	Yes	None		
I	Wise, Barbara A., FNP-C	1013780584	PCP	One Community Health - Infectious Disease and	Yolo	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification	06/27/2023	Yes			
I	Gill, Kimberly C., PMHNP-BC	1649094251	SPEC	Oroville Family Practice Associates	Butte	Psychiatric Mental Health Nurse	American Nurses Credentialing Center	08/28/2024	Yes	None		
I	Bothwell, Alicia BCBA	1437829330	BHP	Pantogran LLC dba Center for Autism and Related Disorders	Solano	Board Certified Assistant Behavior Analyst	Behavior Analyst Certification Board	03/15/2023	Yes	None		
I	Gutridge, Serena BCBA	1124740154	BHP	Pantogran LLC dba Center for Autism and Related Disorders	Solano	BCBA	Behavior Analyst Certification Board	02/25/2026	Yes	None		
I	Prestwich, Lovina BCaBA	1861143851	BHP	Pantogran LLC dba Center for Autism and Related Disorders	Solano	BCABA	Behavior Analyst Certification Board	06/22/2024	Yes	None		
I	Carrillo, Shirley I., NP	1154672566	SPEC	Parkhill Health Inc dba AFC Urgent Care Brentwood	Solano	Nurse Practitioner	None		No	None		
I	Woodard, Kimberli A., PT	1811057698	Allied	Parkside Physical Therapy (Western Physical Therapy)	Butte	Physical Therapy	None		No	None		
I	Ngakam, Jaques PA-C	1194254995	SPEC	Peach Tree Healthcare	Yuba	Physician Assistant Certification	National Commission on Certification of Physician	02/27/2017	Yes	None		
I	Smith, Amanda BCBA	1154871689	BHP	Positive Behavior Supports Corporation	Shasta	BCBA	Behavior Analyst Certification Board	09/30/2013	Yes	None		
I	Jenkins, Kaylah BCBA	1831988864	BHP	Positive Behavior Supports Corporation - Greater Sacramento	Yolo	BCBA	Behavior Analyst Certification Board	05/05/2025	Yes	None		
I	Wood, Erin BCaBA	1073014742	BHP	Positive Behavior Supports Corporation - Greater Sacramento	Yolo	Behavior Analyst	Behavior Analyst Certification Board	04/07/2026	Yes	None		
I	Hajdu, Alice PT	1417421702	Allied	Proactive Spine and Sports Physical Therapy	Shasta	Physical Therapy	None		No	None		
I	Schmidt, Eric S., MD	1720012149	SPEC	Providence Medical Group - Sonoma	Sonoma	Orthopedic Surgery	ABMS of Orthopaedic Surgery	07/13/1990	Yes	Providence	Provisional	
I	Davies, Eileen E., FNP-C	1316339146	SPEC	Providence Medical Group - Urgent Care	Solano	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification	01/07/2015	Yes	None		
I	Douglas, Ana E., FNP-C	1114020997	SPEC	Providence Medical Group - Urgent Care	Solano	Family Nurse Practitioner	American Nurses Credentialing Center	08/01/2006	Yes	None		
I	Ducombs, Christopher PA-C	1407386816	SPEC	Providence Medical Group - Urgent Care	Solano	Physician Assistant Certification	National Commission on Certification of Physician	11/22/2017	Yes	None		
I	Elliott, Jerrold P., PA-C	1982854618	SPEC	Providence Medical Group - Urgent Care	Solano	Physician Assistant Certification	National Commission on Certification of Physician	08/28/2008	Yes	None		
I	Kirk, Richard N., FNP-BC	1952492183	SPEC	Providence Medical Group - Urgent Care	Solano	Family Nurse Practitioner	American Nurses Credentialing Center	05/01/2004	Yes	None		
I	Lopez, Miguel E., FNP-C	1982445383	SPEC	Providence Medical Group - Urgent Care	Solano	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification	05/28/2024	Yes	None		
I	Luce, Damara K., PA-C	1790210540	SPEC	Providence Medical Group - Urgent Care	Solano	Physician Assistant Certification	National Commission on Certification of Physician	04/27/2017	Yes	None		
I	Marshall, Robert F., PA-C	1841696515	SPEC	Providence Medical Group - Urgent Care	Solano	Physician Assistant Certification	National Commission on Certification of Physician	09/03/2015	Yes	None		
I	Morrow, Marcy L., PA-C	1942212600	SPEC	Providence Medical Group - Urgent Care	Solano	Physician Assistant Certification	National Commission on Certification of Physician	09/29/2005	Yes	None		
I	Nguyen, Jenny V., PA-C	1881286813	SPEC	Providence Medical Group - Urgent Care	Solano	Physician Assistant Certification	National Commission on Certification of Physician	11/23/2020	Yes	None		
I	Trost, Jennifer R., PA-C	1447603139	SPEC	Providence Medical Group - Urgent Care	Solano	Physician Assistant Certification	National Commission on Certification of Physician	06/30/2016	Yes	None		
I	Wolfkin, Devon L., FNP-C	1346765823	SPEC	Providence Medical Group - Urgent Care	Solano	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification	07/05/2017	Yes			
I	Javaheri, Shahram MD	1497861439	SPEC	Providence Medical Group- Napa	Napa	Gastroenterology	American Board of Internal Medicine	11/06/2022	Yes	Providence	Provisional	
I	Bell Duffy, Lachlin J., PA-C	1932086964	SPEC	Providence Medical Group, Humboldt - Dermatology	Humboldt	Physician Assistant Certification	National Commission on Certification of Physician	10/16/2025	Yes	None		
I	Moates, Michael W., MD	1750360889	SPEC	Providence Medical Group, Humboldt - Dermatology	Humboldt	Dermatology	ABMS of Dermatology	10/30/1978	Yes	Admitting A	None	
I	Ahmad, Naseer MD	1295804250	SPEC	Providence Medical Group, Humboldt - Hematology/Oncology/F	Humboldt	Medical Oncology	ABMS of Medical Oncology	11/03/1993	Yes	Admitting A	None	
I	Fernandez, Damian O., MD	1760758106	SPEC	Providence Medical Group, Humboldt - Gastro	Humboldt	Gastroenterology	ABMS of Internal Medicine	11/06/2023	Yes	Providence	Provisional	
I	Hajar, Rabab E., MD	1003103805	SPEC	Providence Medical Group, Humboldt - Gastro	Humboldt	Gastroenterology	ABMS of Internal Medicine	11/18/2021	Yes	Providence	Provisional	
I	Martin Chicoine, Colleen A., CNM	1699538975	SPEC	Providence Medical Group, Sonoma	Sonoma	Certified Nurse Midwife	American Midwifery Certification Board	10/01/2023	Yes	None		
I	Nasir, Dena R., MD	1083272819	SPEC	Providence Medical Group, Sonoma	Sonoma	Colon and Rectal Surgery	None		No	Admitting A	None	
I	Duke, Jessica M., MD	1922539923	SPEC	Providence Medical Group, Sonoma - Cardiology	Sonoma	Cardiovascular Disease	American Board of Internal Medicine	10/28/2025	Yes	Admitting A	None	
I	Samuel, Bishoy T., MD	1659506624	PCP	Providence Medical Group, Sonoma (Internal Medicine)	Sonoma	Addiction Medicine	ABMS of Preventive Medicine	01/01/2025	Yes	Admitting A	None	
I	Duong-Tran, John H., MD	1336132224	SPEC	Rainbow Kids Pediatric Urgent Care	Solano	Pediatrics	ABMS of Pediatrics	10/08/1997	Yes	Admitting A	None	
I	Pham, Nhat M., DO	1043579501	SPEC	Rainbow Kids Pediatric Urgent Care	Solano	Urgent Care	None		No	Sutter Medi	Active	
I	Yimer, Kathy MD	1619223534	SPEC	Rainbow Kids Pediatric Urgent Care	Solano	Urgent Care	None		No	Admitting A	None	
I	Boroff, Stacy CADC I	1508713447	W&R	Recover Medical Group	Solano	CADC I	California Consortium of Addiction Programs Prof	07/08/2024	Yes	None		
I	Correa, Casandra RADT	1417780610	W&R	Recover Medical Group	Solano	Wellness and Recovery	California Consortium of Addiction Programs Prof	09/19/2024	Yes	None		
I	Gonzales, Mark LAADC	1619306289	W&R	Recover Medical Group	Solano	Wellness and Recovery	California Consortium of Addiction Programs Prof	03/12/2018	Yes	None		
I	Martinez, Claudia M., AMFT	1801331293	W&R	Recover Medical Group	Solano	Associate Marriage and Fam	None		No	None		
I	Bever, Travis D., PA-C	1184470551	PCP	Redding Rancheria Tribal Health Center	Shasta	Physician Assistant Certification	National Commission on Certification of Physician	06/16/2025	Yes	None		
I	Valladares, Giselle PA-C	1033955471	PCP	Redwoods Rural Health Center	Humboldt	Physician Assistant Certification	National Commission on Certification of Physician	11/12/2025	Yes	None		

App. Type	Full Name	NPI Number	Provider Typ	Name/Street	County Name	Specialty Description	Board Name	Initial Cert Date	Board Certi	Hospital Ne	Staff Cat	Description
I	Vaden, Kashanae Doula	1023817640	SPEC	Resilient Beginnings Doula Services	Solano	Doula	None		No	None		
I	Knuckles, Sierra Doula	1932935152	SPEC	Rhythmic Birth Journeys	Solano	Doula	None		No	None		
I	Cross, Richard N., MD	1831181494	SPEC	Richard Cross, MD RNC Medical Group Inc	Shasta	Orthopaedic Sports Medicin	Previously Board Certified	11/03/2011	No	Mercy Medi	Courtesy	
I	Ali, Ayesha FNP-C	1831593326	PCP	Rolling Hills Clinic - PCP	Tehama	Family Nurse Practitioner	American Academy of Nurse Practitioners Certifica	12/17/2014	Yes	None		
I	Pettit, Raquella E., Doula	1205701802	SPEC	Rooted Beginnings	Solano	Doula	None		No	None		
I	Malik, Saba A., MD	1962909309	PCP	Round Valley Indian Health Center	Mendocino	Family Medicine	ABMS of Family Medicine	07/01/2021	Yes	Admitting A	Active/Admitting	
I	Han, Carol PA-C	1811609365	PCP	Sacramento Community Clinic	Placer	Physician Assistant Certifier	National Commission on Certification of Physician	07/01/2025	Yes	None		
I	Kikumoto, Lindsey PA-C	1154031797	PCP	Sacramento Community Clinic	Placer	Physician Assistant Certifier	National Commission on Certification of Physician	07/22/2025	Yes	None		
I	Tang, Jack PA-C	1619777901	PCP	Sacramento Community Clinic	Placer	Physician Assistant Certifier	National Commission on Certification of Physician	10/31/2025	Yes	None		
I	Kim, Kisung MD	1073939815	PCP	SCHC: Anderson Family Health Center	Shasta	Pediatrics	ABMS of Pediatrics	10/20/2016	Yes	Admitting A	None	
I	Brar, Ravinder K., MD	1588984058	SPEC	Shriners Hospitals for Children	Yolo	Orthopedic Surgery	ABMS of Orthopaedic Surgery	07/24/2018	Yes	Shriners Hc	Active	
I	Rasmussen, Mary A., MD	1073074290	SPEC	Shriners Hospitals for Children	Yolo	Pediatrics	ABMS of Pediatrics	10/12/2023	Yes	Shriners Hc	Consulting	
I	Regan, Charles E., PA-C	1386609824	SPEC	Shriners Hospitals for Children	Yolo	Physician Assistant Certifier	National Commission on Certification of Physician	09/06/2007	Yes	None		
I	Terte, Megan R., MD	1730534488	SPEC	Shriners Hospitals for Children	Yolo	Orthopedic Surgery	ABMS of Orthopaedic Surgery	07/20/2025	Yes	Shriners Hc	Active	
I	Densmore, John PA-C	1841962198	SPEC	Skin and Cancer Institute - Redding	Shasta	Physician Assistant Certifier	National Commission on Certification of Physician	09/20/2021	Yes	None		
I	Mojica, Martin PT	1255298832	Allied	Solano Sports Physical Therapy	Solano	Physical Therapy	None		No	None		
I	Bowen, Alexander M., AGACNP-BC	1710417696	PCP	Stallant Health and Wellness	Del Norte	Adult Gerontology Acute Ca	American Nurses Credentialing Center	12/02/2018	Yes	None		
I	Alekyan, Daniel DO	1700467834	PCP	Sutter Coast Community Clinic (PCP/SPEC)	Del Norte	Family Medicine	ABMS of Family Medicine	07/01/2024	Yes	Sutter Coas	Provisional Active	
I	Boersma, Ellen M., FNP-BC	1265684633	SPEC	Sutter Lakeside Community Clinic	Lake	Family Nurse Practitioner	American Nurses Credentialing Center	12/06/2008	Yes	None		
I	Sommerfeld, Hailey B., CNM	1104517804	SPEC	Sutter Lakeside Community Clinic	Lake	Certified Nurse Midwife	American Midwifery Certification Board	06/01/2025	Yes	None		
I	Zhang, Fan MD	1619051695	SPEC	Sutter Lakeside Community Clinic	Lake	Medical Oncology	ABMS of Internal Medicine	11/3/2004	Yes	Sutter Lake	Provisional	
I	Hansen, Eric T., MD	1154396570	SPEC	Synergy Surgicalists PC	Nevada	Foot and Ankle Surgery	None		No	Sierra Neva	None	
I	Robbins, Elizabeth MD	1730151689	PCP	Tahoe Forest MultiSpecialty Clinics Pediatric/Primary Care Clinic	Nevada	Pediatrics	ABMS of Pediatrics	11/13/1991	Yes	Tahoe Fore	Provisional Active	
I	Espinoza, Ricardo MD	1205403599	SPEC	Telehealth Specialty Medical Group, PC	Placer	Infectious Disease	None		No	Admitting A	None	
I	Hall, Charles E., Jr., MD	1013917459	SPEC	Telehealth Specialty Medical Group, PC	Placer	Physical Medicine & Rehabil	ABMS of Physical Medicine & Rehabilitation	07/01/1999	Yes	Admitting A	None	
I	Nguyen, Jennifer H., FNP-C	1952922395	SPEC	Telehealth Specialty Medical Group, PC	Placer	Family Nurse Practitioner	American Academy of Nurse Practitioners Certifica	06/01/2020	Yes	None		
I	Porter, Melovee RD	1619862117	Allied	Telehealth Specialty Medical Group, PC	Placer	Registered Dietitian	Commission of Dietetic Registration	09/15/2022	Yes	None		
I	Dyer, Mikalia Doula	1902202401	SPEC	The BEST Place for Moms LLC	Butte	Doula	None		No	None		
I	Guzman, David L., DPM	1740208586	SPEC	The Specialist Foot & Ankle	Napa	Podiatric Medicine & Surgery	None		No	Providence	Active	
I	Ward, Beatrix Doula	1407703648	SPEC	Thrive Mama	Shasta	Doula	None		No	None		
I	Alcazar-Pesante, Lisa G., MD	1801089792	PCP	UIHS - Crescent City Health Center	Del Norte	Pediatrics	Meets MPCR#17, Previously Board Certified in FM,	11/14/1990	No	Admitting A	None	
I	Alvarado, Nicole K., PA	1972472660	SPEC	UIHS - Potawot Health Village	Humboldt	Physician Assistant	None		No	None		
I	Grossman, Margart L., MD	1942352075	PCP	UIHS - Potawot Health Village	Humboldt	Family Medicine	ABMS of Family Medicine	07/10/1987	Yes	Admitting A	None	
I	Cline, Hanh D., PA-C	1538307970	SPEC	Valor Oncology - Chico	Butte	Physician Assistant Certifier	National Commission on Certification of Physician	05/30/2017	Yes	None		
I	Stradley, Donald R., Jr., SUDRC I	1750245296	W&R	Visions of the Cross/Men's Residential Treatment Program	Shasta	Wellness and Recovery	California Substance Use Disorder	12/10/2025	Yes	None		
I	Wilkes, Michael S., MD	1194040063	PCP	WellSpace Health J St Community Health Center	Placer	Internal Medicine	Meets MPCR#17, Previously Board Certified in FM, IM, or PEDs		No	Admitting A	None	
I	Schwirblat, Gianvieve L., FNP-C	1568010312	PCP	West County Health Centers, Inc - Russian River Health and Wel	Sonoma	Family Nurse Practitioner	American Academy of Nurse Practitioners Certifica	06/14/2019	Yes	None		
I	Craig, Benjamin FNP-BC	1356828461	PCP	Western Sierra Medical Clinic (Auburn)	Placer	Family Nurse Practitioner	American Nurses Credentialing Center	07/15/2025	Yes	None		
I	Colvin, Kathleen R., FNP-C	1881555472	PCP	Willow Pediatrics	Glenn	Family Nurse Practitioner	American Academy of Nurse Practitioners Certifica	01/12/2026	Yes	None		
I	Duplantier, Tracy A., PA-C	1023129970	PCP	Winters Healthcare Foundation	Yolo	Physician Assistant Certifier	National Commission on Certification of Physician	12/03/1997	Yes	None		
I	Herman, Michele MD	1588600753	PCP	Winters Healthcare Foundation	Yolo	Internal Medicine	ABMS of Internal Medicine	09/13/1989	Yes	Admitting A	None	
I	Palmer, Sloane AGACNP-BC	1487354957	SPEC	Wound MD PC	Solano	Adult-Gerontology Acute Ca	American Nurses Credentialing Center	10/07/2022	Yes	None		
I	Sachman, Jason L., MD	1417275702	SPEC	Wound MD PC	Solano	Wound Care	None		No	Admitting A	None	

PARTNERSHIP HEALTHPLAN OF CALIFORNIA MEETING SUMMARY

(Confidential – Protected by CA. Evidence Code 1157)

*=by phone conference

Draft

Committee: Credentials Committee
 Date: 6/8/2026 7:00 A.M.
 Members Present: Steven Gwiazdowski, MD; David Gorchoff, MD*; Bradley Sandler, MD* ; Brian Montenegro, MD; Craig Rhoades, PA-C*
 by phone conference*

 PHC Staff: Mark Netherda, MD* Medical Director Quality Improvement; Marshall Kubota, MD*; PHC
 by phone conference* Associate Medical Director; Robert Moore, MD*, MPH, MBA, PHC Chief Medical Officer;
 Jeffery Ribordy, MD* Regional Medical Director; Lisa Ward, MD* Regional Medical Director;
 Matthew Morris, MD* Regional Medical Director; Priscila Ayala, Director of Network Services;
 Danika Ahedo, Supervisor of Credentialing; J’aime Seale, Credentialing Team Lead; Nolan Smith,
 Credentialing Specialist II; Morgan Brambley, Credentialing Specialist I; Amanda Arguello, Lead
 Trainer Network Services

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
I. Meeting called to order.	I. Partnership Credentials Chair Mark Netherda, MD, Medical Director of Quality Improvement called the meeting to order at 7:00AM. Credentials Committee roll call taken by J’aime Seale Credentialing Team Lead. Mark Netherda, MD reminded everyone that all items discussed are confidential.			6/10/2026
a. Voting member reminder.	a. Partnership Mark Netherda, MD reminded The Credentials Committee of who the voting members are, and voting is restricted to non-PHC staff. Mark Netherda, MD reminded the committee that all information discussed is confidential in nature.			6/10/2026
Iia. Review and approval of May 13, 2026 Credentials Meeting Summary.	Iia. The Credentials Committee meeting Summary for May 13, 2026 were reviewed by the Committee.	Iia. May 13, 2026 Summary were reviewed. A motion for approval of the Summary was made. First motion approved by David Gorchoff, MD and the second motion approved by Craig Rhodes, PA-C. May 13, 2026 meeting Summary’ motions approved by committee		6/10/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
Iib. Review and approval of Amended April 08, 2026 Credentials Meeting Summary.	Iib. The Credentials Committee meeting amended Summary for April 08, 2026 were reviewed by the Committee. Dr. Netherda explained the Summary were amended to include the committee vote to include Craig Rhodes as a Credentials Committee member. This vote was approved April 8, 2026. Dr. Netherda advised Craig Rhoades, PA-C they could not vote for this motion. Mr. Rhoades acknowledged.	unanimously with no objections. Iib. Amended April 08, 2026 Summary were reviewed. A motion for approval of the Summary was made. First motion approved by Steven Gwiazdowski, MD and the second motion approved by David Gorchoff, MD. Amended April 08, 2026 meeting Summary' motions approved by committee unanimously with no objections.		6/10/2026
III. Old Business. a. No old business to report.	III. Old Business a. No old business to report.	III. Old Business a. No old business to report.		6/10/2026
IV. New Business a. Review and Approval of Routine Practitioner List. b. MPCR200 Clean/Routine Practitioners and Ancillary Practitioners	IV. New Business a. Mark Netherda, MD referred the Credentials Committee to review the routine list of practitioners. b. Mark Netherda, MD explained to the Credentials Committee the MPCR200 Clean/Routine Practitioners and Ancillary Practitioner list. These practitioners are approved by Dr. Netherda Pre-Credentials	IV. New Business a. The Committee reviewed the Routine Practitioner List. A Motion to approve the Routine Practitioner List was made. First motion approved by Bradley Sandler, MD and the second motion approved by Brian Montenegro, MD. Routine Practitioner List motions approved by committee unanimously with no objections. b. The Credentials Committee reviewed the MPCR200 Clean/Routine list. A motion to approve the MPCR200 Clean/Routine Practitioners and Ancillary Practitioners list was made. First motion approved by Bradley		6/10/2026 6/10/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
c. Review and Approval of Revised Policies.	Committee meeting. c. Review and Approval of Revised Policies presented by Danika Ahedo, Credentialing Supervisor. Danika explained the following policies: • MPCR102 - Provider Directory Accuracy. Changes are consent calendar. • MPCR300 - Physician Credentialing and Re-Credentialing Requirements. Changes are consent calendar. • MPCR302 - Behavioral and Mental Health Practitioner Credentialing and Re-credentialing Requirements. Changes are consent calendar. • MPCR303 - Applied Behavioral Health and Substance Use Disorder Practitioner Credentialing and Re-credentialing Requirements. Changes are consent calendar. • MPCR304 - Allied Health Practitioners Credentialing and Re-credentialing Requirements. Changes are consent calendar. • MPCR500 - Ongoing Monitoring of Sanctions. Changes are NCQA language updates. • MPCR701 - Ancillary Care Services Provider Credentialing and Re-credentialing Requirements. Changes are consent calendar.	Sandler, MD and the second motion approved by Brian Montenegro, MD. MPCR200 Clean/Routine list motions approved by committee unanimously with no objections. c. The Committee reviewed the Revised Policies. A motion to approve the revised policies was made. First motion approved by Steven Gwiazdowski, MD and the second motion approved by Bradley Sandler, MD. Revised Policies motions approved by committee unanimously with no objections		6/10/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
d. Delegated Provider	d. Mark Netherda, MD referred the Credentials Committee to practitioner who is associated with delegated groups. Medical Board of California license alert notified Partnership of the practitioners 3-year probation. The probation was ordered due to an Accusation ordered against the practitioner in conjunction with a domestic violence sentence by the Superior Court of California, County of Los Angeles. The delegated groups were notified by Network Services internal Compliance Team of the probation. Delegated groups' responded the information will be presented to their credentials meeting on 6/19/2026. Dr. Kubota stated, Partnership will continue to monitor the Medical Board of California for any information regarding the practitioner. Dr. Gwiazdowski motioned for approval with monitoring.	d. The Committee reviewed the delegated provider information. A motion to approve with monitoring was made. First motion approved by Steven Gwiazdowski, MD and the second motion approved by David Gorchoff, MD. Delegated provider approval with monitoring was approved by committee unanimously with no objections.		6/10/2026
e. Exception	e. Mark Netherda, MD explained to the Credentials Committee practitioner was initially credentialed with Partnership Healthplan on 11/9/2011. Through several re-credential cycles, the provider was reviewed for malpractice case for alleged wrong diagnosis. The practitioner was dismissed from case. Another malpractice case from 6/15/2022 was listed and filed with the practitioner's insurance company on 10/02/2023. This case was listed directly with a CAQH application, this	e. The Committee reviewed the Exception Provider. A motion to approve re-credentialing with monitoring was made. First motion approved by Brian Montenegro, MD and the second motion approved by Steven Gwiazdowski, MD. Exception Provider motions approved by committee unanimously with no objections.		6/10/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
f. Semi-Annual Evaluation of Practitioner Specific Member Complaints (CR5 Quarterly Report) <i>Information Only</i>	application was not utilized by Partnership HealthPlan until 2024 and was not disclosed during the 4th re-credential cycle for the 6/14/2023 credentials meeting. The 5th re-credential cycle for the 6/10/2026 credentials meeting listed the information for Medical Director review. Dr. Netherda elaborated that no sanctions or impositions made on practicing medicine and recommends approve re-credentialing with monitoring. f. Mark Netherda, MD referred to the Credentials Committee to Semi-Annual Evaluation of Practitioner Specific Member Complaints (CR5 Quarterly Report) for the period of January 1, 2026 through March 31, 2026 (3 months). Summary of Findings: Number of Complaints from Perform Quality Improvement (PQI) is 43. Number of Complaints from Grievance and Appeals (G&A) 28. Per Mark Netherda, MD's review there were a total of 15 practitioners involved with a total of 31 complaints. No trend or significant clinical or service issues were identified. As a result, no further action is needed at this time. <i>Information Only</i>	f. <i>Information Only</i>		6/10/2026
V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.		
a. Review and Approval of	a. Review and Approval of Ongoing Monitoring of Sanctions Report. The Credentials	a. The Credentials Committee members reviewed the report. A motion for approval of		6/10/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
Ongoing Monitoring of Sanctions Report.	Committee was asked to review and approve the Ongoing Monitoring of Sanctions Report.	the Ongoing Monitoring of Sanctions Report was made. First motion approved by Steven Gwiazdowski, MD and the second motion approved by Bradley Sandler, MD. Ongoing Monitoring of Sanctions Report motions approved by committee unanimously with no objections.		
b. Practitioner Monitoring List.	b. The Credentials Committee was asked to review the Practitioner Monitoring list. Mark Netherda, MD reminded the committee that the credentialing department monitors these boards for any actions regarding our providers.	b. <i>Informational only.</i>		6/10/2026
VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.	VI. Review and Approval of Consent Calendar Items.		
a. Report of Long-Term Care Facility, Hospital, and Ancillary provider list.	a. Mark Netherda, MD asked the Credentials Committee members to review the report of Long-Term Care Facility, Hospital, and Ancillary provider list.	a/b. The Credentials Committee members reviewed the list of Consent Calendar items. A motion for approval was made for Report of Long Term Care Facility Hospital and Ancillary provider list and Quarterly Delegation Audits. First motion approved by Bradley Sandler, MD and the second motion approved by David Gorchoff, MD. Consent Calendar items motions approved by committee unanimously with no objections.		6/10/2026
b. Quarterly Delegation Audits	b. Mark Netherda, MD presented the 1 st Quarterly Delegation Audits for: • Carelon Behavioral Health • Dignity Health Medical Group – Sierra Nevada • Mercy Medical Group • Woodland Health Clinic • Dignity Health Medical Group – North State • Zipongo Health Provider Group, PA dba			

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	Foodsmart Nutrition Network • Lucile Packard Children's Hospital • Sutter Medical Group Yolo • SNMG : Sutter North Medial Group • Solano CPN • SIP : Sutter Independent Physicians • SMFAS • Sutter Medical Group SacPlacer • Sutter Medical Group Solano • Sutter East Bay Medical Foundation CPN • Sutter East Bay Medical Foundation Employed • SPMF: Sutter Medical Group of the Redwoods CPN • SPMF: Sutter Medical Group of the Redwoods Employed • SPMF: Sutter West Bay Medical Group CPN • SPMF: Sutter West Bay Medical Group Employed • Palo Alto Medical Foundation CPN • Palo Alto Medical Foundation Employed • University of California Davis Health • University of California San Francisco Medical Group • Vision Service Plan (VSP) Steven Gwiazdowski, MD asked why group Northbay was not listed. Priscila Ayala Director of Network Services explained that Northbay is not a delegated group.			
VII. Meeting	VII. Meeting adjourned.			6/10/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
Adjourned.				

Credentials Meeting Summary for June 10, 2026 respectfully prepared and submitted by J'aime Seale Credentialing Lead.



Chairman Signature of Approval _____

Mark Netherda, MD Credentialing Chairman

Date 6/10/2026

App. Ty	Full Name	NPI Number	Provider Type	Cr Name/Street	County Name	Specialty Description
R	Ahn, Sam S.,MD	1558423814	SPEC	North Bay Allergy & Asthma	Napa	Allergy & Immunology
R	Alattar, May MD	1154523371	SPEC	TeleMed2U	Placer	Endocrinology, Diabetes, & Metabolism
I	Ali, Mir K.,LPCC	1518444058	W&R	Drug Abuse Alternatives Ce	Sonoma	Wellness and Recovery
I	Allen, Daniel B.,MD	1063523819	SPEC	Providence Medical Group, I	Sonoma	Plastic Surgery
I	Alvarez, Amy BCBA	1093379133	BHP	Center for Social Dynamics	Solano	BCBA
I	Anderson, Debra A.,FNP-C	1720882582	PCP	River Bend Medical Associa	Yolo	Family Nurse Practitioner
R	Atluri, Mokshasree DO	1366947772	SPEC	Camellia Women's Health	Yolo	Obstetrics and Gynecology
R	Azare, Collier SUDCC II	1780210575	W&R	Visions of the Cross/ Wome	Shasta	Wellness and Recovery
R	Bacon, Anina D.,PA-C	1952739708	SPEC	Providence Medical Group, I	Sonoma	Physician Assistant Certifie
I	Barton, Morgan L.,PA-C	1801532791	SPEC	Providence Medical Group, I	Sonoma	Physician Assistant Certifie
I	Bartschi, Alexis DO	1568111292	PCP	SCHC: Anderson Family He	Shasta	Family Medicine
I	Bellomo, Kimberly BCBA	1780979872	BHP	Pantogran LLC dba Center	Solano	BCBA
R	Bernstein, Allan L.,MD	1992889067	SPEC	Petaluma Health Center	Sonoma	Neurology
R	Bernstein, Mary E., SUDC	1437499563	W&R	Visions of the Cross/Womer	Shasta	Wellness and Recovery
I	Biddle, Justin T.,AGNP-C	1477383859	SPEC	Marin Cancer Care Inc.	Marin	Adult-Gerontology Primary C
I	Black, Charles DO	1790988087	SPEC	Banner Health Clinic	Lassen	Orthopaedic Surgery
I	Boeing, Samantha BCBA	1497297568	BHP	Center for Social Dynamics	Solano	BCBA
I	Booker, Courtnee Doula	1093348799	SPEC	Loula Perinatal Health Servi	Solano	Doula
I	Boyd, Raleigh E.,PA-C	1740998558	SPEC	Providence Medical Group, I	Humboldt	Physician Assistant Certifie
I	Breck, Jennifer PA-C	1821742735	PCP	River Bend Medical Associa	Yolo	Physician Assistant Certifie
I	Britton, Kristina M.,Doula	1487412938	SPEC	Terra Midwifery	Sonoma	Doula
R	Brockett, Erin BCBA	1851952352	BHP	Maxim Healthcare Services	Placer	Behavioral Health
I	Campbell, Christine N.,SU	1821775578	W&R	Drug Abuse Alternatives Ce	Sonoma	Substance Use Disorder Re
I	Carfi-Zavala, Adrienne E.,	1457200677	PCP	Adventist Health Ukiah Valle	Mendocino	Family Nurse Practitioner
R	Carrasquillo Navarro, Mar	1851751408	PCP	Ampla Health Chico Medica	Butte	Internal Medicine
I	Cartacki, Steven Lac	1487430039	Allied	Pivot Acupuncture & Integra	Solano	Acupuncture
I	Carter, Deborah Psy.D	1518268036	BHP	Jigsaw Diagnostics	Solano	Clinical Psychologist
R	Cheng, Jacklyn M.,MD	1306259098	PCP	Santa Rosa Community Hea	Sonoma	Family Medicine
I	Colavin-Bridges, Gianna C	1548567167	W&R	Drug Abuse Alternatives Ce	Sonoma	Licensed Clinical Social Wo
I	Cosh Davis, Christina DC	1811980493	Allied	SCHC: Shasta Community H	Shasta	Chiropractic
I	Crawford, MarLeesia BCE	1669921102	BHP	Center for Social Dynamics	Solano	BCBA
I	Cronin, Daniel Jr., SUDRC	1750223780	W&R	Visions of the Cross/Men's F	Shasta	Wellness and Recovery
I	Cupp, David MD	1497901565	SPEC	Retinal Consultants Medical	Chico	Ophthalmology
I	Dahman, Abdul LCSW	1073146270	W&R	Recover Medical Group	Solano	Licensed Clinical Social Wo
R	Daileader, Jamey BCBA	1881250587	BHP	Center for Social Dynamics,	Sonoma	BCBA
R	Davidson, Brooke N.,Psy.I	1538568407	SPEC	Jigsaw Diagnostics	Solano	Psychology
I	Dawood, Nayyara S.,MD	1194744391	PCP	Elica Health Centers-Halyan	Yolo	Pediatrics
R	D'Costa, Walter F.,DPM	1548336605	SPEC	D'Costa, Walter Francis, DP	Sonoma	Podiatry
I	Delapena, Marci RADT	1790354892	W&R	Aegis Treatment Centers, LI	Shasta	Wellness and Recovery
R	DeRose, Sonja D.,MD	1558849661	PCP	Blue Stone Health & Wellne	Placer	Family Medicine
R	DeTorres, Charles F.,MD	1770510521	PCP	Sonoma Plaza Pediatrics M	Sonoma	Pediatrics
I	DeWitt, Paula BCBA	1013797281	BHP	Family Behavior Solutions	Butte	BCBA
R	Dickerson, Mary H.,CADC	1801411863	W&R	Visions of the Cross/ Wome	Shasta	Wellness and Recovery
R	Dillon, Melissa T.,SUDCC	1619503752	W&R	Aegis Treatment Centers, LI	Shasta	Wellness and Recovery
I	Donovan, Jennifer T.,FNP	1205587086	PCP	West County Health Center	Sonoma	Family Nurse Practitioner
I	Doolin, Shana r., FNP-BC	1811138712	SPEC	Generations Urgent Care PC	Shasta	Family Nurse Practitioner
I	Dowling, Jacob K.,RD	1700280518	Allied	Northeastern Rural Health C	Lassen	Registered Dietitian
I	Dufour, Martin MD	1578792800	PCP	Harmony Health Medical Cli	Yuba	Family Medicine
I	Fay, Mark T.,MD	1972563781	SPEC	Klamath Eye Center	Siskiyou	Ophthalmology
I	Felix, Dafina BCBA	1679195390	BHP	Center for Social Dynamics	Solano	BCBA
I	Fenstermacher Ritchie, Di	1790443109	SPEC	Open Door Community Heal	Humboldt	Chiropractic
I	Ferguson, Sharonda BCB	1659615896	BHP	BM Behavioral Center, LLC	Solano	BCBA
I	Fernandes, Carlo R.,DO	1477907905	PCP	Canby Family Practice Clinic	Modoc	Family Medicine
R	Fife, Timothy A.,MD	1073747663	SPEC	Sacramento Ear Nose and T	Yolo	Otolaryngology
R	Ford, Megan PA-C	1609281252	SPEC	Napa Valley Orthopaedic M	Napa	Physician Assistant Certifie
I	Fosbre, Jonathan FNP-C	1306203195	SPEC	Providence Medical Group -	Solano	Family Nurse Practitioner
I	French, Alexander CADC	1033689765	W&R	Drug Abuse Alternatives Ce	Sonoma	Wellness and Recovery
I	Fusia, Tod, MD	1043269970	SPEC	TeleMed2U	Placer	Urology
I	Gaffen, Danielle R.,RD	1154905727	SPEC	TeleMed2U	Placer	Registered Dietitian
I	Gaitanis, Alexander DO	1114937844	SPEC	Providence Medical Group, I	Humboldt	Hematology and Oncology
R	Garcia, Lulu PA-C	1730467051	PCP	Ole Health	Solano	Physician Assistant Certifie
I	Garcia, Reyna BCBA	1639770167	BHP	Kadient, LLC	Solano	BCBA
I	Garrett, Audrey P.,MD	1063437127	SPEC	Willamette Valley Cancer In	Solano	Gynecologic Oncology
I	Garza, Krista M.,FNP-C	1881766269	PCP	Kimaw Medical Center	Humboldt	Family Nurse Practitioner
R	Gelfand, Elena V.,MD	1154342343	SPEC	Capital Nephrology Medical	Yolo	Nephrology
R	Ghuman, Tejinder P.,MD	1730110487	PCP	Peach Tree Healthcare	Sutter	Pediatrics
I	Golerkansky, Kaylin Psy.D	1144909821	BHP	Burnett Therapeutic Service	Napa	Clinical Psychologist
I	GRANT, Tunisha D.,Doula	1861343303	SPEC	IN THE FAMILY WAY DOUI	Solano	Doula
I	Green, Anna E.,PA-C	1164303319	PCP	SCHC: Anderson Family He	Shasta	Physician Assistant Certifie
R	Green, Cheryl E.,MD	1578635223	PCP	Santa Rosa Community Hea	Sonoma	Pediatrics
I	Grewal, Rupinder K.,FNP-	1548036478	PCP	Riverside Health Clinic of Cr	Colusa	Family Nurse Practitioner
I	Gutermuth, Clover E.,LM	1316644172	SPEC	West County Health Centers	Sonoma	Licensed Midwife
I	Hall, Taylor L.,OD	1497489579	SPEC	Riverside EyeCare Professio	Shasta	Optometry

App. Ty	Full Name	NPI Number	Provider Type	Cr Name/Street	County Name	Specialty Description
I	Harry, June M.,NP	1104384957	SPEC	Shasta Orthopedics & Sport	Shasta	Nurse Practitioner
I	Hartmann, Emily C.,MD	1922263896	SPEC	Hartmann Plastic Surgery P	Butte	Plastic Surgery
R	Hasday, Steven J.,MD	1881198208	SPEC	Sacramento Ear Nose and T	Yolo	Otolaryngology
R	Hashemi, Ladan P.,FNP-E	1376887935	PCP	Elica Health Centers-Halyar	Yolo	Family Nurse Practitioner
I	Hayes, Margaux BCBA	1316448541	BHP	Kadant, LLC	Solano	Board Certified Behavior An
R	Hensley, Randall D.,DC	1174622575	SPEC	Blue Stone Health & Wellne	Placer	Chiropractic
I	Herrera, Monica E.,Doula	1679416903	SPEC	FOR BIRTH & WELLNESS	Solano	Doula
I	Hicks, Elena M.,PMHNP-	1619431269	SPEC	Clarity Pediatrics Medical Gr	Solano	Psychiatric Mental Health Ni
I	Hines, Jessica S.,CATC II	1841930344	W&R	Drug Abuse Alternatives Ce	Sonoma	Wellness and Recovery
R	Hoyal, Ralph P.,DPM	1265498828	SPEC	Ralph Hoyal, DPM	Sonoma	Podiatry
I	Huang, Denis MD	1699390773	SPEC	Retinal Consultants Medical	Placer	Ophthalmology
I	Hudson, Elena L.,SUDCC	1952174518	W&R	Recover Medical Group	Solano	Wellness and Recovery
I	Ibihiwori, Oghenekevwe B	1841968070	BHP	Burnett Therapeutic Service	Napa	BCBA
I	Iles, Nicole M.,NP	1588526958	PCP	Lassen Medical Clinic - Cott	Shasta	Family Nurse Practitioner
I	Inami, Bona BCBA	1952846081	BHP	Center for Social Dynamics	Solano	BCBA
I	Ivy, Olivia M.,MD	1851693436	PCP	Lyon-Martin Community Hea	Solano	Internal Medicine
R	Jacks, Cody J.,PT	1669148391	SPEC	Western Physical Therapy, I	Shasta	Physical Therapy
R	Jean, Elie MD	1558712182	SPEC	Pulmonary Medicine Associ	Yolo	Pulmonary Diseases
I	Jean, Mary Christine C.,Ft	1902754070	SPEC	Parkhill Health Inc dba AFC	Solano	Family Nurse Practitioner
I	Jehtara, Amreen BCBA	1023586310	BHP	Kadant, LLC	Solano	BCBA
R	Jessup, Barbara A.,SUDC	1952922924	W&R	Visions of the Cross/ Wome	Shasta	Wellness and Recovery
R	Jhaveri, Manan A.,MD	1306285739	SPEC	TeleMed2U	Placer	Gastroenterology
R	Johl, Sumit MD	1245314624	PCP	Peach Tree Healthcare	Sutter	Pediatrics
I	Johnson, Yvonne BCBA	1164706339	BHP	Kadant, LLC	Solano	BCBA
I	Kanomata, Nicole P.,FNP-	1366165102	PCP	Stallant Health and Wellnes	Del Norte	Family Nurse Practitioner
R	Keck, Steven E.,SUDCC	1093348369	W&R	Visions of the Cross/Men's F	Shasta	Wellness and Recovery
I	Keddington, Holly PA-C	1194458794	SPEC	Clarity Pediatrics Medical Gr	Solano	Physician Assistant Certific
I	Kelly, Jacqueline M.,FNP-	1235077694	PCP	Lake County Tribal Health S	Lake	Family Nurse Practitioner
I	Kirsten, Kelli BCBA	1467953513	BHP	Kadant, LLC	Placer	BCBA
I	Kline, Rayna G.,PT	1912941816	Allied	Advantage Physical Therapy	Shasta	Physical Therapy
R	Klingman, Robert R.,MD	1982670667	SPEC	Adventist Health Physicians	Napa	Surgery
I	Krause, Thomas BCBA	1851087225	BHP	Pantogran LLC dba Center	Yolo	BCBA
R	Kuninobu, Andrew T.,MD	1548318538	PCP	Blue Stone Health & Wellne	Placer	Family Medicine
R	Laband, Paul M., MD	1427029040	SPEC	Collabria Care DBA Napa V	Napa	Internal Medicine
R	LaGrange, Joshua L.,CAD	1689362147	W&R	Siskiyou County Behavioral	Siskiyou	Wellness and Recovery
I	Lai, Evelyn J.,PPCNP-BC	1770862237	PCP	Open Door Community Heal	Humboldt	Pediatric Primary Care Nurs
I	Larrazabal Martinez, Luis	1316252893	SPEC	Clarity Pediatrics Medical Gr	Solano	Obesity Management
R	Lieben, Katrina R.,CNM	1669610812	SPEC	Mendocino Community Heal	Mendocino	Certified Nurse Midwife
R	Lim, Jackson M.,DPM	1073594727	SPEC	Peach Tree Clinic - Spec	Yuba	Podiatry
I	Liss, Sarah A.,MD	1962665810	SPEC	Clarity Pediatrics Medical Gr	Solano	Obesity Management
I	Littleton, Kacia J.,SUDRC	1467389387	W&R	Empire Recovery Center	Shasta	Wellness and Recovery
I	Long, Courtney BCBA	1114427382	BHP	Pantogran LLC dba Center	Yolo	BCBA
R	Lucarelli, Tammara SUDC	1417583295	W&R	Visions of the Cross/ Wome	Shasta	Wellness and Recovery
I	Lujano, Patricia RADT	1942927363	W&R	Drug Abuse Alternatives Ce	Sonoma	Wellness and Recovery
I	Maina, Iva BCBA	1073129888	BHP	Montera Health California, L	Yolo	BCBA
I	Mallory, Anna BCBA	1063989556	BHP	Kadant, LLC	Solano	Board Certified Behavior An
I	Manyak, Kari M.,Doula	1043162522	SPEC	Kari Marie Doula	Nevada	Doula
R	Marshall, Michelle L.,SUD	1144853177	W&R	Visions of the Cross/ Wome	Shasta	Wellness and Recovery
R	Martin, Nicole D.,CADC I	1326670332	W&R	Visions of the Cross/ Wome	Shasta	Wellness and Recovery
I	Martinez, Anitta J.,FNP-BC	1932093127	PCP	SCHC: Anderson Family He	Shasta	Family Nurse Practitioner
I	Martinez, Viviana BCBA	1992281588	BHP	Kadant, LLC	Solano	BCBA
I	Matsuka, Anastasiya A.,Ft	1841138484	SPEC	Pacific Skin Institute	Yolo	Family Nurse Practitioner
R	McClain, Albert A.,Jr., MD	1811006786	SPEC	Sutter Coast Community Cli	Del Norte	Otolaryngology
R	McClough, Daniel J.,PA-C	1023220167	PCP	Rolling Hills Clinic - PCP	Tehama	Physician Assistant Certific
I	Medina, Kayla E.,FNP-C	1770054678	SPEC	Providence Medical Group -	Solano	Family Nurse Practitioner
R	Mendez, Ricardo J.,PA-C	1033644174	PCP	Ole Health	Napa	Physician Assistant Certific
I	Migliaccio, Pamela L.,FNP	1689059610	PCP	Northeastern Rural Health C	Lassen	Family Nurse Practitioner
I	Miller, Heather C.,BCBA	1487368767	BHP	ACES	Sonoma	BCBA
I	Miller, Nicole BCBA	1548760283	BHP	Kadant, LLC	Solano	BCBA
I	Millsbaugh, Rio BCBA	1396204855	BHP	Roman Empire ABA Service	Solano	BCBA
R	Mitchell, Dalyn E.,SUDCC	1336782556	W&R	Aegis Treatment Centers, LI	Shasta	Wellness and Recovery
I	Mitsunaga, Anna Y.,PT	1851506547	Allied	Evolve Restorative Center	Sonoma	Physical Therapy
I	Montague, Kelly BCBA	1669915807	BHP	Kadant, LLC	Solano	BCBA
I	Montalvo, Celeste FNP-C	1669363230	PCP	Petaluma Health Center	Sonoma	Family Nurse Practitioner
I	Montenegro, Ivan BCBA	1083251987	BHP	Roman Empire ABA Service	Solano	BCBA
I	Naqvi, Syed E.,MD	1073692117	SPEC	La Clinica	Solano	Internal Medicine
I	Negrete-Zavala, Bruno BC	1558963967	BHP	California Sprout MC 1 LLC	Solano	BCBA
I	Ngo, Richard T.,FNP-C	1083647820	PCP	Elica Health Center	Placer	Family Nurse Practitioner
R	Nguyen, Madeline DO	1316333453	PCP	Peach Tree Healthcare	Sutter	Family Medicine
I	Nguyen, Thai H.,DO	1295361343	SPEC	West Coast Kidney	Solano	Nephrology
R	Norris-Skinner, Charla SU	1780217497	W&R	Visions of the Cross/ Wome	Shasta	Wellness and Recovery
R	Olano, Bozena E.,BCBA	1376044644	BHP	Pantogran LLC dba Center	Solano	Behavioral Health
I	Omega, Nicole BCBA	1750884250	BHP	Kadant, LLC	Solano	BCBA

App. Ty	Full Name	NPI Number	Provider Type	Cr Name/Street	County Name	Specialty Description
R	Orozco, Puja PA-C	1568784635	SPEC	Adventist Health St Helena-I	Napa	Physician Assistant Certified
I	Ortega, Jahzeel BCBA	1801430996	BHP	Roman Empire ABA Service	Solano	BCBA
R	Oryn, Danielle E.,DO	1376535070	PCP	Petaluma Health Center	Sonoma	Family Medicine
I	Osorio, Rabita BCBA	1639730005	BHP	Kadiant, LLC	Solano	BCBA
R	Owens, Trisha M.,SUDCC	1922404599	W&R	Aegis Treatment Centers, LI	Shasta	Wellness and Recovery
R	Packer, Jonathan D.,DO	1316472764	SPEC	Pulmonary Medicine Associ	Yolo	Pulmonary Diseases
R	Palmbaum, Glenn D.,PA-C	1619030970	PCP	Peach Tree Healthcare	Sutter	Physician Assistant Certified
I	Papp, Alexandra M.,MD	1225497563	SPEC	Eye Care Center of Napa V	Napa	Ophthalmology
I	Patton, Tamia S., LVN	1336958164	W&R	MedMark Treatment Center	Solano	Licensed Vocational Nurse
R	Pearlman, Joel A.,MD	1154430460	SPEC	Retinal Consultants Medical	Yolo	Ophthalmology
I	Perez, Rolando BCBA	1447902465	BHP	Growing Minds Behavioral S	Solano	BCBA
R	Perlman, Jonathan P.,MD	1972510477	SPEC	Perlman Center for Eye and	Yolo	Ophthalmology
R	Pham, Xuan T.,MD	1649621335	SPEC	Camellia Women's Health	Placer	Obstetrics and Gynecology
R	Piersol, Patricia E.,CNM	1265400824	PCP	Alliance Medical Center	Sonoma	Certified Nurse Midwife
R	Pitcher, Chad R.,DO	1992266100	PCP	Redding Rancheria: Churn C	Shasta	Family Medicine
R	Pitzen, Roger J.,MD	1396742524	PCP	Roger Pitzen, M.D.	Sonoma	Family Medicine
I	Pool, Amber BCBA	1003151465	BHP	Kadiant, LLC	Solano	BCBA
R	Powers, Matthew A.,MD	1295152379	SPEC	Matthew A. Powers, MD MB	Sonoma	Ophthalmology
I	Poyser, Samantha BCBA	1609752260	BHP	Kadiant, LLC	Solano	Board Certified Behavior An
I	Preciado, Erika BCBA	1285199885	BHP	Roman Empire ABA Service	Solano	BCBA
I	Printy, Tatum BCBA	1184266116	BHP	Kadiant, LLC	Solano	BCBA
I	Punsalan, Alicia H.,FNP-B	1104307958	SPEC	Adventist Health Physicians	Sutter	Family Nurse Practitioner
I	Quiambao, Stephanie Gra	1477029692	BHP	Kadiant, LLC	Solano	BCBA
R	Quinn, Rindi SUDCC	1770116709	W&R	Visions of the Cross/ Wome	Shasta	Wellness and Recovery
I	Ragasa, Meleah BCBA	1578033999	BHP	Kadiant, LLC	Solano	BCBA
I	Ramirez, Karla BCBA	1285309088	BHP	Kyo Autism Therapy LLC, fk	Marin	BCBA
R	Rehman, Shahid U.,MD	1104084458	SPEC	NBHG: Center for Neurosci	Solano	Neurology
I	Reich, Savanah L.,FNP-C	1831075191	BOTH	SCHC: Anderson Family He	Shasta	Family Nurse Practitioner
I	Remily, Amberlie BCBA	1902427206	BHP	Roman Empire ABA Service	Solano	BCBA
I	Rewick, Kristen J.,PMHNF	1770039828	SPEC	Clarity Pediatrics Medical Gi	Solano	Psychiatric Mental Health Ni
I	Rhys, Aesara Doula	1295575215	SPEC	Serene Harmony Doula Con	Placer	Doula
I	Riccomini, Monica M.,FNP	1750524914	PCP	Willow Pediatrics	Glenn	Family Nurse Practitioner
I	Rice, Ashley M.,FNP-C	1902322894	PCP	Open Door Community Heal	Humboldt	Family Nurse Practitioner
I	Romero, Sophia S.,RD	1679381370	Allied	SCHC: Shasta Community I	Shasta	Registered Dietitian
I	Romo, Fernie BCBA	1215518873	BHP	Roman Empire ABA Service	Solano	BCBA
R	Rubio, Nadia BCBA	1437507191	BHP	Center for Social Dynamics	Solano	Behavioral Health
I	Russell, Celena SUDRC II	1881331460	W&R	Drug Abuse Alternatives Ce	Sonoma	Wellness and Recovery
I	Sabalza, Maritza BCBA	1083151773	BHP	Burnett Therapeutic Service	Napa	BCBA
I	Safont, Jose L., SUDRC II	1003151531	W&R	Drug Abuse Alternatives Ce	Sonoma	Wellness and Recovery
R	Samaniago, Pedro IV, DC	1528418472	SPEC	Alliance Medical Center	Sonoma	Chiropractic
R	Samuel, Georgina A.,PA-C	1427296292	PCP	OLE Health	Solano	Physician Assistant Certific
I	San Jose, Michelle BCBA	1508107780	BHP	Kadiant, LLC	Solano	BCBA
I	Sanchez, Felix BCBA	1740866433	BHP	Kadiant, LLC	Solano	BCBA
R	Schleben, Roxanne P.,FN	1982214870	PCP	Santa Rosa Community He	Sonoma	Family Nurse Practitioner
I	Schneeweis, Kristen M.,P	1871393199	BOTH	SCHC: Anderson Family He	Shasta	Physician Assistant Certified
R	Schrock, Alisha F.,PT	1144769688	Allied	NBHG: Northbay Rehab Ser	Solano	Physical Therapy
R	Schwartz, Stephen D.,MD	1326154352	SPEC	Redwood Family Dermatolo	Sonoma	Dermatology
I	Shan, Elaine Y.,MD	1053767434	PCP	Elica Health Centers - Marys	Placer	Pediatrics
R	Sianghio, Kathleen R.,FNP	1326506775	SPEC	Communicare OLE Travis	Solano	Family Nurse Practitioner
R	Simmons, Eryn P.,DO	1134570211	SPEC	Generations Urgent Care PC	Shasta	Pediatrics
I	Simmons, Robert BCBA	1245890565	BHP	Roman Empire ABA Service	Solano	BCBA
I	Skotzko, Christine E.,MD	1336227669	W&R	County of Humboldt - Health	Humboldt	Psychiatry
I	Smith, Tanya PA-C	1053600346	PCP	SCHC: Anderson Family He	Shasta	Physician Assistant Certified
I	Starnes, Benjamin M.,MD	1548345283	SPEC	Clarity Pediatrics Medical Gi	Solano	Obesity Management
I	Stevens, Scott K.,MD	1306055413	SPEC	Klamath Eye Center	Siskiyou	Ophthalmology
I	Stone, Valerie FNP-C	1740834019	PCP	West County Health Centers	Sonoma	Family Nurse Practitioner
I	Streitfeld, Samantha Doula	1629949334	SPEC	Loula Perinatal Health Servi	Solano	Doula
I	Tabura, Jody A.,RD	1851969885	Allied	Grassroots Health	Solano	Registered Dietitian
R	Tagle, Amanda G.,MD	1457367179	PCP	Peach Tree Healthcare	Sutter	Pediatric Medicine
I	Tahan, Veysel MD	1700155231	SPEC	Providence Medical Group, I	Humboldt	Gastroenterology
I	Tam, Eric MD	1932629201	SPEC	TeleMed2U	Placer	Physical Medicine & Rehabi
R	Tang, Karen FNP	1013493279	PCP	Peach Tree Healthcare	Sutter	Family Nurse Practitioner
R	Tanzo, Theresa L.,SUDCC	1538558010	W&R	Cache Creek Lodge Inc	Yolo	Wellness and Recovery
R	Tavernetti, Jennifer R.,MD	1538549373	SPEC	Pacific Skin Institute	Sacramento	Dermatology
I	Taylor, Nathaniel BCaBa	1710465596	BHP	Roman Empire ABA Service	Solano	BCBA
I	Theis, Morgan K.,MD	1124361258	PCP	Sonoma Valley Community	Sonoma	Family Medicine
I	Thomas, Jacob BCBA	1639672876	BHP	Kadiant, LLC	Solano	BCBA
I	Topp, Kathryn A., LVN	1548070733	W&R	Drug Abuse Alternatives Ce	Sonoma	Wellness and Recovery
I	Torrez, Cassandra BCBA	1821589086	BHP	Roman Empire ABA Service	Solano	Board Certified Behavior An
I	Van Der Linde, Mone PA-C	1770317703	BOTH	SCHC: Anderson Family He	Shasta	Physician Assistant Certified
R	Villalon, Rachel M.,MD	1083842843	SPEC	NBHG: Center for Pain Man	Solano	Obstetrics and Gynecology
I	Villani, Amanda E.,FNP-C	1386028363	SPEC	Urogynecology Consultants	Placer	Family Nurse Practitioner
I	Waldo, Stephanie BCBA	1215434238	BHP	Kadiant, LLC	Solano	Board Certified Behavior An

App. Ty	Full Name	NPI Number	Provider Type	Cr Name/Street	County Name	Specialty Description
I	Warriach, Ali BCBA	1417577958	BHP	Kadiant, LLC	Solano	BCBA
I	Weinberg, Elizabeth FNP-	1043645013	SPEC	Shasta Orthopedics & Sport	Shasta	Family Nurse Practitioner
R	Wenerstrom, David T.,Sr.	1154955458	W&R	Visions of the Cross/Men's F	Shasta	Wellness and Recovery
R	Wenerstrom, Sandra SUD	1073146593	W&R	Visions of the Cross/Men's F	Shasta	Wellness and Recovery
I	Williams, Kya Doula	1164359345	SPEC	Kya Williams	Mendocino	Doula
R	Williams, Marnie BCBA	1497368104	BHP	Behavior Resources	Yolo	Board Certified Behavior An
R	Wilson, Dewight E.,SUDC	1699221945	W&R	Bi-Bett Corporation Southern	Solano	Wellness and Recovery
I	Wilson, Fiona J.,SUDRC	1750225827	W&R	Aegis Treatment Center LLC	Humboldt	Wellness and Recovery
R	Wong, Reynold C.,MD	1962581694	SPEC	Direct Dermatology Professi	Solano	Dermatology
I	Wyard, Sarah FNP-C	1548746928	PCP	SCHC: Anderson Family He	Shasta	Family Nurse Practitioner
R	Xiong, Lee P.,FNP-C	1407589575	PCP	Peach Tree Healthcare	Sutter	Family Nurse Practitioner
R	Young, Christian C.,FNP-C	1154659431	PCP	Hayfork Community Clinic	Trinity	Family Nurse Practitioner
I	Zane, Linda J.,FNP-C	1770906067	BOTH	SCHC: Anderson Family He	Shasta	Family Nurse Practitioner
I	Zarco Ramos, Miguel BCE	1790391340	BHP	Kadiant, LLC	Placer	Board Certified Behavior An

App. Ty	Full Name	NPI Number	Board Name	Initial	Cert Date	Board Certified	Hospital Name
R	Ahn, Sam S.,MD	1558423814	ABMS of Allergy and Immun		10/08/2010	Yes	Queen of the Valley
R	Alattar, May MD	1154523371	ABMS of Endocrinology, Dia		10/04/2011	Yes	Admitting Agreement
I	Ali, Mir K.,LPCC	1518444058	None			No	None
I	Allen, Daniel B.,MD	1063523819	ABMS of Plastic Surgery		09/09/2000	Yes	Admitting Agreement
I	Alvarez, Amy BCBA	1093379133	Behavior Analyst Certificatio		01/08/2026	Yes	None
I	Anderson, Debra A.,FNP-C	1720882582	American Academy of Nurse		12/30/2025	Yes	None
R	Atluri, Mokshasree DO	1366947772	ABMS of Obstetrics and Gyn		11/14/2025	Yes	Mercy San Juan Medical Ce
R	Azare, Collier SUDCC II	1780210575	California Substance Use Di		06/29/2025	Yes	None
R	Bacon, Anina D.,PA-C	1952739708	National Commission on Ce		06/27/2013	Yes	None
I	Barton, Morgan L.,PA-C	1801532791	National Commission on Ce		05/10/2022	Yes	None
I	Bartschi, Alexis DO	1568111292	ABMS of Family Medicine		07/01/2025	Yes	Admitting Agreement
I	Bellomo, Kimberly BCBA	1780979872	Behavior Analyst Certificatio		02/29/2016	Yes	None
R	Bernstein, Allan L.,MD	1992889067	ABMS of Psychiatry & Neurc		04/30/1976	Yes	Healdsburg Hospital
R	Bernstein, Mary E., SUDC	1437499563	California Substance Use Di		07/14/2025	Yes	None
I	Biddle, Justin T.,AGNP-C	1477383859	American Academy of Nurse		08/01/2024	Yes	None
I	Black, Charles DO	1790988087	Confirmed per AMA, AOA, &			No	Banner Lassen Medical Cen
I	Boeving, Samantha BCBA	1497297568	Behavior Analyst Certificatio		02/14/2025	Yes	None
I	Booker, Courtnee Doula	1093348799	None			Not Applicable	None
I	Boyd, Raleigh E.,PA-C	1740998558	National Commission on Ce		01/24/2023	Yes	None
I	Breck, Jennifer PA-C	1821742735	National Commission on Ce		11/07/2022	Yes	None
I	Britton, Kristina M.,Doula	1487412938	None			No	None
R	Brockett, Erin BCBA	1851952352	Behavior Analyst Certificatio		02/28/2019	Yes	None
I	Campbell, Christine N.,SU	1821775578	California Substance Use Di		08/03/2025	Yes	None
I	Carfi-Zavala, Adrienne E.,	1457200677	American Nurses Credential		08/28/2025	Yes	None
R	Carrasquillo Navarro, Mar	1851751408	ABMS of Internal Medicine		08/27/2018	Yes	Admitting Agreement
I	Cartacki, Steven Lac	1487430039	None			No	None
I	Carter, Deborah Psy.D	1518268036	None			No	None
R	Cheng, Jacklyn M.,MD	1306259098	ABMS of Family Medicine		07/01/2018	Yes	Sutter Santa Rosa Regional
I	Colavin-Bridges, Gianna C	1548567167	None			No	None
I	Cosh Davis, Christina DC	1811980493	None			No	None
I	Crawford, MarLeesia BCE	1669921102	Behavior Analyst Certificatio		02/27/2020	Yes	None
I	Cronin, Daniel Jr., SUDRC	1750223780	California Substance Use Di		04/24/2026	Yes	None
I	Cupp, David MD	1497901565	ABMS of Ophthalmology		06/08/2014	Yes	Mercy General Hospital of S
I	Dahman, Abdul LCSW	1073146270	None			No	None
R	Daileader, Jamey BCBA	1881250587	Behavior Analyst Certificatio		08/14/2021	Yes	None
R	Davidson, Brooke N.,Psy.I	1538568407	None			No	None
I	Dawood, Nayyara S.,MD	1194744391	ABMS of Pediatrics		10/19/1999	Yes	Admitting Agreement
R	D'Costa, Walter F.,DPM	1548336605	None			No	Sutter Santa Rosa Regional
I	Delapena, Marci RADT	1790354892	California Consortium of Ad		06/25/2021	Yes	None
R	DeRose, Sonja D.,MD	1558849661	Meets MPCR#17, Previous		07/10/1992	No	Admitting Agreement
R	DeTorres, Charles F.,MD	1770510521	Meets MPCR #17, Verified			No	Sonoma Valley Hospital
I	DeWitt, Paula BCBA	1013797281	Behavior Analyst Certificatio		10/04/2025	Yes	None
R	Dickerson, Mary H.,CADC	1801411863	California Consortium of Ad		12/03/2002	Yes	None
R	Dillon, Melissa T.,SUDCC	1619503752	California Substance Use Di		08/14/2026	Yes	None
I	Donovan, Jennifer T.,FNP	1205587086	American Academy of Nurse		01/06/2022	Yes	None
I	Doolin, Shana r., FNP-BC	1811138712	American Nurses Credential		11/05/2005	Yes	None
I	Dowling, Jacob K.,RD	1700280518	Commission of Dietetic Reg		07/18/2014	Yes	None
I	Dufour, Martin MD	1578792800	ABMS of Family Medicine		07/12/2010	Yes	Admitting Agreement
I	Fay, Mark T.,MD	1972563781	ABMS of Ophthalmology		11/18/1990	Yes	Admitting Agreement
I	Felix, Dafina BCBA	1679195390	Behavior Analyst Certificatio		09/16/2025	Yes	None
I	Fenstermacher Ritchie, Di	1790443109	None			No	None
I	Ferguson, Sharonda BCB	1659615896	Behavior Analyst Certificatio		09/30/2012	Yes	None
I	Fernandes, Carlo R.,DO	1477907905	ABMS of Family Medicine		11/12/2019	Yes	None
R	Fife, Timothy A.,MD	1073747663	ABMS of Otolaryngology - He		06/01/2015	Yes	Sutter Roseville Medical Ce
R	Ford, Megan PA-C	1609281252	National Commission on Ce		06/19/2014	Yes	None
I	Fosbre, Jonathan FNP-C	1306203195	American Academy of Nurse		01/20/2016	Yes	None
I	French, Alexander CADC	1033689765	California Consortium of Ad		04/10/2023	Yes	None
I	Fusia, Tod, MD	1043269970	ABMS of Urology			Yes	Admitting Agreement
I	Gaffen, Danielle R.,RD	1154905727	Commission of Dietetic Reg		11/13/2020	No	None
I	Gaitanis, Alexander DO	1114937844	None			No	Admitting Agreement
R	Garcia, Lulu PA-C	1730467051	National Commission on Ce		07/14/2011	Yes	None
I	Garcia, Reyna BCBA	1639770167	Behavior Analyst Certificatio		10/28/2025	Yes	None
I	Garrett, Audrey P.,MD	1063437127	ABMS of Obstetrics and Gyn		04/21/2004	Yes	Admitting Agreement
I	Garza, Krista M.,FNP-C	1881766269	American Academy of Nurse		12/01/2008	Yes	None
R	Gelfand, Elena V.,MD	1154342343	ABMS of Internal Medicine		11/07/2001	Yes	Sutter Medical Center Sacra
R	Ghuman, Tejinder P.,MD	1730110487	ABMS of Pediatrics		03/29/1987	Yes	Admitting Agreement
I	Golerkansky, Kaylin Psy.D	1144909821	None			No	None
I	GRANT, Tunisha D.,Doula	1861343303	None			Not Applicable	None
I	Green, Anna E.,PA-C	1164303319	National Commission on Ce		04/30/2020	Yes	None
R	Green, Cheryl E.,MD	1578635223	ABMS of Pediatrics		10/15/2002	Yes	Sutter Santa Rosa Regional
I	Grewal, Rupinder K.,FNP-	1548036478	American Academy of Nurse		09/25/2023	Yes	None
I	Gutermuth, Clover E.,LM	1316644172	None			No	None
I	Hall, Taylor L.,OD	1497489579	None			No	Admitting Agreement

App. Ty	Full Name	NPI Number	Board Name	Initial Cert Date	Board Certified	Hospital Name
I	Harry, June M.,NP	1104384957	None		No	None
I	Hartmann, Emily C.,MD	1922263896	ABMS of Plastic Surgery	11/12/2016	Yes	Enloe Medical Center
R	Hasday, Steven J.,MD	1881198208	ABMS of Otolaryngology-He	11/01/2025	Yes	Mercy General Hospital of S
R	Hashemi, Ladan P.,FNP-E	1376887935	American Nurses Credential	12/15/2012	Yes	None
I	Hayes, Margaux BCBA	1316448541	Behavior Analyst Certificatio	01/04/2024	Yes	None
R	Hensley, Randall D.,DC	1174622575	None		No	None
I	Herrera, Monica E.,Doula	1679416903	None		Not Applicable	None
I	Hicks, Elena M.,PMHNP-	1619431269	American Nurses Credential	11/16/2018	Yes	None
I	Hines, Jessica S.,CATC II	1841930344	Addiction Counselor Certific	07/13/2024	Yes	None
R	Hoyal, Ralph P.,DPM	1265498828	None		No	Admitting Agreement
I	Huang, Denis MD	1699390773	ABMS of Ophthalmology	05/02/2025	Yes	Admitting Agreement
I	Hudson, Elena L.,SUDCC	1952174518	California Substance Use Di	06/01/2025	Yes	None
I	Ibihiwiori, Oghenekevwe B	1841968070	Behavior Analyst Certificatio	04/01/2023	Yes	None
I	Iles, Nicole M.,NP	1588526958	None		No	None
I	Inami, Bona BCBA	1952846081	Behavior Analyst Certificatio	12/02/2021	Yes	None
I	Ivy, Olivia M.,MD	1851693436	None		No	Admitting Agreement
R	Jacks, Cody J.,PT	1669148391	None		Not Applicable	None
R	Jean, Elie MD	1558712182	ABMS of Internal Medicine	11/29/2022	Yes	Sutter Roseville Medical Cer
I	Jean, Mary Christine C.,FI	1902754070	American Nurses Credential	01/08/2026	Yes	None
I	Jehtara, Amreen BCBA	1023586310	Behavior Analyst Certificatio	08/31/2019	Yes	None
R	Jessup, Barbara A.,SUDC	1952922924	California Substance Use Di	11/18/2024	Yes	None
R	Jhaveri, Manan A.,MD	1306285739	ABMS of Internal Medicine	11/06/2023	Yes	Admitting Agreement
R	Johl, Sumit MD	1245314624	Meets MPCR#17, Previous	11/13/1991	No	Admitting Agreement
I	Johnson, Yvonne BCBA	1164706339	Behavior Analyst Certificatio	01/31/2011	Yes	None
I	Kanomata, Nicole P.,FNP-	1366165102	American Academy of Nurs	10/06/2022	Yes	None
R	Keck, Steven E.,SUDCC	1093348369	California Substance Use Di	12/02/2025	Yes	None
I	Keddington, Holly PA-C	1194458794	National Commission on Ce	06/11/2024	Yes	None
I	Kelly, Jacqueline M.,FNP-	1235077694	American Academy of Nurs	02/02/2026		None
I	Kirsten, Kelli BCBA	1467953513	Behavior Analyst Certificatio	04/19/2023	Yes	None
I	Kline, Rayna G.,PT	1912941816	None		No	None
R	Klingman, Robert R.,MD	1982670667	ABMS of Surgery	11/05/1990	No	NorthBay Medical Center/ N
I	Krause, Thomas BCBA	1851087225	Behavior Analyst Certificatio	02/28/2026	Yes	None
R	Kuninobu, Andrew T.,MD	1548318538	ABMS of Family Medicine	07/14/1995	Yes	Admitting Agreement
R	Laband, Paul M., MD	1427029040	ABMS of Internal Medicine	08/21/1996	Yes	Queen of the Valley
R	LaGrange, Joshua L.,CAD	1689362147	California Consortium of Ad	09/09/2024	Yes	None
I	Lai, Evelyn J.,PPCNP-BC	1770862237	American Nurses Credential	07/03/2021	Yes	None
I	Larrazabal Martinez, Luis	1316252893	None		No	Admitting Agreement
R	Lieben, Katrina R.,CNM	1669610812	American Midwifery Certifica	12/01/2008	Yes	None
R	Lim, Jackson M.,DPM	1073594727	Previously Board Certified	07/28/1999	No	Admitting Agreement
I	Liss, Sarah A.,MD	1962665810	None		No	Admitting Agreement
I	Littleton, Kacia J.,SUDRC	1467389387	California Substance Use Di	11/25/2025	Yes	None
I	Long, Courtney BCBA	1114427382	Behavior Analyst Certificatio	06/01/2022		None
R	Lucarelli, Tammara SUDC	1417583295	California Substance Use Di	06/06/2025	Yes	None
I	Lujano, Patricia RADT	1942927363	California Consortium of Ad	01/09/2025	Yes	None
I	Maina, Iva BCBA	1073129888	Behavior Analyst Certificatio	10/14/2024	Yes	None
I	Mallory, Anna BCBA	1063989556	Behavior Analyst Certificatio	01/23/2025	Yes	None
I	Manyak, Kari M.,Doula	1043162522	None		No	None
R	Marshall, Michelle L.,SUD	1144853177	California Substance Use Di	04/11/2026	Yes	None
R	Martin, Nicole D.,CADC I	1326670332	California Consortium of Ad	11/30/2020	Yes	None
I	Martinez, Anitta J.,FNP-BC	1932093127	American Nurses Credential	08/28/2025	Yes	None
I	Martinez, Viviana BCBA	1992281588	Behavior Analyst Certificatio	10/17/2025	Yes	None
I	Matsuka, Anastasiya A.,FI	1841138484	American Nurses Credential	02/09/2026	Yes	None
R	McClain, Albert A.,Jr., MD	1811006786	ABMS of Otolaryngology - He	05/09/1995	Yes	Sutter Coast Hospital
R	McClough, Daniel J.,PA-C	1023220167	National Commission on Ce	01/18/2008	Yes	None
I	Medina, Kayla E.,FNP-C	1770054678	American Academy of Nurs	08/20/2018	Yes	None
R	Mendez, Ricardo J.,PA-C	1033644174	National Commission on Ce	02/16/2017	Yes	None
I	Migliaccio, Pamela L.,FNP	1689059610	American Academy of Nurs	06/17/2015	Yes	None
I	Miller, Heather C.,BCBA	1487368767	Behavior Analyst Certificatio	12/23/2022	Yes	None
I	Miller, Nicole BCBA	1548760283	Behavior Analyst Certificatio	05/31/2015	Yes	None
I	Millsbaugh, Rio BCBA	1396204855	Behavior Analyst Certificatio	05/21/2024	Yes	None
R	Mitchell, Dalyn E.,SUDCC	1336782556	California Substance Use Di	08/26/2025	Yes	None
I	Mitsunaga, Anna Y.,PT	1851506547	None		No	None
I	Montague, Kelly BCBA	1669915807	Behavior Analyst Certificatio	01/31/2011	Yes	None
I	Montalvo, Celeste FNP-C	1669363230	American Academy of Nurs	04/25/2025	Yes	None
I	Montenegro, Ivan BCBA	1083251987	Behavior Analyst Certificatio	09/07/2021	Yes	None
I	Naqvi, Syed E.,MD	1073692117	ABMS of Internal Medicine	09/13/1989	Yes	Admitting Agreement
I	Negrete-Zavala, Bruno BC	1558963967	Behavior Analyst Certificatio	04/27/2023	Yes	None
I	Ngo, Richard T.,FNP-C	1083647820	American Academy of Nurs	01/16/2013	Yes	None
R	Nguyen, Madeline DO	1316333453	ABMS of Family Medicine	07/01/2018	Yes	Admitting Agreement
I	Nguyen, Thai H.,DO	1295361343	None		No	Admitting Agreement
R	Norris-Skinner, Charla SU	1780217497	California Substance Use Di	04/01/2026	Yes	None
R	Olano, Bozena E.,BCBA	1376044644	Behavior Analyst Certificatio	08/22/2022	Yes	None
I	Omega, Nicole BCBA	1750884250	Behavior Analyst Certificatio	12/20/2024	Yes	None

App. Ty	Full Name	NPI Number	Board Name	Initial Cert Date	Board Certified	Hospital Name
R	Orozco, Puja PA-C	1568784635	National Commission on Ce	10/22/2009	Yes	None
I	Ortega, Jahzeel BCBA	1801430996	Behavior Analyst Certificatio	10/30/2025	Yes	None
R	Oryn, Danielle E.,DO	1376535070	ABMS of Family Medicine	04/19/2013	Yes	Petaluma Valley Hospital
I	Osorio, Rabita BCBA	1639730005	Behavior Analyst Certificatio	05/29/2021	Yes	None
R	Owens, Trisha M.,SUDCC	1922404599	California Substance Use Di	09/19/2024	Yes	None
R	Packer, Jonathan D.,DO	1316472764	ABMS of Internal Medicine	11/29/2022	Yes	Sutter Santa Rosa Regional
R	Palmbaum, Glenn D.,PA-C	1619030970	National Commission on Ce	11/09/2000	Yes	None
I	Papp, Alexandra M.,MD	1225497563	ABMS of Ophthalmology	06/08/2024	Yes	Admitting Agreement
I	Patton, Tamia S., LVN	1336958164	None		No	None
R	Pearlman, Joel A.,MD	1154430460	ABMS of Ophthalmology	05/13/2001	Yes	Mercy General Hospital of S
I	Perez, Rolando BCBA	1447902465	Behavior Analyst Certificatio	01/05/2026	Yes	None
R	Perlman, Jonathan P.,MD	1972510477	ABMS of Ophthalmology	11/24/1991	Yes	Sutter Davis Hospital
R	Pham, Xuan T.,MD	1649621335	ABMS of Obstetrics and Gyr	11/18/2022	Yes	Mercy San Juan Medical Ce
R	Piersol, Patricia E.,CNM	1265400824	American Midwifery Certificc	07/01/1993	Yes	None
R	Pitcher, Chad R.,DO	1992266100	ABMS of Family Medicine	07/02/2022	Yes	Mercy Medical Center of Rei
R	Pitzen, Roger J.,MD	1396742524	ABMS of Family Medicine	07/11/1980	Yes	Santa Rosa Memorial Hospi
I	Pool, Amber BCBA	1003151465	Behavior Analyst Certificatio	01/31/2012	Yes	None
R	Powers, Matthew A.,MD	1295152379	ABMS of Ophthalmology	09/21/2019	Yes	Sutter Santa Rosa Regional
I	Poyser, Samantha BCBA	1609752260	Behavior Analyst Certificatio	07/20/2022	Yes	None
I	Preciado, Erika BCBA	1285199885	Behavior Analyst Certificatio	11/07/2025	Yes	None
I	Printy, Tatum BCBA	1184266116	Behavior Analyst Certificatio	03/25/2022	Yes	None
I	Punsalan, Alicia H.,FNP-B	1104307958	American Nurses Credential	09/01/2018	Yes	None
I	Quiambao, Stephanie Gra	1477029692	Behavior Analyst Certificatio	02/23/2021	Yes	None
R	Quinn, Rindi SUDCC	1770116709	California Substance Use Di	02/04/2025	Yes	None
I	Ragasa, Meleah BCBA	1578033999	Behavior Analyst Certificatio	06/03/2021	Yes	None
I	Ramirez, Karla BCBA	1285309088	Behavior Analyst Certificatio	04/07/2026	Yes	None
R	Rehman, Shahid U.,MD	1104084458	ABMS of Psychiatry & Neur	09/20/2012	Yes	NorthBay Medical Center/ N
I	Reich, Savanah L.,FNP-C	1831075191	American Academy of Nurse	08/15/2025	Yes	None
I	Remily, Amberlie BCBA	1902427206	Behavior Analyst Certificatio	04/17/2023	Yes	None
I	Rewick, Kristen J.,PMHNF	1770039828	American Nurses Credential	05/30/2022	Yes	None
I	Rhys, Aesara Doula	1295575215	None		Not Applicable	None
I	Riccomini, Monica M.,FNF	1750524914	American Nurses Credential	08/11/2007	Yes	None
I	Rice, Ashley M.,FNP-C	1902322894	American Academy of Nurse	07/05/2017	Yes	None
I	Romero, Sophia S.,RD	1679381370	Commission of Dietetic Reg	11/20/2024	Yes	None
I	Romo, Fernie BCBA	1215518873	Behavior Analyst Certificatio	09/17/2024	Yes	None
R	Rubio, Nadia BCBA	1437507191	Behavior Analyst Certificatio	04/23/2022	Yes	None
I	Russell, Celena SUDRC II	1881331460	California Substance Use Di	03/28/2026	Yes	None
I	Sabalza, Maritza BCBA	1083151773	Behavior Analyst Certificatio	04/14/2023	Yes	None
I	Safont, Jose L., SUDRC II	1003151531	California Substance Use Di	12/20/2025	Yes	None
R	Samaniego, Pedro IV, DC	1528418472	None		No	None
R	Samuel, Georgina A.,PA-C	1427296292	National Commission on Ce	12/11/2008	Yes	None
I	San Jose, Michelle BCBA	1508107780	Behavior Analyst Certificatio	01/31/2012	Yes	None
I	Sanchez, Felix BCBA	1740866433	Behavior Analyst Certificatio	10/06/2021	Yes	None
R	Schleben, Roxanne P.,FN	1982214870	American Nurses Credential	06/25/2020	Yes	None
I	Schneeweis, Kristen M.,P	1871393199	National Commission on Ce	06/04/2025	Yes	None
R	Schrock, Alisha F.,PT	1144769688	None		No	None
R	Schwartz, Stephen D.,MD	1326154352	ABMS of Dermatology	09/14/1975	Yes	Admitting Agreement
I	Shan, Elaine Y.,MD	1053767434	ABMS of Pediatrics	10/18/2019	Yes	Admitting Agreement
R	Siangghio, Kathleen R.,FNF	1326506775	American Academy of Nurse	06/15/2018	Yes	None
R	Simmons, Eryn P.,DO	1134570211	ABMS of Pediatrics	10/18/2019	Yes	Admitting Agreement
I	Simmons, Robert BCBA	1245890565	Behavior Analyst Certificatio	02/28/2019	Yes	None
I	Skotzko, Christine E.,MD	1336227669	ABMS of Psychiatry & Neur	04/30/1994	Yes	Admitting Agreement
I	Smith, Tanya PA-C	1053600346	National Commission on Ce	06/24/2010	Yes	None
I	Starnes, Benjamin M.,MD	1548345283	None		No	Admitting Agreement
I	Stevens, Scott K.,MD	1306055413	ABMS of Ophthalmology	11/07/2010	Yes	Admitting Agreement
I	Stone, Valerie FNP-C	1740834019	American Academy of Nurse	07/17/2025	Yes	None
I	Streitfeld, Samantha Doula	1629949334	None		Not Applicable	None
I	Tabura, Jody A.,RD	1851969885	Commission of Dietetic Reg	10/01/1997	Yes	None
R	Tagle, Amanda G.,MD	1457367179	Meets MPCR #17, Verified F		Not Applicable	Admitting Agreement
I	Tahan, Veysel MD	1700155231	ABMS of Internal Medicine	11/20/2019	Yes	Providence St. Joseph Hosp
I	Tam, Eric MD	1932629201	ABMS of Physical Medicine	07/01/2023	Yes	Admitting Agreement
R	Tang, Karen FNP	1013493279	American Academy of Nurse	06/02/2022	Yes	None
R	Tanzo, Theresa L.,SUDCC	1538558010	California Substance Use Di	12/02/2025	Yes	None
R	Tavernetti, Jennifer R.,MD	1538549373	ABMS of Dermatology	07/26/2019	Yes	Admitting Agreement
I	Taylor, Nathaniel BCaBA	1710465596	Behavior Analyst Certificatio	07/15/2020	Yes	None
I	Theis, Morgan K.,MD	1124361258	ABMS of Family Medicine	07/01/2016	Yes	Admitting Agreement
I	Thomas, Jacob BCBA	1639672876	Behavior Analyst Certificatio	06/18/2024	Yes	None
I	Topp, Kathryn A., LVN	1548070733	None		No	None
I	Torrez, Cassandra BCBA	1821589086	Behavior Analyst Certificatio	11/30/2019	Yes	None
I	Van Der Linde, Mone PA-C	1770317703	National Commission on Ce	10/22/2024	Yes	None
R	Villalon, Rachel M.,MD	1083842843	ABMS of Obstetrics and Gyr	12/09/2016	Yes	NorthBay Medical Center/ N
I	Villani, Amanda E.,FNP-C	1386028363	American Academy of Nurse	08/05/2015	Yes	None
I	Waldo, Stephanie BCBA	1215434238	Behavior Analyst Certificatio	11/30/2019	Yes	None

App. Ty	Full Name	NPI Number	Board Name	Initial Cert Date	Board Certified	Hospital Name
I	Warriach, Ali BCBA	1417577958	Behavior Analyst Certificatio	01/02/2026	Yes	None
I	Weinberg, Elizabeth FNP-	1043645013	American Nurses Credential	07/26/2013	Yes	None
R	Wenerstrom, David T.,Sr.	1154955458	California Substance Use Di	07/11/2024	Yes	None
R	Wenerstrom, Sandra SUD	1073146593	California Substance Use Di	04/26/2026	Yes	None
I	Williams, Kya Doula	1164359345	None		No	None
R	Williams, Marnie BCBA	1497368104	Behavior Analyst Certificatio	08/07/2020	Yes	None
R	Wilson, Dewight E.,SUDC	1699221945	California Substance Use Di	07/26/2024	Yes	None
I	Wilson, Fiona J.,SUDRC	11750225827	California Substance Use Di	08/30/2025	Yes	None
R	Wong, Reynold C.,MD	1962581694	ABMS of Dermatology	10/29/1984	Yes	Admitting Agreement
I	Wyard, Sarah FNP-C	1548746928	American Academy of Nurse	06/21/2018	Yes	None
R	Xiong, Lee P.,FNP-C	1407589575	American Academy of Nurse	06/16/2022	Yes	None
R	Young, Christian C.,FNP-C	1154659431	American Academy of Nurse	06/30/2016	Yes	None
I	Zane, Linda J.,FNP-C	1770906067	American Academy of Nurse	02/06/2014	Yes	None
I	Zarco Ramos, Miguel BCE	1790391340	Behavior Analyst Certificatio	11/06/2025	Yes	None

App. Ty	Full Name	NPI Number	Staff Cat Description
R	Ahn, Sam S.,MD	1558423814	Consulting
R	Alattar, May MD	1154523371	None
I	Ali, Mir K.,LPCC	1518444058	
I	Allen, Daniel B.,MD	1063523819	None
I	Alvarez, Amy BCBA	1093379133	
I	Anderson, Debra A.,FNP-C	1720882582	
R	Atluri, Mokshasree DO	1366947772	Active
R	Azare, Collier SUDCC II	1780210575	
R	Bacon, Anina D.,PA-C	1952739708	
I	Barton, Morgan L.,PA-C	1801532791	
I	Bartschi, Alexis DO	1568111292	None
I	Bellomo, Kimberly BCBA	1780979872	
R	Bernstein, Allan L.,MD	1992889067	Consulting
R	Bernstein, Mary E., SUDC	1437499563	
I	Biddle, Justin T.,AGNP-C	1477383859	
I	Black, Charles DO	1790988087	Temporary
I	Boeing, Samantha BCBA	1497297568	
I	Booker, Courtnee Doula	1093348799	
I	Boyd, Rileigh E.,PA-C	1740998558	
I	Breck, Jennifer PA-C	1821742735	
I	Britton, Kristina M.,Doula	1487412938	
R	Brockett, Erin BCBA	1851952352	
I	Campbell, Christine N.,SU	1821775578	
I	Carfi-Zavala, Adrienne E.,	1457200677	
R	Carrasquillo Navarro, Mar	1851751408	None
I	Cartacki, Steven Lac	1487430039	
I	Carter, Deborah Psy.D	1518268036	
R	Cheng, Jacklyn M.,MD	1306259098	Active
I	Colavin-Bridges, Gianna C	1548567167	
I	Cosh Davis, Christina DC	1811980493	
I	Crawford, Mar'Leesia BCE	1669921102	
I	Cronin, Daniel Jr., SUDRC	1750223780	
I	Cupp, David MD	1497901565	Active
I	Dahman, Abdul LCSW	1073146270	
R	Daileader, Jamey BCBA	1881250587	
R	Davidson, Brooke N.,Psy.I	1538568407	
I	Dawood, Nayyara S.,MD	1194744391	Transfer
R	D'Costa, Walter F.,DPM	1548336605	Active
I	Delapena, Marci RADT	1790354892	
R	DeRose, Sonja D.,MD	1558849661	None
R	DeTorres, Charles F.,MD	1770510521	Courtesy
I	DeWitt, Paula BCBA	1013797281	
R	Dickerson, Mary H.,CADC	1801411863	
R	Dillon, Melissa T.,SUDCC	1619503752	
I	Donovan, Jennifer T.,FNP	1205587086	
I	Doolin, Shana r., FNP-BC	1811138712	
I	Dowling, Jacob K.,RD	1700280518	
I	Dufour, Martin MD	1578792800	None
I	Fay, Mark T.,MD	1972563781	None
I	Felix, Dafina BCBA	1679195390	
I	Fenstermacher Ritchie, Di	1790443109	
I	Ferguson, Sharonda BCB	1659615896	
I	Fernandes, Carlo R.,DO	1477907905	
R	Fife, Timothy A.,MD	1073747663	Active
R	Ford, Megan PA-C	1609281252	
I	Fosbre, Jonathan FNP-C	1306203195	
I	French, Alexander CADC	1033689765	
I	Fusia, Tod, MD	1043269970	
I	Gaffen, Danielle R.,RD	1154905727	
I	Gaitanis, Alexander DO	1114937844	None
R	Garcia, Lulu PA-C	1730467051	
I	Garcia, Reyna BCBA	1639770167	
I	Garrett, Audrey P.,MD	1063437127	None
I	Garza, Krista M.,FNP-C	1881766269	
R	Gelfand, Elena V.,MD	1154342343	Active
R	Ghuman, Tejinder P.,MD	1730110487	None
I	Golerkansky, Kaylin Psy.D	1144909821	
I	GRANT, Tunisha D.,Doula	1861343303	
I	Green, Anna E.,PA-C	1164303319	
R	Green, Cheryl E.,MD	1578635223	Active
I	Grewal, Rupinder K.,FNP-	1548036478	
I	Gutermuth, Clover E.,LM	1316644172	
I	Hall, Taylor L.,OD	1497489579	None

App. Ty	Full Name	NPI Number	Staff Cat Description
I	Harry, June M.,NP	1104384957	
I	Hartmann, Emily C.,MD	1922263896	Active
R	Hasday, Steven J.,MD	1881198208	Active
R	Hashemi, Ladan P.,FNP-E	1376887935	
I	Hayes, Margaux BCBA	1316448541	
R	Hensley, Randall D.,DC	1174622575	
I	Herrera, Monica E.,Doula	1679416903	
I	Hicks, Elena M.,PMHNP-	1619431269	
I	Hines, Jessica S.,CATC II	1841930344	
R	Hoyal, Ralph P.,DPM	1265498828	None
I	Huang, Denis MD	1699390773	None
I	Hudson, Elena L.,SUDCC	1952174518	
I	Ibihiwiori, Oghenekevwe B	1841968070	
I	Iles, Nicole M.,NP	1588526958	
I	Inami, Bona BCBA	1952846081	
I	Ivy, Olivia M.,MD	1851693436	Active
R	Jacks, Cody J.,PT	1669148391	
R	Jean, Elie MD	1558712182	Active
I	Jean, Mary Christine C.,Ft	1902754070	
I	Jehtara, Amreen BCBA	1023586310	
R	Jessup, Barbara A.,SUDC	1952922924	
R	Jhaveri, Manan A.,MD	1306285739	None
R	Johl, Sumit MD	1245314624	None
I	Johnson, Yvonne BCBA	1164706339	
I	Kanomata, Nicole P.,FNP-	1366165102	
R	Keck, Steven E.,SUDCC	1093348369	
I	Keddington, Holly PA-C	1194458794	
I	Kelly, Jacqueline M.,FNP-	1235077694	
I	Kirsten, Kelli BCBA	1467953513	
I	Kline, Rayna G.,PT	1912941816	
R	Klingman, Robert R.,MD	1982670667	Active
I	Krause, Thomas BCBA	1851087225	
R	Kuninobu, Andrew T.,MD	1548318538	None
R	Laband, Paul M., MD	1427029040	Affiliate
R	LaGrange, Joshua L.,CAD	1689362147	
I	Lai, Evelyn J.,PPCNP-BC	1770862237	
I	Larrazabal Martinez, Luis	1316252893	None
R	Lieben, Katrina R.,CNM	1669610812	
R	Lim, Jackson M.,DPM	1073594727	None
I	Liss, Sarah A.,MD	1962665810	None
I	Littleton, Kacia J.,SUDRC	1467389387	
I	Long, Courtney BCBA	1114427382	
R	Lucarelli, Tammara SUDC	1417583295	
I	Lujano, Patricia RADT	1942927363	
I	Maina, Iva BCBA	1073129888	
I	Mallory, Anna BCBA	1063989556	
I	Manyak, Kari M.,Doula	1043162522	
R	Marshall, Michelle L.,SUD	1144853177	
R	Martin, Nicole D.,CADC I	1326670332	
I	Martinez, Anitta J.,FNP-B	1932093127	
I	Martinez, Viviana BCBA	1992281588	
I	Matsuka, Anastasiya A.,Ft	1841138484	
R	McClain, Albert A.,Jr., MD	1811006786	Active
R	McClough, Daniel J.,PA-C	1023220167	
I	Medina, Kayla E.,FNP-C	1770054678	
R	Mendez, Ricardo J.,PA-C	1033644174	
I	Migliaccio, Pamela L.,FNP	1689059610	
I	Miller, Heather C.,BCBA	1487368767	
I	Miller, Nicole BCBA	1548760283	
I	Millspaugh, Rio BCBA	1396204855	
R	Mitchell, Dalyn E.,SUDCC	1336782556	
I	Mitsunaga, Anna Y.,PT	1851506547	
I	Montague, Kelly BCBA	1669915807	
I	Montalvo, Celeste FNP-C	1669363230	
I	Montenegro, Ivan BCBA	1083251987	
I	Naqvi, Syed E.,MD	1073692117	None
I	Negrete-Zavala, Bruno BC	1558963967	
I	Ngo, Richard T.,FNP-C	1083647820	
R	Nguyen, Madeline DO	1316333453	None
I	Nguyen, Thai H.,DO	1295361343	None
R	Norris-Skinner, Charla SU	1780217497	
R	Olano, Bozena E.,BCBA	1376044644	
I	Omega, Nicole BCBA	1750884250	

App. Ty	Full Name	NPI Number	Staff Cat Description
R	Orozco, Puja PA-C	1568784635	
I	Ortega, Jahzeel BCBA	1801430996	
R	Oryn, Danielle E.,DO	1376535070	Affiliate
I	Osorio, Rabita BCBA	1639730005	
R	Owens, Trisha M.,SUDCC	1922404599	
R	Packer, Jonathan D.,DO	1316472764	Active
R	Palmbaum, Glenn D.,PA-C	1619030970	
I	Papp, Alexandra M.,MD	1225497563	None
I	Patton, Tamia S., LVN	1336958164	
R	Pearlman, Joel A.,MD	1154430460	Active
I	Perez, Rolando BCBA	1447902465	
R	Perlman, Jonathan P.,MD	1972510477	Active
R	Pham, Xuan T.,MD	1649621335	Active
R	Piersol, Patricia E.,CNM	1265400824	
R	Pitcher, Chad R.,DO	1992266100	Courtesy
R	Pitzen, Roger J.,MD	1396742524	Courtesy
I	Pool, Amber BCBA	1003151465	
R	Powers, Matthew A.,MD	1295152379	Active
I	Poyser, Samantha BCBA	1609752260	
I	Preciado, Erika BCBA	1285199885	
I	Printy, Tatum BCBA	1184266116	
I	Punsalan, Alicia H.,FNP-B	1104307958	
I	Quiambao, Stephanie Gra	1477029692	
R	Quinn, Rindi SUDCC	1770116709	
I	Ragasa, Meleah BCBA	1578033999	
I	Ramirez, Karla BCBA	1285309088	
R	Rehman, Shahid U.,MD	1104084458	Active Attending
I	Reich, Savanah L.,FNP-C	1831075191	
I	Remily, Amberlie BCBA	1902427206	
I	Rewick, Kristen J.,PMHNF	1770039828	
I	Rhys, Aesara Doula	1295575215	
I	Riccomini, Monica M.,FNF	1750524914	
I	Rice, Ashley M.,FNP-C	1902322894	
I	Romero, Sophia S.,RD	1679381370	
I	Romo, Fernie BCBA	1215518873	
R	Rubio, Nadia BCBA	1437507191	
I	Russell, Celena SUDRC II	1881331460	
I	Sabalza, Maritza BCBA	1083151773	
I	Safont, Jose L., SUDRC II	1003151531	
R	Samaniego, Pedro IV, DC	1528418472	
R	Samuel, Georgina A.,PA-C	1427296292	
I	San Jose, Michelle BCBA	1508107780	
I	Sanchez, Felix BCBA	1740866433	
R	Schleben, Roxanne P.,FN	1982214870	
I	Schneeweis, Kristen M.,P	1871393199	
R	Schrock, Alisha F.,PT	1144769688	
R	Schwartz, Stephen D.,MD	1326154352	None
I	Shan, Elaine Y.,MD	1053767434	None
R	Sianghio, Kathleen R.,FNF	1326506775	
R	Simmons, Eryn P.,DO	1134570211	None
I	Simmons, Robert BCBA	1245890565	
I	Skotzko, Christine E.,MD	1336227669	None
I	Smith, Tanya PA-C	1053600346	
I	Starnes, Benjamin M.,MD	1548345283	None
I	Stevens, Scott K.,MD	1306055413	None
I	Stone, Valerie FNP-C	1740834019	
I	Streitfeld, Samantha Doula	1629949334	
I	Tabura, Jody A.,RD	1851969885	
R	Tagle, Amanda G.,MD	1457367179	None
I	Tahan, Veysel MD	1700155231	Provisional
I	Tam, Eric MD	1932629201	None
R	Tang, Karen FNP	1013493279	
R	Tanzo, Theresa L.,SUDCC	1538558010	
R	Tavernetti, Jennifer R.,MD	1538549373	None
I	Taylor, Nathaniel BCaBA	1710465596	
I	Theis, Morgan K.,MD	1124361258	Active
I	Thomas, Jacob BCBA	1639672876	
I	Topp, Kathryn A., LVN	1548070733	
I	Torrez, Cassandra BCBA	1821589086	
I	Van Der Linde, Mone PA-C	1770317703	
R	Villalon, Rachel M.,MD	1083842843	Active Attending
I	Villani, Amanda E.,FNP-C	1386028363	
I	Waldo, Stephanie BCBA	1215434238	

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I	Warriach, Ali BCBA	1417577958	
I	Weinberg, Elizabeth FNP-	1043645013	
R	Wenerstrom, David T.,Sr.	1154955458	
R	Wenerstrom, Sandra SUD	1073146593	
I	Williams, Kya Doula	1164359345	
R	Williams, Marnie BCBA	1497368104	
R	Wilson, Dewight E.,SUDC	1699221945	
I	Wilson, Fiona J.,SUDRC	1750225827	
R	Wong, Reynold C.,MD	1962581694	None
I	Wynd, Sarah FNP-C	1548746928	
R	Xiong, Lee P.,FNP-C	1407589575	
R	Young, Christian C.,FNP-C	1154659431	
I	Zane, Linda J.,FNP-C	1770906067	
I	Zarco Ramos, Miguel BCE	1790391340	

Summary of Proposed Measure Changes for Measurement Year 2027

(A) Core Measurement Set Measures

Providers have the potential to earn a total of 100 points in two measurement areas: Clinical Domain and Non-Clinical Domain. Individual measure values will be assigned to the final and approved measurement set.

Key:

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

2026 Measures	2027 Recommendations
Clinical Domain	
Family Medicine: - Breast Cancer Screening (40-74yo) - Cervical Cancer Screening - Child and Adolescent Well Care Visits - Childhood Immunization Status: Combo 10 - Colorectal Cancer Screening - Comprehensive Diabetes Management: HbA1c Good Control - Comprehensive Diabetes Management: Retinal Eye Exams - Controlling High Blood Pressure - Immunizations for Adolescents – Combo 2 - Well-Child Visits in the First 15 Months of Life - Lead Screening in Children - Chlamydia Screening (16-24yo) - Kidney Health Evaluation for Patients with Diabetes - Well-Child Visits in the first 15-30 months of life – Monitoring - Topical fluoride in Children – Monitoring - Reducing Healthcare Disparity (Participation is Optional)	Family Medicine: - Breast Cancer Screening (40-74yo) - Cervical Cancer Screening - Child and Adolescent Well Care Visits - Childhood Immunization Status: Combo 10 - Colorectal Cancer Screening - Comprehensive Diabetes Management: HbA1c Good Control ~~Comprehensive Diabetes Management: Retinal Eye Exams~~ — Retire to Monitoring Status - Controlling High Blood Pressure - Immunizations for Adolescents – Combo 2 - Well-Child Visits in the First 15 Months of Life - Lead Screening in Children ~~Chlamydia Screening (16-24yo)~~ — Retire to Monitoring Status - Kidney Health Evaluation for Patients with Diabetes - Well-Child Visits in the first 15-30 months of life – Keep as Monitoring - Topical fluoride in Children – Keep as Monitoring 16. Developmental Screening – New Monitoring 17. First Timely Prenatal Care Visit – New Monitoring 18. Adult Immunization – New Monitoring 19. Follow-up after Acute and Urgent Care Visits for Asthma – New Monitoring

Summary of Proposed Measure Changes for Measurement Year 2027

	20. Asthma Medication Ratio – New Monitoring 21. Tobacco Use Screening and Cessation – New Monitoring 22. Reducing Healthcare Disparity (Participation is Optional)
Clinical Domain	
Internal Medicine: - Breast Cancer Screening (40-74yo) - Cervical Cancer Screening - Colorectal Cancer Screening - Controlling High Blood Pressure - Comprehensive Diabetes Management: HbA1c Good Control - Comprehensive Diabetes Management: Retinal Eye Exams - Chlamydia Screening (21-24yo) - Reducing Healthcare Disparity (Participation is Optional) - Kidney Health Evaluation for Patients with Diabetes	Internal Medicine: - Breast Cancer Screening (40-74yo) - Cervical Cancer Screening - Colorectal Cancer Screening - Controlling High Blood Pressure - Comprehensive Diabetes Management: HbA1c Good Control ~~Comprehensive Diabetes Management: Retinal Eye Exams~~ – Retire to Monitoring Status ~~Chlamydia Screening (21-24yo)~~ – Retire to Monitoring Status - Kidney Health Evaluation for Patients with Diabetes - First Timely Prenatal Care Visit – New Monitoring - Adult Immunization – New Monitoring - Follow-up after Acute and Urgent Care Visits for Asthma – New Monitoring - Asthma Medication Ratio – New Monitoring - Tobacco Use Screening and Cessation – New Monitoring ~~Reducing Healthcare Disparity~~ (Participation is Optional)
Clinical Domain	
Pediatric Medicine: - Child and Adolescent Well Care Visits - Childhood Immunization Status: Combo 10 - Immunizations for Adolescents – Combo 2 - Well-Child Visits in the First 15 Months of Life	Pediatric Medicine: - Child and Adolescent Well Care Visits - Childhood Immunization Status: Combo 10 - Immunizations for Adolescents – Combo 2 - Well-Child Visits in the First 15 Months of Life

Summary of Proposed Measure Changes for Measurement Year 2027

5. Lead Screening in Children 6. Well-Child Visits in the first 15-30 months of life 7. Chlamydia Screening (16-20yo) 8. Topical fluoride in Children – Monitoring 9. Reducing Healthcare Disparity (Participation is Optional)	5. Lead Screening in Children 6. Well-Child Visits in the first 15-30 months of life 7. ~~Chlamydia Screening (16-20yo)~~ — Retire to Monitoring Status 8. Topical fluoride in Children – Keep as Monitoring 9. Developmental Screening – New Monitoring 10. Follow-up after Acute and Urgent Care Visits for Asthma – New Monitoring 11. Asthma Medication Ratio – New Monitoring 12. Tobacco Use Screening and Cessation – New Monitoring 13. ~~Reducing Healthcare Disparity (Participation is Optional)~~

Non-Clinical Domain	
Family Medicine and Internal Medicine: 1. Ambulatory Care Sensitive Admissions 2. Follow-up within 7 days after Hospital Discharge 3. Avoidable ED Visits 4. PCP Office Visits 5. Patient Experience	Family Medicine and Internal Medicine: 1. Potentially Preventable Admissions 2. Follow-up within 7 days after Hospital Discharge 3. Low-Acuity Non-Emergent ED Visits 4. PCP Office Visits 5. Patient Experience
Non-Clinical Domain	
Pediatric Medicine: 1. Avoidable ED Visits 2. PCP Office Visits 3. Patient Experience	Pediatric Medicine: 1. Low-Acuity Non-Emergent ED Visits 2. PCP Office Visits 3. Patient Experience

Summary of Proposed Measure Changes for Measurement Year 2027

(B) Unit of Service Measures

Providers receive payment for each unit of service they provide.

Unit of Service	
All Sites: 1. Clinician Education on Improving Medication Management 2. Advance Care Planning 3. Extended Office Hours 4. PCMH Certification 5. Peer-led and Pediatric Group Visits 6. Health Information Exchange 7. Health Equity 8. Tobacco Use Screening 9. Electronic Clinical Data Systems (ECDS)	All Sites: 1. Clinician Education on Improving Medication Management 2. Advance Care Planning 3. Extended Office Hours 4. PCMH Certification 5. Peer-led and Pediatric Group Visits 6. Health Information Exchange 7. Health Equity 8. ~~Tobacco Use Screening – Retire~~ 9. ~~Electronic Clinical Data Systems (ECDS) – Retire as Gateway Measure~~

Programmatic Changes:

I. Descriptions of Potential 2027 Measure Changes for Core Measurement Set

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

- 1) Chlamydia Screening (Clinical Measure: All Practice Types) – Retire then adopt HEDIS criteria and make a monitoring measure. Measure is no longer an MCAS reporting measure, but screening is still important to complete and relevant to monitor.
- 2) Reducing Healthcare Disparity (Optional Clinical Measure: All Practice Types) – Retire as DHCS has changed its approach for plans and expectations around reducing healthcare disparities. There are also signs that there may be guidance coming from DMHC which could influence how Partnership approaches disparity reduction. In the interim, Partnership is defaulting to its current Health Equity Unit of Service measure to allow practices autonomy in identifying and closing disparities among their patient populations.

Summary of Proposed Measure Changes for Measurement Year 2027

- 3) Patient Experience (Non-Clinical Measure: All Practice Types) – Redesign to requirements. For CG-CAHPS, part of the payment will depend on submitting a robust Improvement plan including reporting on monthly 3NA, continuity, dropped call rates, no-show rates, and recent individual provider-level satisfaction surveys. For Survey Option, a robust improvement plan including reporting on current 3NA, continuity, dropped call rates, no-show rates, and individual provider-level satisfaction will be required with both submission templates: Part 1 and Part 2.

The two composite measures for the CG-CAHPS survey are access and communication, which are key drivers to patient satisfaction. Operational reports and clinic-level point of care survey reports can help identify barriers and develop improvement plans which can lead to increased patient satisfaction. According to Agency for Healthcare Research and Quality, when patients share their experiences about their health care, they offer crucial insights about the safety of that care. Lack of appropriate access to high-quality care, good communication, cleanliness, care coordination, information during discharge, as well as lack of responsiveness to patient requests for help, can lead to patient harm (<https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html>).

- 4) Comprehensive Diabetes Management: Retinal Eye Exams (Clinical Measure: Family Medicine and Internal Medicine): Retire and move to monitoring status. While the Diabetes Retinal Eye Exam measure may no longer be appropriate to retain as a scored measure, it should remain as a monitoring measure because it continues to provide valuable insight into preventive diabetes care performance. For the DSNP population in particular, retinal eye exam completion reflects members' access to specialty care, effectiveness of outreach and care coordination, and overall engagement in chronic disease management. Maintaining this measure in a monitoring capacity supports early identification of care gaps, helps target interventions for high-risk members, and preserves visibility into an important clinical service without requiring it to drive formal stars scoring.

B. Potential Additions as New Measures – Core Measurement Set

- 1) Developmental Screening (Family Medicine and Pediatric Practice) – **New Monitoring**

According to the CDC, developmental disabilities are common. In the United States, about one in six children aged three to 17 years has one or more developmental disabilities, such as autism or attention-deficit/hyperactivity disorder. Identifying developmental delays and disabilities early is key so children and their families can get

Summary of Proposed Measure Changes for Measurement Year 2027

the services and support that they need as early as possible (<https://www.cdc.gov/act-early/about/developmental-monitoring-and-screening.html>).

2) First Timely Prenatal Care Visit (Family and Internal Medicine Practice) – **New Monitoring**

According to NCQA, preventive medicine is fundamental to prenatal care. Ensuring early initiation of prenatal care is an important component of programs that aim to improve maternal and infant health outcomes. Inadequate prenatal care raises the risk of adverse birth outcomes, potentially because the healthcare provider has fewer opportunities to identify and manage conditions that can have a negative impact (<https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/prenatal-and-postpartum-care-ppc/>).

3) Adult Immunization (Family and Internal Medicine Practice) – **New Monitoring**

According to the CDC, vaccines have greatly reduced diseases that once routinely harmed or killed people. People all over the world, including in the United States, still become seriously ill or even die from diseases that vaccines can help prevent. It is important for patients stay up to date on recommended vaccines (<https://www.cdc.gov/vaccines-adults/reasons/index.html>).

4) Follow-up after Acute and Urgent Care Visits for Asthma (All Practice Types) – **New Monitoring**

According to NCQA and CDC asthma data in 2021, 6.5% of children and 8% of adults in the United States had asthma and the disease was responsible for 3,517 deaths. Asthma is a complex, chronic disease that occurs in all ages. If poorly controlled or triggered by an environmental factor, it can result in episodic exacerbations with significant health and financial consequences. While asthma exacerbations are medical emergencies requiring acute interventions, they may be avoided using preventive care (<https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/follow-up-after-acute-and-urgent-care-visits-for-asthma-aaf-e/>). This measure is highly likely to become an MCAS measure in the future.

5) Asthma Medication Ratio (All Practice Types) – **New Monitoring**

According to NCQA, asthma is a treatable, manageable, condition that affects more than 25 million people in the United States. Managing this condition with appropriate medications could save the United States. billions of dollars in medical costs. The prevalence and cost of asthma have increased over the past decade,

Summary of Proposed Measure Changes for Measurement Year 2027

demonstrating the need for better access to care and medication. Appropriate medication management for patients with asthma could reduce the need for rescue medication—as well as the costs associated with ER visits, inpatient admissions, and missed days of work or school (<https://www.ncqa.org/report-cards/health-plans/state-of-health-care-quality-report/asthma-medication-ratio-amr/>). While NCQA and MCAS are retiring this measure (reason for removal from accountability), this measure is associated with less ED visits for asthma, so this measure could plausibly affect the hospital admission rate for asthma.

6) Tobacco Use Screening and Cessation (All Practice Types) – **New Monitoring**

The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and United States Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco. Tobacco use is the leading preventable cause of disease, disability, and death in the United States. In 2014, it was estimated that 480,000 deaths annually are attributed to cigarette smoking, including secondhand smoke. In 2019 (the most recent data currently available), an estimated 50.6 million United States adults (20.8% of the adult population) used tobacco; 14.0% of the United States adult population currently smoked cigarettes; and 4.5% of the United States adult population used electronic cigarettes (e-cigarettes) (<https://www.uspreventiveservicestaskforce.org/uspstf/recommendation/tobacco-use-in-adults-and-pregnant-women-counseling-and-interventions>). This measure will be clarified to include screening and counselling on vaping, as well as traditional cigarette smoking.

7) Ambulatory Care Sensitive Admissions (Family Practice and Internal Medicine) – Measure name change for reporting purposes.

8) Avoidable Emergency Department (ED) Visits (All Practice Types) – Measure name change for reporting purposes.

Summary of Proposed Measure Changes for Measurement Year 2027

II. Descriptions of Potential 2027 Measure Changes for Unit of Service Measurement Set

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

- 1) Tobacco Use Screening (All Practice Types) – Retire then adopt HEDIS criteria and make a clinical monitoring measure. Newly added MY2026 HEDIS measure includes both adolescents (12 years of age and older) and adults along with a requirement for cessation intervention.
- 2) Electronic Clinical Data Systems (ECDS) (All Practice Types) – Retire and turn into a core measure to earn points in specific core measures: BCS, CCS, COL, LSC, IMA, and CIS10. NCQA and MCAS measures will be transitioning to ECDS reporting only (i.e., no manual uploads will be permitted) by 2029. This data exchange from the provider's Electronic Health Records to Datalink (a qualified HEDIS data aggregator), allows Partnership to capture clinical screenings, immunization records, follow-up care, and outcomes.

B. Potential Additions as New Measures – Unit of Service

N/A

Healthcare Effectiveness Data and Information Set (HEDIS®)

MY2025 / RY2026 Summary of Performance

Presented by:

Kristine Gual, Director of Quality Measurement

Today's Topics

- MY2025 Quality Accountability Programs
- DHCS Managed Care Accountability Set (MCAS) Results
[MY2025 MCAS Annual Summary of Performance](#)
- NCQA Health Plan Accreditation (HPA) - Projected Star Rating
[MY2025 NCQA HPA Annual Summary of Performance](#)



MY2025 HEDIS Performance and DHCS Accountability Programs

Partnership's Quality Accountability Programs

Program	Geographic Impact	Financial Impact	Low Performance Trigger	Path to High Performance
Quality Withholds and Incentive Program	Quality Rating Regions	\$Tens of Millions	<67th percentile performance AND <25% YoY improvement	North Bay Area: Achievement Rural Upper North and Rural Upper Central: Year-over year improvement
Clinical Efficiencies	Plan Wide	\$Tens of Millions	High inpatient utilization by members with complex chronic conditions	Intensive case management of high-risk members
Community Reinvestments - Quality	County	\$Millions	2+ measures <50th percentile in any measure domain	County-level measure prioritization
Quality Sanctions	County	\$100k - \$500k	<50th percentile performance	Data completeness , impact of high performance in other programs
Quality Factor Score	Plan Wide	None	None	n/a
NCQA Health Plan Rating	Plan Wide	None	None	n/a

MCAS: Accountable Measures MY2025

Domain	Measure	
Behavioral Health	FUA-30	F-Up after ED Visit for Substance Use
	FUM-30	F-Up after ED Visit for Mental Illness
Pediatric	WCV	Child & Adolescent Well Care Visits**
	CIS-E	Childhood Immunizations**
	DEV	Developmental Screening in 0-3yrs
	IMA-E	Immunizations for Adolescents**
	LSC	Lead Screening in Children
	TFL-CH	Topical Fluoride for Children
	W30+6	Well Child Visits: 0-15 Months**
	W30+2	Well Child Visits: 15-30 Months**

Domain	Measure	
Chronic Disease	GSD	Hemoglobin A1c Poor Control (>9%)**
	CBP	Controlling High BP**
	AMR	Asthma Medication Ratio
Reproductive /Cancer Prevention	BCS-E	Breast Cancer Screening
	CCS-E	Cervical Cancer Screening
	CHL	Chlamydia Screening
	PPC-Pre	Timeliness of Prenatal Care**
	PPC-Post	Postpartum Care**

**** Designates a Quality Withhold measure**

- 18 measures in MY2025
- All 18 measures from MY2024 continue in MY2025
- Accountable measures must meet or exceed the Minimum Performance Level (MPL) (i.e. 50th percentile national Medicaid percentile) to avoid sanctions
- Quality Withhold Measures must show significant year-over-year improvement or exceed 67th percentile for full points
- Community Reinvestment additional 5% triggered by 1+ measure < MPL in each measure domain

Accountability Programs Emphasize Local Performance

- Path to high performance on DHCS accountability programs is through **county** and **regional** measure rate improvement
- North Bay Area (Fairfield & Santa Rosa): sustaining high **achievement**
 - >67th percentile on all MCAS measures
- Rural Upper North (Redding and Eureka) and Rural Upper Central (Auburn and Chico): continuous **improvement on prioritized measures**
 - Rural North: Moving towards 67th percentile on Withhold measures
 - Rural Central: Moving towards 50th percentile on Withhold measures





MY2025 DHCS Managed Care Accountability Set (MCAS) Results

MY2025 Plan-Wide MCAS Performance

Measure	MY2025 RATE
Behavioral Health Domain	
Follow-Up After Emergency Department Visit for Substance Use - 30-Days (FUA-30)	41.35%
Follow-Up After Emergency Department Visit for Mental Illness - 30-Days (FUM-30)	50.26%
Children's Health Domain	
Child and Adolescent Well-Care Visits (WCV) **	52.57%
Childhood Immunization Status - Combination 10 (CIS-E) **	26.74%
Developmental Screening in the First Three Years of Life (DEV)	39.42%
Immunizations for Adolescents - Combination 2 (IMA-E) **	39.39%
Lead Screening in Children (LSC)	74.94%
Topical Fluoride for Children (TFL)	21.07%
Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months (W30-2) **	76.64%
Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months (W30-6) **	64.64%

Measure	MY2025 RATE
Chronic Disease Domain	
Asthma Medication Ratio (AMR)	73.33%
Controlling High Blood Pressure (CBP) **	67.40%
Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) ** ^	27.74%
Reproductive Health and Cancer Prevention Domain	
Breast Cancer Screening (BCS-E)	53.43%
Cervical Cancer Screening (CCS-E)	48.08%
Chlamydia Screening in Women (CHL)	58.98%
Prenatal and Postpartum Care: Postpartum Care (PPC-Post) **	90.02%
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) **	87.10%

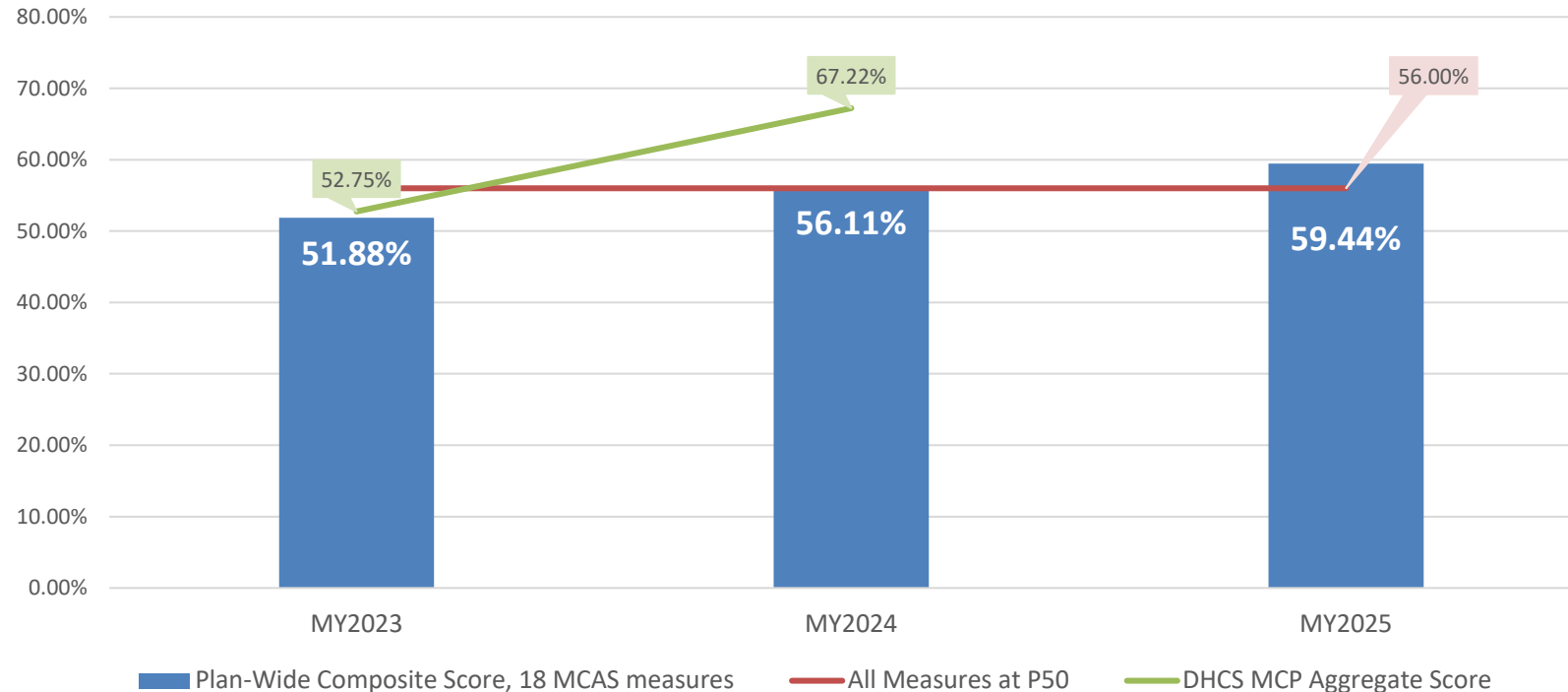
Benchmark
90 th
67 th or 75 th
50 th – MPL or >50 th (CMS)
25 th or 33 rd
<25 th or <50 th (CMS)

** Quality Withhold measure

^ Inverse measure, lower rate is better

MCAS Composite Score, MY2023 – MY2025

MY2023-MY2025 Composite Score, Plan-Wide



Quality Compass Benchmark	Points Awarded per Measure's Performance
90th	10
82.5th	9
75th	8
62.5th	7
50th – MPL or >50 th (CMS)	6
37.5th	5
25th	4
17.5th	3
10th	2
<10 th or <50 th (CMS)	1

- Composite score represents Partnership's aggregated performance on all 18 MCAS measures (measure benchmarks met in points / highest possible benchmarks in points)
- Preliminary version of DHCS Quality Factor Score, published in Fall 2026

Withhold Measures: Regional Strengths

Sustained High Performing Measures

	Plan-Wide	
Measure Description	MY2024	MY2025 YoY points change
Childhood Immunization Status - Combination 10 (CIS-E) **	50th	50th +2.16%
Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months (W30-2) **	67th	67th +4.42%
Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) ** ^	50th	67th -4.87% *
Prenatal and Postpartum Care: Postpartum Care (PPC-Post) **	90th	90th +0.49%

North Bay Area Rating Region	
MY2024	MY2025
67th	90th
67th	75th
33rd	50th
90th	90th

Rural Upper Central Rating Region	
MY2024	MY2025
<25th	50th
<25th	50th
25th	50th
75th	75th

Rural Upper North Rating Region	
MY2024	MY2025
<25th	<25th
50th	50th
50th	50th
75th	75th

Benchmark
90 th
67 th or 75 th
50 th – MPL or >50 th (CMS)
25 th or 33 rd
<25 th or <50 th (CMS)

** Quality Withhold measure

^ Inverse measure, lower rate is better

 Improvement opportunity

Withhold Measures: Regional Opportunities

Highest Priority Opportunities for Performance Improvement

Measure Description	Plan-Wide		North Bay Area Rating Region		Rural Upper Central Rating Region		Rural Upper North Rating Region		Benchmark
	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	
Child and Adolescent Well-Care Visits (WCV) **	33rd	33rd +3.74%	33rd	50th	25th	25th	25th	25th	90 th
Immunizations for Adolescents - Combination 2 (IMA-E) **	50th	67th +1.46%	75th	90th	25th	33rd	<25th	33rd	67 th or 75 th
Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months (W30-6) **	75th	50th -2.41%	75th	75th	<25th	<25th	75th	67th	50 th – MPL or >50 th (CMS)
Controlling High Blood Pressure (CBP) **	75th	33rd -2.19%	50th	75th	25th	<25th	25th	50th	25 th or 33 rd
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) **	50th	50th +1.70%	<25th	90th	25th	<25th	<25th	25th	<25 th or <50 th (CMS)

** Quality Withhold measure

 Improvement opportunity

MCAS Performance: Regional Strengths

Additional MCAS Measures, Newly Above the 50th Percentile (Plan-Wide)

Measure Description	Plan-Wide		North Bay Area Rating Region		Rural Upper Central Rating Region		Rural Upper North Rating Region		Benchmark
	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	
Follow-Up After Emergency Department Visit for Substance Use - 30-Days (FUA-30)	33rd	50th +8.08%	25th	50th	25th	50th	25th	67th	90 th
Asthma Medication Ratio (AMR) *	33rd	75th +8.62%	50th	90th	<25th	75th	25th	75th	67 th or 75 th
Chlamydia Screening in Women (CHL) *	33rd	50th +3.40%	50th	75th	25th	33rd	25th	33rd	50 th – MPL or >50 th (CMS)
									25 th or 33 rd
									<25 th or <50 th (CMS)

* Measure removed from MCAS set in MY2026

 Improvement opportunity

MCAS Performance: Regional Opportunities

Additional MCAS Measures, Opportunities for Performance Improvement

	Plan-Wide		North Bay Area Rating Region		Rural Upper Central Rating Region		Rural Upper North Rating Region		
Measure Description	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	Benchmark
Developmental Screening in the First Three Years of Life (DEV) ^	<50th	50th +9.77%	<50th	50th	50th	<50th	<50th	<50th	90 th
Lead Screening in Children (LSC)	75th	67th +3.16%	50th	50th	50th	33rd	75th	67th	67 th or 75 th
Topical Fluoride for Children (TFL) ^	<50th	<50th +8.67%	<50th	50th	50th	50th	<50th	<50th	50 th – MPL or >50 th (CMS)
Cervical Cancer Screening (CCS-E)	50th (Hybrid)	25th -11.04%	75th (Hybrid)	50th	<25th (Hybrid)	<25th	25th (Hybrid)	50th	25 th or 33 rd
									<25 th or <50 th (CMS)

^ CMS measure, 50th percentile is highest benchmark

Improvement opportunity

MCAS Performance: Data Completeness/ Measure Limitations

Significant Data Completeness and Measure Limitation Issues

DHCS: No sanctions on FUM-30 or BCS-E in MY2025

Measure Description	Plan-Wide		North Bay Area Rating Region		Rural Upper Central Rating Region		Rural Upper North Rating Region		Benchmark
	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	
Follow-Up After Emergency Department Visit for Mental Illness - 30-Days (FUM-30)	<25th	<25th +21.25%	<25th	<25th	<25th	<25th	<25th	33rd	90 th
Breast Cancer Screening (BCS-E)	50th	33rd -2.86%	50th	50th	<25th	<25th	25th	<25th	67 th or 75 th
									50 th – MPL or >50 th (CMS)
									25 th or 33 rd
									<25 th or <50 th (CMS)



Conclusion

Key Takeaways

- High achievement or year-over-year improvement on **MCAS Withhold measures at the Regional Level** is the highest priority for network – this will drive success in all DHCS Accountability Programs and our NCQA Star Rating
- 2026 Priority Improvement Areas for Rating Regions, provider specific priorities will be aligned with this strategy:

North Bay Area (Marin, Napa, Solano, Sonoma, Yolo)	Rural Upper Central (Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba)	Rural Upper North (Del Norte, Humboldt, Lake, Lassen, Mendocino, Modoc, Shasta, Siskiyou, Trinity)
Towards Regional 67th percentile: 1. Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) 2. Child and Adolescent Well-Care Visits (WCV) 3. Lead Screening in Children (LSC) 4. Cervical Cancer Screening (CCS-E) 5. Follow-Up After Emergency Department Visit for Substance Use - 30-Days (FUA-30) 6. Colorectal Cancer Screening (COL) – New in MY2026!	Towards Regional 50th percentile: 1. Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) – select counties towards 67th 2. Controlling High Blood Pressure (CBP) 3. Child and Adolescent Well-Care Visits (WCV) 4. Immunizations for Adolescents - Combination 2 (IMA-E) 5. Timeliness of Prenatal Care (PPC-Pre) 6. Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months (W30-6)	Towards Regional 67th percentile: 1. Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) 2. Controlling High Blood Pressure (CBP) 3. Child and Adolescent Well-Care Visits (WCV) 4. Immunizations for Adolescents - Combination 2 (IMA-E) 5. Timeliness of Prenatal Care (PPC-Pre) 6. Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months (W30-2)

Questions?

HEDIS Team: hedisteam@partnershiphp.org

[MY2025 MCAS Annual Summary of Performance](#)

[MY2025 NCQA HPA Annual Summary of Performance](#)



Healthcare Effectiveness Data and Information Set (HEDIS®)

Measurement Year 2025 / Reporting Year 2026

**Managed Care Accountability Set (MCAS)
Summary of Performance
June 2026**

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1.0 Introduction

As a Medi-Cal Managed Care Plan, Partnership provides health care coverage for 24 counties in Northern California – the largest geographic footprint of any Medi-Cal Managed Care Plan in California. The health plan covers over 900,000 members who qualify for coverage based on low household income, and who make up a substantial portion of Northern California’s total population. The annual clinical measure performance analysis contained in this Annual Summary of Performance, centered on 18 HEDIS measures selected by DHCS, is intended to give the best possible understanding of the status of quality outcomes for the low-income population served in these counties.

Partnership generates a detailed Annual Summary of Performance and distributes it widely so that stakeholders in Northern California – local governments, county public health, medical and behavioral health providers, hospitals, and community foundations – can use current, local, accurate, and audited data to prioritize activities to meet the health care needs of their communities. The Summary of Performance contains regional and county-level data that show local strengths and opportunities for preventative health care based on national benchmarks. Behind each measure are many community members who were able to access the preventative services they needed to stay healthy, or who faced challenges and struggles to receive care.

In the end, it takes the entire health care delivery system working together to improve the health outcomes contained in this report. Partnership encourages everyone reading this report to review their local data closely, and look for a handful of ways their organization, alone or with others, can drive improvement on one or more measure that is important to them.

Partnership is always happy to connect organizations and community members within our network to resources and activities to help our members, and the communities we serve, be healthy. Please reach out to our Performance Improvement team at ImprovementAcademy@partnershiphp.org if you would like to learn more about activities in your area.

Thank you for your dedication to improving the health of our communities.

2.0 Notable Changes to the Measurement Year (MY) 2025 Annual Summary of Performance Report

MY2025 continued to host two required separate audits:

- DHCS / MCAS required reporting: Health Service Advisory Group (HSAG) Auditor (this report's focus)
- NCQA HEDIS Health Plan Accreditation / HPA: Advent Advisory Auditor

Partnership HEDIS Reporting Populations – MY2025

In MY2025, Partnership observed slight decrease in overall membership by approximately 1.3%, to 895,339 assigned members in December 2025.

Partnership reports one Plan-Wide rate for all 24 counties in its network for the MCAS measure set to its DHCS auditor, HSAG.

Starting in MY2024, Partnership also reports county-wide rates for all MCAS measures and their respective sub-measures to DHCS directly. DHCS uses county-wide rates to calculate outcomes for multiple accountability programs that are described below. County level rates for hybrid measures are calculated using a county-level oversample populations (minimum size of 100 members).

The impact of population shifts in Partnership's network from the 10 new counties joining the Partnership network in January 2024 continues to impact HEDIS measure reporting populations differently, depending on each measure's continuous enrollment requirements as defined in the NCQA HEDIS MY2025 Technical Specifications. One measure, Breast Cancer Screening, ECDS (BCS-E), requires continuous enrollment greater than one year for a member to be included in the measure's eligible population, which meant that very few members from incoming counties met the criteria to be included in the measures' plan-wide rates in MY2025. All other MCAS measures in the 10 incoming counties have eligible populations that reflect the current membership.

DHCS Managed Care Accountability Set (MCAS) Measure Set – MY2025

Table 1 shows the MY2025 DHCS MCAS Measure Set, which are the eighteen (18) NCQA HEDIS and CMS clinical measures that all California Medi-Cal Managed Care Plans are held to the Minimum Performance Level (MPL) of the Quality Compass 50th percentile. The table includes information such as measure domain and Quality Withhold and Incentive program flags, which are relevant to DHCS Accountability programs described below. All eighteen (18) measures in the MCAS measure set are continuous from MY2023-MY2025.

Table 1: MY2025 DHCS Managed Care Accountability Set – Measures Held to MPL (50th Percentile)

Measure Domain	Measure Abbr	Measure Name	DHCS Quality Withhold Program Measure?
Behavioral Health	FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	
Behavioral Health	FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	
Children's Health	WCV	Child and Adolescent Well-Care Visits	Y
Children's Health	CIS-E	Childhood Immunization Status - Combination 10	Y
Children's Health	IMA-E	Immunizations for Adolescents - Combination 2	Y
Children's Health	W30-2	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months	Y
Children's Health	W30-6	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months	Y
Children's Health	DEV	Developmental Screening in the First Three Years of Life	
Children's Health	LSC	Lead Screening in Children	
Children's Health	TFL	Topical Fluoride for Children	
Chronic Disease	CBP	Controlling High Blood Pressure	Y
Chronic Disease	GSD	Glycemic Status Assessment for Patients With Diabetes (>9%)	Y
Chronic Disease	AMR	Asthma Medication Ratio	
Reproductive Health and Cancer Prevention	PPC-Post	Prenatal and Postpartum Care: Postpartum Care	Y
Reproductive Health and Cancer Prevention	PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Y
Reproductive Health and Cancer Prevention	BCS-E	Breast Cancer Screening	
Reproductive Health and Cancer Prevention	CCS-E	Cervical Cancer Screening	
Reproductive Health and Cancer Prevention	CHL	Chlamydia Screening in Women	

NCQA released changes to several existing clinical measures used in DHCS MCAS for MY2025:

- ECDS measure Childhood Immunization Status Combination 10 (CIS-10-E) replaced the hybrid measure Childhood Immunization Status Combination 10 (CIS-10).

- ECDS measure Immunizations for Adolescents Combination 2 (IMA-2-E) replaced the hybrid measure Immunizations for Adolescents Combination 2 (IMA-2).
- ECDS measure Cervical Cancer Screening (CCS-E) replaced hybrid measure Cervical Cancer Screening (CCS).
- Breast Cancer Screening (BCS-E)'s age band expanded from 52-75 years to include members 42-75 years.

DHCS Accountability Programs

Since 2019, DHCS has introduced multiple MCP accountability programs that align plan MCAS measure performance with DHCS's Comprehensive Quality Strategy and Bold Goals Initiative. **Table 2** outlines DHCS accountability programs that are driven by MY2025 measure performance, and each program is described below. Results for each program are announced late in the Reporting Year, after the publication of the Annual Summary of Performance.

Table 2: DHCS Accountability Programs Driven by MCAS Measure Performance, MY2025

Program	Description	Geographic Impact	Financial Impact	Financial Impact Trigger
Quality Withholds and Incentive Program	MCP's earn back withheld revenue with high regional performance or improvement on subset of MCAS measures Incentive earnback with closing regional disparities on WCV measure	Quality Rating Regions	1% of MCP's annual revenue earned back	<67th percentile performance AND <25% YoY improvement
Clinical Efficiencies	Performance on clinical efficiency measures (mostly inpatient) impact MCP rate setting	Plan Wide	Plan rates	Main driver: low performance Ambulatory Sensitive Admissions
Community Reinvestments Quality	5% annual net income automatically invested in county community projects, Quality Factor is an additional investment amount based on quality measure performance	County	Additional 7.5% of annual net income - prorated by county membership	2+ measures <50th percentile in a measure domain
Quality Sanctions	Fines for performance below 50th percentile on all MCAS measures	County	Measure population not served is main factor	<50th percentile
Quality Factor Score	Composite MCAS measure score used to compare MCP performance state-wide	Plan Wide	None	None

Quality Withholds and Incentives Program

DHCS's Quality Withholds and Incentives accountability program allows Partnership to earn back a percentage of its withheld income from DHCS based on high performance or significantly improved year-over-year performance on a subset of MCAS measures, as well as two CAHPS measures. The Withholds and Incentives accountability program will be applied to Partnership's three (3) Quality Rating Regions based on MY2025 measure performance. DHCS will use county-level measure rates to calculate weighted regional rates for Partnership's three (3) Quality Rating Regions.

Table 1 (above) flags MY2025 MCAS measures that are included in the Quality Withholds program.



DHCS Quality Rating Region	Counties
North Bay	Marin, Napa, Sonoma, Solano, Yolo
Rural Upper North	Del Norte, Humboldt, Lassen, Lake, Mendocino, Modoc, Shasta, Siskiyou, Trinity
Rural Upper Central	Butte, Colusa, Glenn, Nevada, Placer, Plumas, Sierra, Sutter, Tehama, Yuba

Clinical Efficiency Program

This program focuses on reducing inefficient utilization of healthcare services by eliminating a portion of inefficient spend during MCP rate development. DHCS's program focuses on several aspects of inefficient spend: Potentially Preventable Admissions (PPA) is the largest current factor impacting Partnership. Though PPA is not an NCQA HEDIS measure, a number of drivers of PPA are indicated in MCAS measures, such as Controlling Blood Pressure (CBP) and Asthma Medication Ratio (AMR).

Quality Accountability Community Reinvestment Program

The Community Reinvestment Program is DHCS's newest accountability program for Managed Care Plans. This program requires Partnership to pay counties with multiple measures below the 50th percentile in any of four (4) measure domains 7.5 percent of annual net income, pro-rated by county membership. **Table 1** (above) shows the MY2025 MCAS measures within the four measure domains.

Quality Sanctions Program

DHCS intends to hold all California Managed Care Plans accountable for sanctions for all MCAS Accountable measures that did not reach the 50th percentile benchmark at either the county level or at the level of groups of counties. In MY2025 sanctions will be applied to all 24 counties in Partnership's network.

Quality Factor Score

DHCS uses a scoring methodology to determine an aggregated Quality Factor Score (QFS), which ranks health plan performance relative to California Medicaid reporting health plans. This score is reputational in nature and carries no financial risk for Partnership.

Partnership's Efforts to Improve Data Quality – MY2025

Partnership was able to use a number of new supplemental data sources in the MY2025 HEDIS Annual project.

Electronic Clinical Data Systems (ECDS) Vendor: Partnership expanded its use of Datalink, an NCQA Certified Data Aggregator software, in MY2025, and received auditor approval to include records in the MY2025 HEDIS Project. The use of clinical data towards HEDIS measure rate calculation is an important step towards readiness for NCQA's planned transition of hybrid measures to ECDS measures by 2029, which require structured clinical data for measure rate generation; and towards readiness for CMS's Interoperability Framework.

Records from over 30 practices within Partnership's provider network were included in the MY2025 HEDIS Annual Project. Partnership continues to make progress with leveraging Datalink as a supplemental data source:

- Even without full implementation across the Partnership network, Datalink made a significant positive impact on administrative rates for MCAS Accountable measures. To summarize, the impact of Datalink on measure rates includes:
 - o 23% of total care gaps closed for the CBP administrative measure, plan-wide
 - o 17% of total care gaps closed for the GSD administrative measure, plan-wide
 - o 18% of total care gaps closed for the BCS-E ECDS measure, plan-wide
 - o 12% of total care gaps closed for the CCS-E ECDS measure, plan-wide
- Partnership is preparing for the addition of three (3) Depression Screening measures to the MCAS accountable measure set in MY2026: Depression Screening for Adolescents and Adults (DSF-E-SC); Prenatal Depression Screening (PND-E-SC); and Postpartum Depression Screening (PDS-E-SC). Datalink will be the sole source of data for these three measures.

Year Round Medical Record Review for Well-Child Visits in the First 30 Months of Life (W30) and Prenatal and Postpartum Care (PPC) measures: In MY2024, the QI department identified a systems issue with newborns' temporary member ID's that caused underreporting of newborn visit rates for the W30 measure. To address, the HEDIS team completed a supplemental Medical Record Review of the entire W30 measure eligible population in early 2025, which was accepted as a supplemental data source by HSAG's auditor. The supplemental Medical Record Review made a dramatic impact on the rates for both W30 submeasures, and both W30 submeasure rates scored above the 67th percentile for MY2024.

In MY2025, the HEDIS team repeated the Medical Record Review as a year-round effort, which allowed the team more time to collect and review charts for the W30 eligible population. The team also expanded the scope of the year-round Medical Record Review to allow the Prenatal and Postpartum Care (PPC) submeasures to benefit from the extended review period.

Electronic Record on Demand (ERD) Clinical Data retrieval pilot: Partnership piloted an additional clinical data retrieval methodology supported by the plan's HEDIS certified software vendor, Inovalon. The pilot was focused on retrieving clinical records for measures that were not included in the ECDS Datalink scope which resulted in a slight increase in rates across 22 measures in the MCAS and NCQA Health Plan Accreditation measure sets. Further assessment is underway to determine the potential to expand this effort.

Sacramento Valley MedShare (SVMS): SVMS is a Health Information Exchange used by practices and health systems throughout Northern California. In MY2025, Partnership received auditor approval to use Encounter, Lab, and Measurement (i.e., blood pressure readings) records towards the HEDIS Annual Project, which had a significant impact on several MCAS measures in MY2025. SVMS's Immunization records did not receive auditor approval to be included in the MY2025 HEDIS rate generation.

Root cause analysis of fluoride varnish services: Partnership worked with DHCS in 2024 - 2025 to better understand how it receives fluoride varnish claims and encounters that can be counted towards the Topical Fluoride for Children (TFL) MCAS measure, most of which are billed to Denti-Cal from Federally Qualified Health Center (FQHC), Rural Health Center (RHC), and Tribal Health Dental Centers and then sent to Partnership. In 2025 Partnership actively worked with DHCS and Dental Centers throughout its network to standardize and spread dental fluoride varnish coding that would accurately capture completed services towards the MY2025 measure. The plan also created a Dental Liaison role on the Quality Improvement team to promote pediatric dental care and ensure that the Partnership network has high quality dental directory resources and referral pathways for pediatric members. This has resulted in significant improvements to Partnership's ability to accurately report pediatric fluoride varnish application rates.

HEDIS Annual Project Outcomes

Partnership successfully launched our HEDIS® MY2025 / RY2026 data collection and reporting audits incorporating all changes as noted above.

DHCS MCAS Accountable Measures

In MY2025 / RY2026 HEDIS® Annual Final Reporting, DHCS announced that it is planning to hold managed care plans (MCPs) accountable and imposing financial sanctions on 18 selected Hybrid and Administrative measures performing below the minimum performance level (MPL - 50th national Medicaid percentile). The same 18 MCAS accountable measures from MY2024 continued into MY2025. See **Section 2** above for a full description of DHCS accountability programs.

Results of an additional 10 MCAS measures were reported but were not part of the accountability measure set in MY2025 (“reporting only measures”). The full list of MY2025 MCAS measures can be found on the DHCS website: <https://www.dhcs.ca.gov/dataandstats/reports/Documents/Medi-Cal-Accountability-Set-Reporting-Year-2026.pdf>

Much of the measure performance analysis that follows is based on the performance of the 18 accountable MCAS measures per NCQA Quality Compass 2025 Benchmarks, developed on MY2024 performance.

3.0 Plan-Wide MCAS Performance Relative to Quality Compass® Medicaid Benchmarks

● Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)

■ Below MVL (minimum performance level, based on NCQA's Quality Compass Medicaid 50th percentile)

Plan Wide Performance			Medicaid National Benchmarks			
Abbr	Measure	Plan Wide	25TH	50TH	75TH	90TH
Behavioral Health Domain						
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	41.35%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	50.26%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain						
CIS-E	Childhood Immunization Status - Combination 10	26.74%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life ^{1,3}	39.42%		37.40%		
IMA-E	Immunizations for Adolescents - Combination 2	39.39%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	74.94%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children ³	21.07%		21.50%		
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months ⁵	76.64%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months ⁵	64.64%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	52.57%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain						
AMR	Asthma Medication Ratio	73.33%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure ¹	67.40%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) ^{1,4}	27.74%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain						
BCS-E	Breast Cancer Screening ²	53.43%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	48.08%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	58.98%	48.48%	56.30%	65.47%	70.67%
PPC-Post	Prenatal and Postpartum Care: Postpartum Care ¹	90.02%	78.10%	82.48%	85.15%	88.32%
PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	87.10%	82.97%	86.37%	89.78%	91.97%

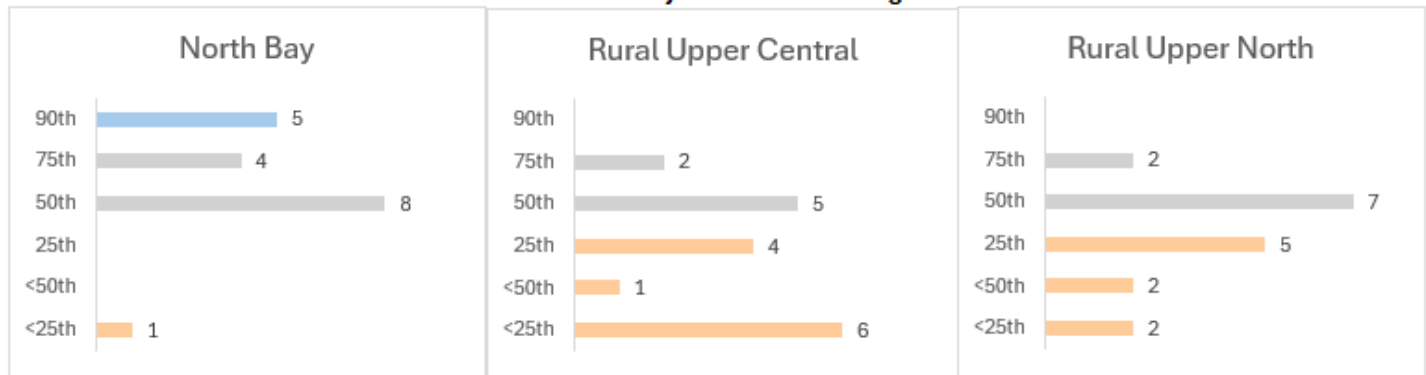
(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

4.0 MCAS Summary of Performance by Region

Regional Distribution of Measures by Percentile Ranking

- **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
- **Below MFL** (minimum performance level, based on NCQA's Quality Compass Medicaid 50th percentile)

Distribution of Measure by Percentile Ranking



4.1 MCAS Measures at or Above the High Performance Level (HPL) – 90th Percentile

Measures at or Above the High Performance Level (HPL) – 90th Percentile

Abbr	Measures	North Bay
Children's Health Domain		
CIS-E	Childhood Immunization Status - Combination 10	●
IMA-E	Immunizations for Adolescents - Combination 2	●
Chronic Disease Domain		
AMR	Asthma Medication Ratio	●
Reproductive Health and Cancer Prevention Domain		
PPC-Post	Prenatal and Postpartum Care: Postpartum Care ¹	●
PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	●

4.2 MCAS Measures below the Minimum Performance Level (MPL) - 50th Percentile

Measures below the Minimum Performance Level (MPL) - 50th Percentile				
Abbr	Measures	North Bay	Rural Upper Central	Rural Upper North
Behavioral Health Domain				
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness (FUM)-30-Day Follow-Up	●	●	●
Children's Health Domain				
CIS-E	Childhood Immunization Status ECDS (CIS-E)-Combination 10			●
DEV	Developmental Screening in the First Three Years of Life (DEV-CH)-Total, All Ages		●	●
IMA-E	Immunizations for Adolescents ECDS (IMA-E)-Combination 2		●	●
LSC	Lead Screening in Children (LSC)		●	
TFL	Topical Fluoride for Children (TFL-CH)-Numerator 1 Total			●
W30-6	Well Child 30 (W30)-Well Child Visits in the First 15 Months		●	
WCV	Child and Adolescent Well-Care Visits (WCV)-Total		●	●
Chronic Disease Domain				
CBP	Controlling High Blood Pressure (CBP)-Non-Medicare Total		●	
Reproductive Health and Cancer Prevention Domain				
BCS	Breast Cancer Screening ECDS (BCS-E)-Non-Medicare Total		●	●
CCS	Cervical Cancer Screening ECDS (CCS-E)		●	
CHL	Chlamydia Screening in Women (CHL)-Total		●	●
PPC-Pre	Prenatal and Postpartum Care (PPC)-Timeliness of Prenatal Care		●	●

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.0 MCAS Summary of Performance by County

5.1 MCAS Distribution of Percentile Rankings by County

 Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
 Below MVL (minimum performance level, based on NCQA's Quality Compass Medicaid 50th percentile)

Distribution of Percentile Rankings by County



NOTE: The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. Performance below the 50th percentile is indicated by the <50th column in the graph.

5.2 MCAS Percentile Ranking Change from Prior Year

Where measures remained in the MCAS in MY2025, the next set of tables show that Partnership observed a number of measures that declined or improved in percentile ranking relative to prior year. The NCQA Quality Compass 2025 Benchmarks, which were developed based on MY2024 performance, result in the percentile rankings below.

At the County level, a comparison of county-level performance between MY2024 and MY2025 in Partnership's 24 counties shows:

- 147 county-level measures, or 34% of 432 county-level measures, improved in performance and moved to a higher benchmark in MY2025.
- 204 county-level measures, or 47% of 432 county-level measures, stayed at their same benchmark as MY2024 in MY2025.
- 81 county-level measures, or 19% of 432 county-level measures, declined in performance and moved to a lower benchmark in MY2025.

5.2.1 MCAS Percentile Ranking Change MY2024-2025 – Auburn Region: Nevada, Placer, Plumas, Sierra Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		NEVADA		PLACER		PLUMAS		SIERRA	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain									
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	50th	25th	<25th	50th	<25th	50th	<25th	90th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	25th	<25th	<25th	<25th	50th	90th	<25th
Children's Health Domain									
CIS-E	Childhood Immunization Status - Combination 10	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
DEV	Developmental Screening in the First Three Years of Life ^{1,3}	50th	<50th	50th	50th	<50th	<50th	<50th	<50th
IMA-E	Immunizations for Adolescents - Combination 2	<25th	<25th	25th	<25th	<25th	<25th	<25th	25th
LSC	Lead Screening in Children	75th	25th	50th	50th	75th	<25th	<25th	<25th
TFL	Topical Fluoride for Children ³	<50th	<50th	50th	50th	<50th	<50th	<50th	<50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months ⁵	90th	<25th	<25th	25th	<25th	<25th	<25th	<25th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months ⁵	<25th	<25th	<25th	25th	<25th	<25th	<25th	<25th
WCV	Child and Adolescent Well-Care Visits	<25th	<25th	25th	25th	<25th	<25th	<25th	<25th
Chronic Disease Domain									
AMR	Asthma Medication Ratio	<25th	50th	<25th	90th	90th	25th	<25th	90th
CBP	Controlling High Blood Pressure ¹	<25th	50th	<25th	<25th	<25th	<25th	<25th	<25th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) ^{1,4}	50th	25th	50th	25th	90th	<25th	0	25th
Reproductive Health and Cancer Prevention Domain									
BCS-E	Breast Cancer Screening ²	90th	25th	<25th	<25th	<25th	<25th	<25th	<25th
CCS-E	Cervical Cancer Screening	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
CHL	Chlamydia Screening in Women	<25th	25th	50th	50th	<25th	<25th	<25th	<25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care ¹	75th	90th	75th	25th	25th	75th	<25th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	25th	50th	<25th	<25th	75th	25th	<25th	25th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.2 MCAS Percentile Ranking Change MY2024-2025 – Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		BUTTE		COLUSA		GLENN		SUTTER		YUBA	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain											
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	<25th	50th	25th	50th	25th	25th	<25th	50th	<25th	50th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	<25th	<25th	25th	<25th	<25th	<25th	50th	<25th	50th
Children's Health Domain											
CIS-E	Childhood Immunization Status - Combination 10	<25th	50th	<25th	50th	50th	75th	90th	75th	90th	75th
DEV	Developmental Screening in the First Three Years of Life ^{1,3}	<50th	<50th	50th	<50th	50th	50th	50th	50th	50th	50th
IMA-E	Immunizations for Adolescents - Combination 2	<25th	<25th	<25th	<25th	50th	<25th	50th	90th	50th	90th
LSC	Lead Screening in Children	<25th	<25th	90th	50th	75th	50th	90th	75th	90th	75th
TFL	Topical Fluoride for Children ³	<50th	<50th	50th	50th	<50th	<50th	50th	50th	50th	50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months ⁵	<25th	50th	90th	75th	<25th	50th	<25th	90th	<25th	90th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months ⁵	<25th	25th	<25th	<25th	<25th	<25th	<25th	25th	<25th	25th
WCV	Child and Adolescent Well-Care Visits	<25th	<25th	50th	90th	50th	50th	50th	50th	50th	50th
Chronic Disease Domain											
AMR	Asthma Medication Ratio	50th	50th	<25th	90th	90th	90th	<25th	50th	<25th	50th
CBP	Controlling High Blood Pressure ¹	50th	<25th	25th	25th	75th	<25th	50th	<25th	50th	<25th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) ^{1,4}	90th	50th	50th	25th	50th	<25th	50th	75th	50th	75th
Reproductive Health and Cancer Prevention Domain											
BCS-E	Breast Cancer Screening ²	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
CCS-E	Cervical Cancer Screening	<25th	<25th	<25th	25th	<25th	<25th	<25th	<25th	<25th	<25th
CHL	Chlamydia Screening in Women	25th	25th	25th	25th	25th	25th	50th	25th	50th	25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care ¹	90th	75th	90th	90th	75th	75th	90th	90th	90th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	25th	<25th	<25th	90th	25th	<25th	50th	25th	50th	25th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.3 MCAS Percentile Ranking Change MY2024-2025 – Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		DEL NORTE		HUMBOLDT		LAKE		MENDOCINO	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain									
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	25th	50th	25th	75th	25th	50th	25th	25th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	<25th	<25th	25th	<25th	<25th	<25th	<25th
Children's Health Domain									
CIS-E	Childhood Immunization Status - Combination 10	<25th	<25th	<25th	25th	25th	50th	50th	50th
DEV	Developmental Screening in the First Three Years of Life ^{1,3}	<50th	<50th	50th	50th	<50th	<50th	<50th	<50th
IMA-E	Immunizations for Adolescents - Combination 2	50th	25th	50th	75th	50th	90th	<25th	50th
LSC	Lead Screening in Children	<25th	25th	90th	50th	50th	90th	75th	90th
TFL	Topical Fluoride for Children ³	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months ⁵	50th	<25th	75th	50th	75th	90th	75th	75th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months ⁵	75th	<25th	75th	25th	90th	90th	90th	90th
WCV	Child and Adolescent Well-Care Visits	25th	50th	25th	25th	25th	25th	25th	25th
Chronic Disease Domain									
AMR	Asthma Medication Ratio	25th	75th	25th	50th	<25th	90th	25th	90th
CBP	Controlling High Blood Pressure ¹	<25th	25th	75th	90th	<25th	75th	25th	<25th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) ^{1,4}	50th	75th	0	75th	90th	<25th	50th	50th
Reproductive Health and Cancer Prevention Domain									
BCS-E	Breast Cancer Screening ²	<25th	<25th	25th	25th	25th	<25th	50th	25th
CCS-E	Cervical Cancer Screening	<25th	<25th	25th	50th	<25th	50th	25th	50th
CHL	Chlamydia Screening in Women	<25th	25th	25th	25th	25th	50th	25th	25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care ¹	25th	<25th	90th	90th	90th	90th	90th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	<25th	<25th	<25th	<25th	50th	90th	50th	50th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.4 MCAS Percentile Ranking Change MY2024-2025 – Fairfield Region: Napa, Solano, Yolo Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		NAPA		SOLANO		YOLO	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain							
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	<25th	50th	<25th	50th	<25th	25th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	<25th	<25th	<25th	<25th	<25th
Children's Health Domain							
CIS-E	Childhood Immunization Status - Combination 10	90th	90th	50th	75th	75th	50th
DEV	Developmental Screening in the First Three Years of Life ^{1,3}	<50th	<50th	<50th	<50th	50th	50th
IMA-E	Immunizations for Adolescents - Combination 2	90th	90th	75th	75th	75th	90th
LSC	Lead Screening in Children	90th	90th	75th	50th	50th	50th
TFL	Topical Fluoride for Children ³	<50th	50th	<50th	50th	50th	50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months ⁵	75th	75th	<25th	50th	75th	75th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months ⁵	25th	90th	25th	25th	<25th	50th
WCV	Child and Adolescent Well-Care Visits	50th	75th	<25th	<25th	50th	25th
Chronic Disease Domain							
AMR	Asthma Medication Ratio	90th	90th	25th	75th	50th	90th
CBP	Controlling High Blood Pressure ¹	25th	75th	50th	75th	25th	75th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) ^{1,4}	50th	50th	90th	25th	50th	50th
Reproductive Health and Cancer Prevention Domain							
BCS-E	Breast Cancer Screening ²	90th	90th	50th	25th	75th	50th
CCS-E	Cervical Cancer Screening	25th	50th	<25th	<25th	25th	25th
CHL	Chlamydia Screening in Women	<25th	50th	50th	75th	25th	25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care ¹	90th	50th	90th	90th	50th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	<25th	90th	25th	25th	<25th	90th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.5 MCAS Percentile Ranking Change MY2024-2025 – Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties

Tehama County is excluded from the Redding Region table, since the County joined Partnership in 2024.

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		LASSEN		MODOC		SHASTA		SISKIYOU		TEHAMA		TRINITY	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain													
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	<25th	25th	<25th	75th	25th	75th	50th	25th	<25th	25th	<25th	25th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	<25th	<25th	<25th	<25th	50th	<25th	50th	<25th	<25th	<25th	25th
Children's Health Domain													
CIS-E	Childhood Immunization Status - Combination 10	<25th	<25th	<25th	<25th	<25th	<25th	25th	<25th	<25th	25th	<25th	<25th
DEV	Developmental Screening in the First Three Years of Life ^{1,3}	<50th	<50th	<50th	50th	<50th	<50th	<50th	50th	<50th	<50th	<50th	<50th
IMA-E	Immunizations for Adolescents - Combination 2	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th
LSC	Lead Screening in Children	75th	25th	90th	25th	50th	50th	25th	25th	75th	25th	75th	25th
TFL	Topical Fluoride for Children ³	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th	<50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months ⁵	50th	<25th	<25th	<25th	<25th	25th	25th	<25th	75th	50th	<25th	<25th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months ⁵	50th	25th	<25th	<25th	75th	50th	<25th	25th	90th	<25th	25th	<25th
WCV	Child and Adolescent Well-Care Visits	<25th	<25th	25th	<25th	<25th	25th	25th	25th	<25th	25th	25th	<25th
Chronic Disease Domain													
AMR	Asthma Medication Ratio	<25th	75th	25th	90th	<25th	50th	25th	90th	<25th	50th	<25th	<25th
CBP	Controlling High Blood Pressure ¹	50th	25th	<25th	<25th	<25th	50th	50th	75th	25th	25th	<25th	<25th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) ^{1,4}	50th	<25th	25th	75th	25th	90th	<25th	50th	90th	25th	25th	50th
Reproductive Health and Cancer Prevention Domain													
BCS-E	Breast Cancer Screening ²	<25th	<25th	25th	25th	50th	<25th	25th	25th	<25th	<25th	25th	<25th
CCS-E	Cervical Cancer Screening	<25th	<25th	<25th	25th	25th	25th	25th	25th	<25th	<25th	25th	25th
CHL	Chlamydia Screening in Women	<25th	25th	<25th	<25th	25th	25th	<25th	25th	25th	25th	<25th	<25th
PPC-POST	Prenatal and Postpartum Care: Postpartum Care ¹	25th	50th	25th	<25th	<25th	75th	75th	<25th	25th	75th	<25th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	50th	50th	25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	<25th	25th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.2.6 MCAS Percentile Ranking Change MY2024-2025 – Santa Rosa Region: Marin, Sonoma Counties

- Measure percentile ranking improved from Prior Year
- Measure percentile ranking decreased from Prior Year

		MARIN		SONOMA	
ABBR	MEASURES	MY2024	MY2025	MY2024	MY2025
Behavioral Health Domain					
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	50th	50th	25th	50th
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	<25th	25th	<25th	25th
Children's Health Domain					
CIS-E	Childhood Immunization Status - Combination 10	50th	90th	75th	90th
DEV	Developmental Screening in the First Three Years of Life ^{1,3}	50th	50th	<50th	50th
IMA-E	Immunizations for Adolescents - Combination 2	90th	90th	90th	90th
LSC	Lead Screening in Children	90th	90th	25th	<25th
TFL	Topical Fluoride for Children ³	<50th	50th	<50th	50th
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months ⁵	90th	90th	50th	75th
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months ⁵	90th	90th	90th	90th
WCV	Child and Adolescent Well-Care Visits	50th	50th	50th	50th
Chronic Disease Domain					
AMR	Asthma Medication Ratio	25th	75th	50th	90th
CBP	Controlling High Blood Pressure ¹	50th	25th	75th	90th
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) ^{1,4}	50th	25th	<25th	75th
Reproductive Health and Cancer Prevention Domain					
BCS-E	Breast Cancer Screening ²	75th	50th	50th	50th
CCS-E	Cervical Cancer Screening	25th	50th	50th	50th
CHL	Chlamydia Screening in Women	90th	90th	25th	50th
PPC-POST ₁	Prenatal and Postpartum Care: Postpartum Care	90th	90th	90th	90th
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	50th	90th	25th	90th

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3 MY2025 MCAS Annual Performance by County

5.3.1 MCAS Auburn Region: Nevada, Placer, Plumas, Sierra Counties

- Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
● Below MLE (minimum performance level, based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Auburn				National Medicaid Benchmarks			
Abbr	Measure	NEVADA	PLACER	PLUMAS	SIERRA	25TH	50TH	75TH	90TH
Behavioral Health Domain									
FUA-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	38.97%	44.96%	45.71%	100.00%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	52.27%	41.97%	57.50%	12.50%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain									
CIS-E	Childhood Immunization Status - Combination 10	13.61%	16.47%	0.00%	10.00%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life ^{1,3}	23.53%	43.14%	4.90%	17.39%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	13.01%	29.10%	10.13%	33.33%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	67.00%	75.00%	45.28%	20.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children ³	13.02%	22.72%	7.38%	9.05%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months ⁵	64.09%	70.53%	57.14%	66.67%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months ⁵	41.76%	60.71%	30.56%	12.50%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	44.69%	50.27%	39.48%	32.61%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain									
AMR	Asthma Medication Ratio	67.27%	80.43%	63.16%	100.00%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure ¹	71.00%	53.00%	62.00%	52.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) ^{1,4}	32.00%	31.00%	73.00%	31.58%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain									
BCS-E	Breast Cancer Screening ²	52.94%	50.00%	0.00%	0.00%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	38.96%	38.27%	16.37%	30.77%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	48.90%	58.83%	27.07%	7.69%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care ¹	95.00%	82.00%	86.44%	100.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	87.00%	77.00%	84.75%	83.33%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.2 MCAS Chico Region: Butte, Colusa, Glenn, Sutter, Yuba Counties

● Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)

● Below MVL (minimum performance level, based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Chico					National Medicaid Benchmarks			
Abbr	Measure	BUTTE	COLUSA	GLENN	SUTTER	YUBA	25TH	50TH	75TH	90TH
Behavioral Health Domain										
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	43.34%	39.13%	35.59%	39.47%	37.50%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	45.25%	54.02%	48.21%	59.72%	60.21%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain										
CIS-E	Childhood Immunization Status - Combination 10	27.77%	28.78%	30.41%	33.50%	23.46%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life ^{1, 3}	20.59%	23.53%	48.04%	55.88%	49.02%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	25.62%	29.13%	24.44%	51.93%	43.35%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	55.00%	75.00%	75.00%	80.00%	65.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children ³	20.23%	31.82%	14.70%	35.18%	26.02%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months ⁵	74.16%	81.75%	75.17%	88.04%	76.98%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months ⁵	59.95%	55.75%	35.88%	58.51%	54.14%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	44.32%	68.06%	57.58%	59.83%	50.26%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain										
AMR	Asthma Medication Ratio	68.79%	80.00%	78.35%	69.62%	64.93%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure ¹	61.00%	64.00%	62.00%	64.00%	55.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) ^{1, 4}	30.00%	31.00%	36.00%	26.00%	26.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain										
BCS-E	Breast Cancer Screening ²	36.96%	11.11%	42.86%	40.00%	44.44%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	36.16%	49.25%	44.72%	46.08%	40.79%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	54.53%	50.94%	50.75%	55.91%	58.97%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care ¹	87.00%	97.00%	87.00%	88.00%	82.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	81.00%	93.00%	69.00%	86.00%	87.00%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.3 MCAS Eureka Region: Del Norte, Humboldt, Lake, Mendocino Counties

● **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
● **Below MVL** (minimum performance level, based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Eureka				National Medicaid Benchmarks			
Abbr	Measures	DEL NORTE	HUMBOLDT	LAKE	MENDOCINO	25TH	50TH	75TH	90TH
Behavioral Health Domain									
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	41.73%	46.22%	39.31%	35.44%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	47.18%	53.14%	47.34%	49.04%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain									
CIS-E	Childhood Immunization Status - Combination 10	5.07%	21.66%	26.90%	25.16%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life ^{1,3}	32.35%	53.92%	26.47%	17.65%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	33.94%	41.59%	50.19%	36.23%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	65.00%	74.00%	84.00%	84.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children ³	9.86%	9.53%	7.08%	10.69%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months ⁵	62.07%	75.81%	86.24%	79.66%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months ⁵	56.92%	61.39%	80.12%	77.86%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	55.90%	51.56%	50.46%	55.28%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain									
AMR	Asthma Medication Ratio	74.07%	65.52%	81.37%	80.37%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure ¹	66.00%	79.00%	75.00%	58.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) ^{1,4}	24.00%	25.00%	39.00%	29.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain									
BCS-E	Breast Cancer Screening ²	46.57%	52.24%	47.58%	53.30%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	46.91%	53.01%	54.00%	55.98%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	52.49%	53.82%	63.70%	56.29%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care ¹	76.00%	93.00%	89.00%	94.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	80.00%	79.00%	94.00%	88.00%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.4 MCAS Fairfield Region: Solano, Yolo, and Napa Counties

● **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)
● **Below MUL** (minimum performance level, based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Fairfield			National Medicaid Benchmarks			
Abbr	Measures	NAPA	SOLANO	YOLO	25TH	50TH	75TH	90TH
Behavioral Health Domain								
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	40.11%	40.75%	33.33%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	40.49%	47.36%	39.97%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain								
CIS-E	Childhood Immunization Status - Combination 10	38.56%	32.03%	26.68%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life ^{1,3}	11.76%	34.31%	44.12%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	57.56%	46.98%	48.03%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	86.00%	74.00%	72.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children ³	27.05%	22.99%	25.19%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months ⁵	80.13%	72.82%	78.63%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months ⁵	75.36%	62.18%	66.98%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	64.08%	48.38%	54.46%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain								
AMR	Asthma Medication Ratio	84.88%	74.58%	77.20%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure ¹	73.00%	73.00%	74.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) ^{1,4}	30.00%	34.00%	28.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain								
BCS-E	Breast Cancer Screening ²	68.63%	52.50%	56.03%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	53.29%	45.82%	51.78%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	60.46%	69.97%	55.05%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care ¹	84.00%	92.00%	95.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	93.00%	86.00%	94.00%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.5 MCAS Redding Region: Lassen, Modoc, Shasta, Siskiyou, Tehama, Trinity Counties

● Above HPL (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)

● Below MVL (minimum performance level, based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Redding						National Medicaid Benchmarks			
Abbr	Measures	LASSEN	MODOC	SHASTA	SISKIYOU	TEHAMA	TRINITY	25TH	50TH	75TH	90TH
Behavioral Health Domain											
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	29.63%	48.00%	51.58%	34.92%	28.31%	30.77%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	47.27%	41.67%	59.20%	62.81%	38.10%	52.94%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain											
CIS-E	Childhood Immunization Status - Combination 10	3.23%	11.11%	10.02%	16.49%	20.05%	3.45%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life ^{1, 3}	22.55%	45.00%	35.29%	43.14%	36.27%	11.76%	-	37.40%	-	-
IMA-E	Immunizations for Adolescents - Combination 2	11.54%	16.92%	18.75%	19.22%	26.33%	15.49%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	62.77%	66.67%	74.00%	63.00%	68.00%	67.80%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children ³	8.54%	5.13%	13.67%	10.63%	14.06%	10.26%	-	21.50%	-	-
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months ⁵	54.08%	59.52%	71.36%	67.91%	77.10%	62.71%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months ⁵	58.70%	45.71%	64.69%	59.05%	57.81%	46.51%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	33.68%	47.08%	49.71%	50.13%	51.95%	49.07%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain											
AMR	Asthma Medication Ratio	71.43%	100.00%	65.33%	78.26%	69.06%	45.71%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure ¹	67.00%	57.00%	71.00%	73.00%	65.00%	54.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) ^{1, 4}	39.00%	26.00%	23.00%	28.00%	31.00%	28.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain											
BCS-E	Breast Cancer Screening ²	39.31%	51.72%	45.02%	50.99%	50.00%	34.53%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	44.09%	49.74%	51.11%	51.49%	40.93%	49.61%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	53.59%	46.05%	54.35%	51.43%	53.02%	40.00%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care ¹	82.76%	64.86%	86.00%	76.00%	86.00%	90.91%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	88.51%	70.27%	79.00%	81.00%	78.00%	86.36%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

5.3.6 MCAS Santa Rosa Region: Marin, Sonoma Counties

● **Above HPL** (high performance level, based on NCQA's Quality Compass Medicaid 90th percentile)

● **Below MVL** (minimum performance level, based on NCQA's Quality Compass Medicaid 50th percentile)

		Partnership Region - Santa Rosa		National Medicaid Benchmarks			
Abbr	Measures	MARIN	SONOMA	25TH	50TH	75TH	90TH
Behavioral Health Domain							
FUA-30	Follow-Up After Emergency Department Visit for Substance Use - 30-Days	43.18%	39.74%	30.17%	39.10%	45.80%	53.27%
FUM-30	Follow-Up After Emergency Department Visit for Mental Illness - 30-Days	55.08%	54.83%	50.47%	57.13%	64.91%	74.67%
Children's Health Domain							
CIS-E	Childhood Immunization Status - Combination 10	45.92%	40.14%	19.77%	23.89%	28.86%	34.79%
DEV	Developmental Screening in the First Three Years of Life ^{1, 3}	81.37%	41.18%		37.40%		
IMA-E	Immunizations for Adolescents - Combination 2	67.47%	55.78%	29.42%	34.14%	40.19%	47.16%
LSC	Lead Screening in Children	86.00%	61.00%	61.31%	69.96%	76.34%	82.86%
TFL	Topical Fluoride for Children ³	41.72%	27.35%		21.50%		
W30-2+	Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months ⁵	91.59%	78.86%	68.38%	72.32%	77.50%	82.12%
W30-6+	Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months ⁵	78.83%	74.53%	58.04%	63.38%	67.49%	71.71%
WCV	Child and Adolescent Well-Care Visits	60.35%	58.16%	49.68%	55.41%	61.47%	67.63%
Chronic Disease Domain							
AMR	Asthma Medication Ratio	73.23%	79.28%	57.63%	63.66%	70.39%	76.25%
CBP	Controlling High Blood Pressure ¹	64.00%	74.00%	63.75%	67.88%	71.34%	75.43%
GSD>9	Glycemic Status Assessment for Patients With Diabetes (>9%) ^{1, 4}	34.00%	23.00%	35.77%	30.41%	26.52%	23.60%
Reproductive Health and Cancer Prevention Domain							
BCS-E	Breast Cancer Screening ²	60.55%	57.12%	50.53%	55.87%	61.43%	66.31%
CCS-E	Cervical Cancer Screening	55.26%	57.41%	47.10%	52.32%	57.83%	64.21%
CHL	Chlamydia Screening in Women	77.57%	60.86%	48.48%	56.30%	65.47%	70.67%
PPC-POST	Prenatal and Postpartum Care: Postpartum Care ¹	98.00%	98.00%	78.10%	82.48%	85.15%	88.32%
PPC-PRE	Prenatal and Postpartum Care: Timeliness of Prenatal Care ¹	93.00%	97.00%	82.97%	86.37%	89.78%	91.97%

(1) Hybrid Measures: Measure rates are calculated using a systematic minimum required sample drawn from the eligible population. (2) BCS-E expanded its age range to 42-75 years in MY2025. The measure disruption is not reflected in the MY2024 BCS-E benchmark that is applied to the MY2025 measure rate. (3) The Developmental Screening for Children (DEV) and Topical Fluoride for Children (TFL-CH) measures are CMS Child Core Set measures, and only have one (1) benchmark, the 50th percentile, which is the FFY 2024 State Median. (4) GSD is an inverted measure: a lower rate results in better performance. (5) W30-6+ and W30-2+ measure rates were calculated using Supplemental Medical Records Review combined with administrative data in MY2025. NOTE: Report excludes measures reported to DHCS where DHCS does not hold Managed Care plans accountable for meeting specific performance targets.

6.0 Overall Health Plan Ranking: DHCS Managed Care Accountability Set (MCAS)

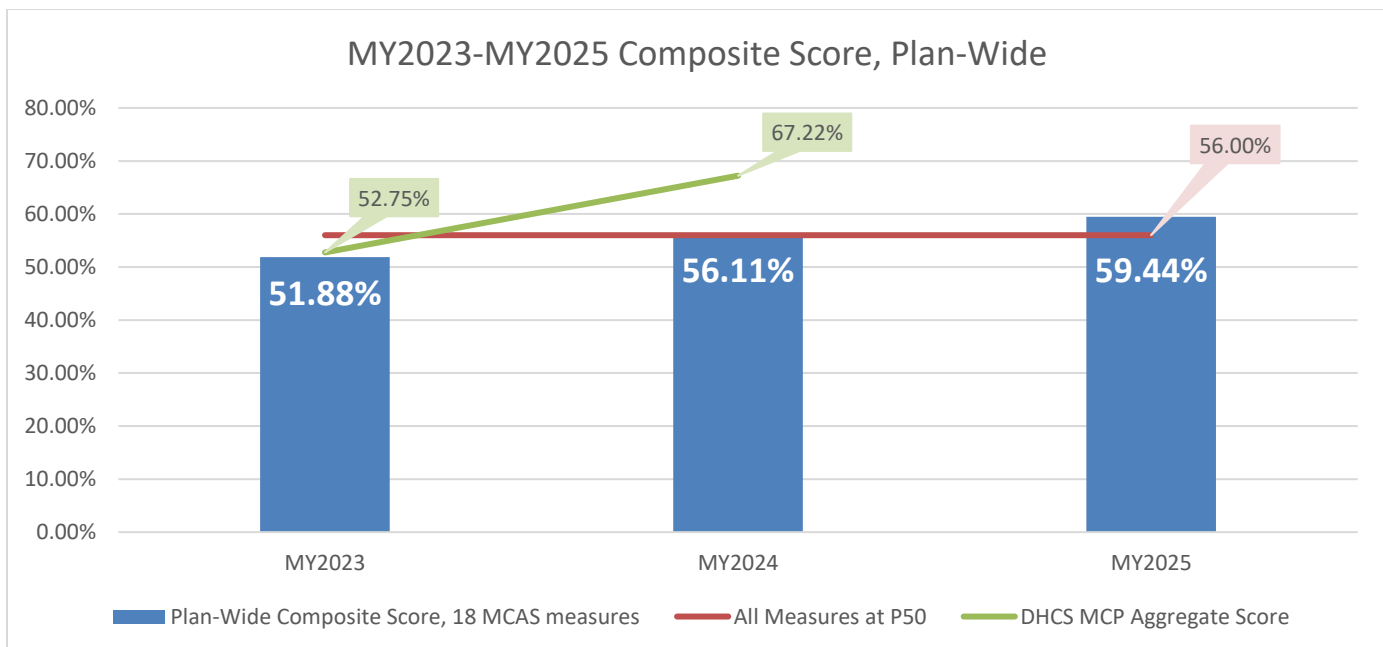
DHCS uses a scoring methodology to determine an aggregated Quality Factor Score (QFS), which ranks health plan performance relative to California Medicaid reporting health plans. Partnership adopts DHCS' scoring methodology to determine Partnership's composite scores year over year. The composite score is based on the plan-wide measure rates for all measures in the MCAS measure set.

To calculate the composite score, each measure is given a score from one to ten based on performance relative to national benchmarks. A composite score is then calculated by dividing total earned points by total possible points.

The Quality Compass 2025 Benchmarks, which were developed based on national MY2024 performance, are the most currently available benchmarks. These benchmarks were used by Partnership to determine percentile rankings and the following composite scoring year over year analysis. Annually each fall, DHCS releases a dashboard displaying the plan's Quality Factor Scores and associated rankings to other health plans, along with the Reporting Year's MCP Aggregate Score. The results of this ranking will be published upon the release of this information later in 2026.

Overall, the MY2025 HEDIS® Composite Performance Year over Year Comparison indicates a 5.93% increase in aggregate plan-wide performance from MY2024 to MY2025.

MY2025 HEDIS® Composite Performance Year over Year Comparison: DHCS Managed Care Accountability Set (MCAS)



Note: MY2025/R Y2026: Total Points Earned: 107 Points out of 180 Total Points (18 measures included)

- In MY2025, 18 measures were held accountable to the MPL. The MCAS measure set has included the same 18 measures between MY2023 – MY2025.
- The MY2025 Quality Factor Score will be released by DHCS in Fall 2026, and the MY2025 MCP Aggregate Score will be updated at that time.

7.0 Year-over-year Performance Trends and Initial Assessment of Results

7.1 Year-over-year Performance Trends

Plan-Wide, Partnership saw the following Year over Year changes in Plan-Wide rates between MY2024 and MY2025:

- 6 of 18 measures moved to a higher benchmark in MY2025.
- 7 of 18 measures stayed at their same benchmark as MY2024 in MY2025.
- 5 of 18 measures moved to a lower benchmark in MY2025.

7.2 Plan-Wide Strengths: Measure Performing Above MPL

12 of the 18 measures in the MCAS Accountable set had plan-wide rates that exceeded the Minimum Performance Level in MY2025.

Three measures are newly above the Minimum Performance Level in MY2025, as seen in the Table below.

Table: MCAS Measures Newly Above MPL in MY2025

Measure Description	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North		Benchmark
	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	
Follow-Up After Emergency Department Visit for Substance Use - 30-Days (FUA-30)	33rd	50th +8.08%	25th	50th	25th	50th	25th	67th	90 th
Asthma Medication Ratio (AMR)	33rd	75th +8.62%	50th	90th	<25th	75th	25th	75th	67 th or 75 th
Chlamydia Screening in Women (CHL)	33rd	50th +3.40%	50th	75th	25th	33rd	25th	33rd	50 th – MPL or >50 th (CMS)
									25 th or 33 rd
									<25 th or <50 th (CMS)

Follow-up After Emergency Department (ED) Visit for Substance Use (FUA-30): Partnership's plan-wide rate for FUA-30 is newly over the 50th percentile plan-wide and in all three Rating Regions in MY2025, with a plan-wide increase over 8% in performance. Partnership worked collaboratively with county partners to close care gaps and enhance data collection and reporting of qualifying follow-up services. Additionally, MY2025 was a year of sustained focus on maximizing data capture opportunities from DHCS's data feed. Finally, DHCS released All Plan Letter 26-003 in early 2026 that mandates data sharing for behavioral health visits, including visits for substance use treatment; Partnership believes that this prescribed approach to data sharing will increase access to sensitive data required for accurate rate reporting.

Asthma Medication Ration (AMR): Partnership rates were at the 75th percentile, plan-wide and at or above the 75th percentile in all three Rating Regions, in MY2025. The HEDIS team reviewed updates to its AMR custom code mapping frequently during the MY2025 Annual Project and

requested several custom code mappings from their auditor. In MY2025, Partnership added a Unit of Service (UOS) measure to its PCP QIP, to incentivize practices to host Academic Detailing sessions with Partnership's Pharmacy team. The Pharmacy team reviews pharmacy claims data to improve medication management for asthma and other chronic conditions. The AMR measure was retired at the end of MY2025, and is replaced by a Reporting Only measure, Follow-Up After Acute and Urgent Care Visits for Asthma (AAF-E), in MY2026.

Chlamydia Screening in Women (CHL): Partnership added the CHL measure to its PCP QIP in MY2025, which allowed practices to monitor their performance on this measure. As a result Chlamydia Screening rates increased in North Bay Area in MY2025 and the plan-wide rate is over the 50th percentile. DHCS retired CHL from the MCAS measure set at the end of MY2025.

Four additional measures have sustained Plan-Wide performance above the MPL since MY2024.

Table: MCAS Measures With Sustained Performance above the MPL MY2024-2025

Measure Description	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North	
	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Childhood Immunization Status - Combination 10 (CIS-E)	50th	50th +2.16%	67th	90th	<25th	50th	<25th	<25th
Well-Child Visits in the First 30 Months of Life - 2+ visits in 15-30 months (W30-2)	67th	67th +4.42%	67th	75th	<25th	50th	50th	50th
Glycemic Status Assessment for Patients With Diabetes (>9%) (GSD) *	50th	67th -4.87% *	33rd	50th	25th	50th	50th	50th
Prenatal and Postpartum Care: Postpartum Care (PPC-Post)	90th	90th +0.49%	90th	90th	75th	75th	75th	75th

Benchmark

90th

67th or 75th

50th – MPL or >50th (CMS)

25th or 33rd

<25th or <50th (CMS)

* Glycemic Status Assessment is an inverse measure, and a decline in YoY performance indicates improvement.

Childhood Immunizations ECDS (CIS-E): Partnership sustained its Plan-Wide rate above the 50th percentile on this measure in MY2025, despite the measure transitioning from a hybrid measure to an ECDS measure. The sustained performance is partially due to a small plan-wide rate increase, and also due to the continuing decline in the national percentiles between MY2024 and MY2025. North Bay Area and Rural Upper Central counties had significantly stronger measure performance than Rural Upper North counties. Interestingly, Partnership's rate for influenza vaccines, which is the most widely refused vaccine in the measure series, is above the 50th percentile, which is likely the cause of our plan-wide benchmark remaining above the 50th percentile. High rates of parental refusal, especially in Rural Upper North counties, continue to be a major factor in measure performance, which is not a permitted exclusion under the HEDIS measure. Partnership recommends a focus on completing Well Child Visits for children under 2 years as a driver for higher completion rates for this measure.

Well Child Visits in the First 30 Months of Life: 2+ Visits 15-30 Months (W30-2): The W30-2 measure continues its second year at the 67th percentile and is above the 50th percentile in all three Rating Regions. Partnership continues to address the known data completeness issues around the W30 measure by completing a Medical Record Review (MRR) of the entire eligible population for the W30 measure. By requesting charts from PCP's and completing a Medical Record Review, Partnership treats the measure as a hybrid measure and receives auditor approval annually to include the W30 MRR as a supplemental data source.

In addition, the HEDIS team conducted a W30 Kaizen across the organization which primarily identified gaps in incomplete claims submission. Finally, Partnership is working closely with DHCS as an active participant in the DHCS Early Childhood Affinity State Work group to improve newborn visit capture statewide.

Glycemic Status Assessment for Patients with Diabetes (>9%) (GSD): GSD's Plan-Wide rate improved by 4.87% in MY2025 (as an inverse measure, improvement is reflected as a lower rate). GSD is a hybrid measure, and Medical Record Review also shows sustained performance within all three Rating Regions. Partnership's Health Information Exchange, Sacramento Valley MedShare (SVMS) is a clearinghouse for lab data, which helps support the Medical Record Review for this measure. Additionally, Partnership expanded use of an NCQA Data Aggregator, Datalink, in MY2025 – as described in Section 1, Datalink is a promising new source of clinical data, including Hemoglobin A1c results. Finally, the increased use of OCHIN Epic within the PCP network means that more practices have the ability to automate the CPTII coding that is required to support this measure.

Postpartum Care (PPC-Post): Postpartum Care visits continue to be a source of strength for Partnership, with sustained performance over the 90th percentile. Interventions to maintain high postpartum care rates are described in Section 9 and include refinements to the Growing Together Program and equity focused programs centered on communities with lower prenatal and postpartum visit rates.

7.3 Opportunities for Improvement

After analyzing the MY2025 annual results and year over year performance comparisons, measures below the MPL can be categorized across three primary drivers.

- 1.) Performance** – Members qualifying under a measure did not receive the required care per measure specifications and designated timeframes
- 2.) Data Completeness** – Data used to generate reported rates has gaps, decreasing confidence that reported rates accurately reflect performance.
- 3.) Measure Limitations** – Measure specifications determine how data is collected through the reporting of rate performance. Measure specifications can detract from a measure’s intended purpose. In these cases, specifications can limit accurate representation of performance as well as detection of recent improvements that are in alignment with the measure’s purpose and clinical practice.

7.3.1 MCAS Measures with Regional Performance Opportunities

Seven measures are performance improvement opportunities for specific areas of Partnership’s network. These measures have sustained performance below the MPL in specific Rating Regions and counties, and data completeness issues are not the primary driver of low measure rates.

Partnership has prioritized **five measures** as its **highest priority for improvement in 2026 onward** at the regional level:

Table: Prioritized MCAS Measures with Performance Opportunities

Measure Description	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North	
	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Child and Adolescent Well-Care Visits (WCV)	33rd	33rd +3.74%	33rd	50th	25th	25th	25th	25th
Immunizations for Adolescents - Combination 2 (IMA-E)	50th	67th +1.46%	75th	90th	25th	33rd	<25th	33rd
Well-Child Visits in the First 30 Months of Life - 6+ visits in 0-15 months (W30-6)	75th	50th -2.41%	75th	75th	<25th	<25th	75th	67th
Controlling High Blood Pressure (CBP)	75th	33rd -2.19%	50th	75th	25th	<25th	25th	50th
Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre)	50th	50th +1.70%	<25th	90th	25th	<25th	<25th	25th

Benchmark

90th

67th or 75th

50th – MPL or >50th (CMS)

25th or 33rd

<25th or <50th (CMS)

Child and Adolescent Well Care Visits (WCV): This measure requires an annual well care visit for children and adolescents between the ages of 3-21. While plan-wide performance improved slightly in MY2025, it was not sufficient to meet the MPL benchmark, which increased in MY2025.

Given this measure's demand, performance is largely impacted by access constraints. Young adults ages 18-21 years have by far the lowest rate of well care visit completion within the measure; for several reasons, one of which is to preserve access for younger age bands, the young adult age band is not included in Partnership's PCP QIP WCV measure. Therefore, Partnership requires very high completion rates for children ages 3-17 years (partial payment at 75th percentile and full payment at 90th percentile) in its PCP QIP.

Immunizations for Adolescents (IMA-E): Though Partnership's Plan-Wide rate was at the 67th percentile, regional rates that are approaching the 50th percentile are prioritized as an improvement opportunity for Rural Upper North and Rural Upper Central regions. Because some of the vaccinations included in this measure are required for public school enrollment, this is historically a higher performing childhood vaccination measure than Childhood Immunization Series (CIS-E). Encouragingly, MY2025 shows several counties in Rural Upper North and Rural Upper Central regions exceeding the MPL for this measure along with all North Bay Area counties, and Partnership sees high performance on IMA-E across its network as an achievable goal. The predominant causes of low rates are missing or late secondary doses of the HPV immunization series and high rates of parental refusal.

Well Child Visits in the First 30 Months of Life: 6+ Visits Birth-15 Months (W30-6): The W30-6 measure continues its strong performance in North Bay Area and Rural Upper North Rating Regions. The decline in performance was driven by low performance in the Rural Upper Central Region. MY2025 is the first year that significant numbers of children were in the eligible population for W30-6 in Rural Upper Central counties, and MY2025 should be considered a baseline year for the region. As with W30-2, Partnership completes a Medical Record Review (MRR) of the entire eligible population for the W30 measure, so low performance indicates a low service completion rate, not a data completeness issue.

Controlling Blood Pressure (CBP): This measure was one of the few measures that declined in performance in MY2025, falling from the 75th percentile to the 25th percentile. The decline in performance was driven by low performance in the Rural Upper Central Region and will be a high priority area of focus in MY2026 onward.

Timeliness of Prenatal Care (PPC-Pre): Once again, Partnership just met the MPL for the Plan-Wide rate for this measure in MY2025. While North Bay Area's regional performance improved dramatically in MY2025, PPC-Pre remains an important improvement opportunity for Rural Upper North and Rural Upper Central counties. The HEDIS team observed several performance issues around prenatal visits, noting that many members receive their first prenatal visit outside of the measure timeline, and that visits do not include all of the required components of a prenatal visit. Prenatal visits will continue to be a measure of regional focus in MY2026 onwards to overcome the challenges for birthing populations in the rural North (ie: prenatal care deserts, loss of L&D units and critical access hospitals).

An additional **four measures** are improvement opportunities in 2026 onward at the regional level:

Table: Additional MCAS Measures with Performance Opportunities

Measure Description	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North	
	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025
Developmental Screening in the First Three Years of Life (DEV)	<50th	50th +9.77%	<50th	50th	50th	<50th	<50th	<50th
Lead Screening in Children (LSC)	75th	67th +3.16%	50th	50th	50th	33rd	75th	67th
Topical Fluoride for Children (TFL)	<50th	<50th +8.67%	<50th	50th	50th	50th	<50th	<50th
Cervical Cancer Screening (CCS-E)	50th (Hybrid)	25th -11.04%	75th (Hybrid)	50th	<25th (Hybrid)	<25th	25th (Hybrid)	50th

Benchmark

90th

67th or 75th

50th – MPL or >50th (CMS)

25th or 33rd

<25th or <50th (CMS)

Developmental Screening (DEV): In MY2025, DHCS transitioned the Developmental Screening measure from administrative to hybrid, which is recommended by CMS, the measure steward. As a hybrid measure, Partnership had the opportunity to complete a Medical Record Review on this measure in MY2025, which helped to overcome measure coding limitations seen in past years' HEDIS rates.

While only one Rating Region (North Bay Area) achieved the MPL for this measure, the other two regions were very close to the 50th percentile in MY2025. Partnership recommends a focus on completing Well Child Visits for children ages 1-3 years as a driver for higher completion rates for this measure.

Lead Screening for Children (LSC): Partnership sustained performance over the 50th percentile on the LSC measure in MY2025 in North Bay Area and Rural Upper North. Sustained high performance is related to the inclusion of the measure in the PCP QIP, which allows practices to measure their improvement throughout the measurement year, as well as interventions to maintain high lead screening rates described in Section 9. This measure is at the 33rd percentile in Rural Upper Central region and represents a regional improvement opportunity. Partnership recommends a focus on completing Well Child Visits for children ages 1-3 years as a driver for higher completion rates for this measure.

Topical Fluoride for Children (TFL-CH): The largest driver of performance on this measure is Denti-Cal claims data provided by DHCS. Partnership engaged very closely with DHCS's Data Team around improving the completeness of data around this measure, with significant success in MY2025. The use of an ICD-10 code (Z29.3) indicating fluoride varnish application is now mandated on Denti-Cal claims, to allow complete data capture. For the second year in a row, Partnership showed significant year-over-year improvement in TFL-CH rates, and is less than 1 percentage point from meeting the MPL for the measure in MY2025. (There are no additional

benchmarks for this measure.) The Rural Upper North has an improvement opportunity for TFL-CH. Partnership recommends a focus on completing Well Child Visits for children ages 1-20 years as a driver for higher completion rates for this measure.

Cervical Cancer Screening (CCS-E): Cervical Cancer Screening transitioned from a hybrid to an ECDS measure in MY2025. Plan-wide performance at the 25th percentile was driven by low performance in the Rural Upper Central region. While CCS-E represents an improvement opportunity for Rural Upper Central counties, expansion of Datalink will also address data capture of historical screens that occurred prior to the network joining Partnership.

As noted in Section 9, Partnership is promoting self-swab testing to members through PCPs, now that this method has received FDA approval and can be counted towards this HEDIS measure in MY2026 and onward.

7.3.2 MCAS Measures with Data Completeness and Measure Limitation Issues

Finally, two measures performed below the MPL in MY2025 primarily because of data completeness and measure limitation issues. Partnership has documented and escalated data completeness issues around both measures directly to DHCS and is engaged in interventions and activities meant to improve the quality and completeness of data, where relevant.

Table: MCAS Measures with Data Completeness and Measure Limitation Issues

Measure Description	Plan-Wide		North Bay Area		Rural Upper Central		Rural Upper North		Benchmark
	MY2024	MY2025 YoY points change	MY2024	MY2025	MY2024	MY2025	MY2024	MY2025	
Follow-Up After Emergency Department Visit for Mental Illness - 30-Days (FUM-30)	<25th	<25th +21.25%	<25th	<25th	<25th	<25th	<25th	33rd	90 th 67 th or 75 th 50 th – MPL or >50 th (CMS)
Breast Cancer Screening (BCS-E)	50th	33rd -2.86%	50th	50th	<25th	<25th	25th	<25th	25 th or 33 rd <25 th or <50 th (CMS)

Follow-up After Emergency Department (ED) Visit for Mental Illness (FUM-30): Partnership's plan-wide rate for FUM-30 increased over 20 percentage points in MY2025. Partnership benefitted from a revised NCQA measure definition that expanded the scope of services counting as a follow-up visit, as well as sustained focus on maximizing data capture opportunities from DHCS's data feed. While the plan made significant gains in data capture from DHCS data feeds, Partnership is still not receiving a full year's worth of data from County DBH's to apply to this measure during the HEDIS project timeline. Partnership is actively working with DHCS to improve the quality of our data feed, and exploring other opportunities to receive clinical data from County DBH EMR's to improve the completeness of our data.

Breast Cancer Screening (BCS-E): The Breast Cancer Screening measure transitioned its age range from 52-74 years to 42-74 years. This has resulted in a misalignment of the MY2025 measure (42-74 years), with the NCQA benchmark applied, that was based on MY2024 national

outcomes (52-74 years). Once NCQA creates a national benchmark based on the new age range (later in 2026), this measure limitation issue will no longer exist.

Partnership has recommended to DHCS that Medi-Cal MCP's be held accountable for the 52-74 years sub-measure, which does align with the MY2024 NCQA benchmark. In the majority of counties, Partnership's performance would be above the 50th percentile in MY2025 for DHCS accountability programs if this recommendation is acted upon by DHCS.

Because the measure has long continuous enrollment requirements for members to be included in the measure, MY2025's measure still included very few members from the Rural Upper Central Rating Region.

7.4 Comparing MY2025 MCAS Results to MY2025 PCP QIP Results

The clinical measures included in the Primary Care Provider Quality Incentive Program (PCP QIP) are designed to reflect HEDIS measure priorities. Most PCP QIP clinical measures have very similar definitions to their HEDIS measure counterparts, and strong performance on PCP QIP measures should be reflected in strong HEDIS measure performance. Differences between PCP QIP and HEDIS measures are designed to improve providers' ability to impact the population in the measure. Some examples include:

- Partnership relaxes the strict continuous enrollment requirements in PCP QIP measures that are present in many HEDIS measures. Several measures (AMR, BCS-E, and W30) require members be continuously enrolled with a MCP for 11 months to be included in the HEDIS measure; Partnership relaxed this requirement so that incoming members could be included in their PCP QIP cohorts.
- Partnership allows PCPs to upload supplemental data for all PCP QIP measures. HEDIS administrative and ECDS measures only allow claims and encounter data, as well as auditor approved supplemental data, to be applied to a HEDIS measure.
- Two PCP QIP measures have smaller age bands than their aligned HEDIS measures to prioritize focus on the highest priority age bands in the eligible populations: Child and Adolescent Well-Care Visits and Topical Fluoride for Children. An additional PCP QIP measure had a larger eligible population than the HEDIS measure: Chlamydia Screening in Women.

Overall, plan-wide performance improved significantly (≥ 5 percent) on the following continuous measures on the PCP QIP that are aligned with MCAS measures between MY2024 and MY2025:

- Cervical Cancer Screening
- Diabetes – HbA1c Good Control

Several measures were added to the PCP QIP measure set in MY2025 to align with the MCAS measure set:

- Breast Cancer Screening, 40-51 years (monitoring measure)

- Chlamydia Screening
- Topical Fluoride for Children – 1-5 years (monitoring measure)
- Well Child Visits 15-30 Months (monitoring measures)

The MY2025 MCAS measure plan-wide performance trends were consistent with corresponding MY2025 PCP QIP results in most cases.

Unsurprisingly, the two PCP QIP measures with smaller age bands (Child and Adolescent Well-Care Visits and Topical Fluoride for Children) had higher performance than their HEDIS measure counterpart, and the one PCP QIP measure with a larger eligible population (Chlamydia Screening in Women) had lower performance than its HEDIS measure counterpart.

The PCP QIP Cervical Cancer Screening measure performed significantly higher than its HEDIS counterpart. This is due to the HEDIS measure transitioning to an ECDS measure in MY2025, which exposed significant data completeness issues with the measure. Partnership will be addressing these issues in 2026 onward by focusing on best practices in coding and clinical data exchange via Health Information Exchanges and Datalink.

All other HEDIS measures that are aligned with PCP QIP measures showed slightly higher plan wide performance in the HEDIS measure than in the plan wide PCP QIP.

7.5 Next Steps in Finalizing Assessment of Results

- DHCS will finalize Quality Factor Scoring of all managed care plans, based on composite scoring, in fall 2026.
- DHCS has not yet announced the outcomes of MY2025 accountability programs described in Section 1. DHCS will share sanctions and the results of other accountability programs with plans including Partnership.
- Final assessment of results will be used to adapt quality measure score improvement strategies and tactics in 2026-2027.

8.0 Summary of MCAS Measures in Partnership's Quality Improvement Programs

The table below provides a summary of included in the Measures Managed Care Accountability Sets (MCAS) Measures included in Partnership's Quality Improvement Programs, Measurement Year 2025.

HEDIS® Measures	MCAS Accountable/Reporting	MY2024 QIP Measure	MY2025 QIP Measure	QIP Program
Asthma Medication Ration (AMR)*	Accountable			None
Breast Cancer Screening (BCS-E)*	Accountable	X	X	PCP QIP Ages 52-74 years – Clinical Ages 40-51 years – Monitoring
Cervical Cancer Screening (CCS-E)	Accountable	X	X	PCP QIP
Childhood Immunization Status (CIS-E) – Combo 10	Accountable	X	X	PCP QIP
Chlamydia Screening (CHL)	Accountable		X	PCP QIP Monitoring
Colorectal Cancer Screening (COL-E)	Reporting	X	X	PCP QIP
Controlling High Blood Pressure (CBP)	Accountable	X	X	PCP QIP
Developmental Screening in the First Three Years of Life (DEV)	Accountable			None
Eye Exam for Patients with Diabetes (EED)	Reporting	X	X	PCP QIP
Glycemic Status Assessment for Patients with Diabetes—Glycemic Status (>9%), Poor Control (GSD)	Accountable	X	X	PCP QIP QIP uses the inverse of this measure: Good Control, HbA1c Good Control <9%
Immunizations for Adolescents (IMA-E) – Combo 2	Accountable	X	X	PCP QIP
Lead Screening in Children (LSC)	Accountable	X	X	PCP QIP
Postpartum Depression Screening (PDS-E)	Reporting	X	X	Perinatal QIP
Prenatal Depression Screening (PND-E)	Reporting	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Postpartum Care	Accountable	X	X	Perinatal QIP
Prenatal and Postpartum Care (PPC) – Timeliness of Prenatal Care	Accountable	X	X	Perinatal QIP
Prenatal Immunization Status – combo (PRS-E)	Reporting	X	X	Perinatal QIP
Topical Fluoride for Children (TFL)	Accountable		X	PCP QIP Ages 1-5 years - Monitoring
Well-Child Visits in the First 30 Months of Life—15 to 30 Months—Two or More Well-Child Visits (W30-2)	Accountable		X	PCP QIP

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HEDIS® Measures	MCAS Accountable/Reporting	MY2024 QIP Measure	MY2025 QIP Measure	QIP Program
Well-Child Visits in the First 30 Months of Life—0 to 15 Months—Six or More Well-Child Visits (W30-6)	Accountable	X	X	PCP QIP
Child and Adolescent Well-Care Visits (WCV)	Accountable	X	X	PCP QIP

PCP QIP Measurement Set: <http://www.partnershiphp.org/Providers/Quality/Pages/PCPQIPLandingPage.aspx>



9.0 Measurement Year 2024 Managed Care Accountability Site (MCAS) Measurement Set Descriptions-Accountable Measures

HEDIS Measure	Measure Indicator	Measure Definition
Asthma Medication Ratio (AMR)	Total	The percentage of members 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year.
Breast Cancer Screening (BCS-E)	Non-Medicare Total	The percentage of women 42–74 years of age who had a mammogram to screen for breast cancer as of December 31 of the measurement year.
Cervical Cancer Screening (CCS-E)	Total	- The percentage of women 21–64 years of age who were screened for cervical cancer using either of the following criteria: - Women 21–64 years of age who had cervical cytology performed within the last 3 years - Women 30–64 years of age who had cervical high-risk human papillomavirus (hrHPV) testing performed within the last 5 years - Women 30–64 years of age who had cervical cytology/high-risk human papillomavirus (hrHPV) cotesting within the last 5 years
Child and Adolescent Well-Care Visits (WCV)	Total	- The percentage of members 3–21 years of age who had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year. - Total. The sum of the age stratifications (ages 3–21) as of December 31 of the measurement year.

HEDIS Measure	Measure Indicator	Measure Definition
Childhood Immunization Status (CIS-E)	Combination 10	The percentage of children 2 years of age who had four diphtheria, tetanus and acellular pertussis (DTaP); three polio (IPV); one measles, mumps and rubella (MMR); three haemophilus influenza type B (HiB); three hepatitis B (HepB), one chicken pox (VZV); four pneumococcal conjugate (PCV); one hepatitis A (HepA); two or three rotavirus (RV); and two influenza (flu) vaccines by their second birthday. The measure calculates a rate for each vaccine and three combination rates.
Chlamydia Screening in Women (CHL)	Total	- The percentage of women 16–24 years of age who were identified as sexually active and who had at least one test for chlamydia during the measurement year. - Total: the sum of the age stratifications.
Controlling High Blood Pressure (CBP) *	Total	The percentage of members 18–85 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled (<140/90 mm Hg) during the measurement year.
Developmental Screening in the First Three Years of Life (DEV_CH) *	Total All Ages	- Percentage of children screened for risk of developmental, behavioral, and social delays using a standardized screening tool in the 12 months preceding or on their first, second, or third birthday. - This measure is a CMS FFY 2023 Child Core Set Measure, held to the DHCS designated MPL.
Follow-Up After ED Visit for Mental Illness – 30 days (FUM)	Total	- The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness or intentional self-harm, who had a follow-up visit for mental illness. - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).

HEDIS Measure	Measure Indicator	Measure Definition
Follow-Up After ED Visit for Substance Abuse – 30 days (FUA)	Total	- The percentage of emergency department (ED) visits among members age 13 years and older with a principal diagnosis of substance use disorder (SUD), or any diagnosis of drug overdose, for which there was follow-up. - The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days).
Immunizations for Adolescents (IMA-E)	Combination 2	- The percentage of adolescents 13 years of age who had one dose of meningococcal vaccine, one tetanus, diphtheria toxoids and acellular pertussis (Tdap) vaccine, and have completed the human papillomavirus (HPV) vaccine series by their 13th birthday. The measure calculates a rate for each vaccine and two combination rates. - Combination 2. Adolescents who have had all three indicators (meningococcal, Tdap and HPV).
Hemoglobin A1c Control for Patients With Diabetes (GSD)*	HbA1c poor control (>9.0%)	- The percentage of members 18–75 years of age with diabetes (type 1 and type 2) who had each of the Measure Indicators performed. - HbA1c poor control (>9.0%). The most recent HbA1c level is >9.0% or is missing a result, or if an HbA1c test was not done during the measurement year.
Lead Screening in Children (LSC) *	Total	- The percentage of children 2 years of age who had one or more capillary or venous lead blood test for lead poisoning by their second birthday. - At least one lead capillary or venous blood test (Lead Tests Value Set) on or before the child's second birthday.

HEDIS Measure	Measure Indicator	Measure Definition
Prenatal and Postpartum Care (PPC) *	- Timeliness of Prenatal Care - Postpartum Care	- The percentage of deliveries of live births on or between October 8 of the year prior to the measurement year and October 7 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. - Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit in the first trimester, on or before the enrollment start date or within 42 days of enrollment in the organization. - Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 7 and 84 days after delivery.
Topical Fluoride for Children (TFL-CH)	Total ages 1 through 20	- Percentage of enrolled children ages 1 through 20 who received at least two topical fluoride applications as: (1) dental or oral health services, (2) dental services, and (3) oral health services within the measurement year. - This measure is a CMS FFY 2023 Child Core Set Measure, held to the DHCS designated MPL.
Well-Child Visits in the First 30 Months of Life (W30)	- Well-Child Visits in the First 15 Months - Well-Child Visits for Age 15 Months–30 Months.	- The percentage of members who had the following number of well-child visits with a PCP during the last 15 months. The following rates are reported: - Well-Child Visits in the First 15 Months. Children who turned 15 months old during the measurement year: Six or more well-child visits. - Well-Child Visits for Age 15 Months–30 Months. Children who turned 30 months old during the measurement year: Two or more well-child visits.

* Hybrid Measures. A random sample of the eligible population is used in calculating performance, as opposed to the entire eligible population.

10.0 Quality Improvement Initiatives - HEDIS Score Improvement

Partnership's Quality Improvement organization-wide goals for 2025-2026 focused on four measure domains similar to those defined under the DHCS Managed Care Accountability Set (MCAS) measures:

1. Behavioral Health
2. Pediatrics
3. Chronic Diseases
4. Women's Health and Perinatal

The Quality Measure Score Improvement (QMSI) effort continues to better coordinate service and performance across the organization and to raise Partnership's overall performance in quality measures, as defined under DHCS MCAS and NCQA Health Plan Accreditation (HPA). This effort involved team formation under QMSI to encompass all current and potentially future accountable measures by measure family within each workgroup team: Pediatric, Chronic Diseases, Behavioral Health, Women's Health and Perinatal Care. Each workgroup monitored and reviewed all measure performance where data was available, assessed current improvement efforts, identified gaps and initiated new performance improvement activities.

QMSI workgroups consisted of cross-functional teams led by Quality and included representation from across the organization, such as: Care Coordination, Claims, Health Education, Office of the CMO, Pharmacy, Population Health, Provider Relations, Quality and/or regional leadership. The following summaries include what each measure-family QMSI Workgroup Team achieved in 2025-2026.

10.1 Behavioral Health Measure Activities

Sac Valley MedShare Data Exchange: Partnership HealthPlan of California and SacValley MedShare (SVMS): To improve data sharing capabilities between Behavioral Health Plans (BHPs) and Partnership, the partnership with SacValley MedShare (SVMS) was expanded to include county participation. By the end of 2025, Partnership and SVMS successfully onboarded all participating counties into a unified data exchange, significantly strengthening regional data-sharing infrastructure. Partnership's auditor, HSAG, approved use of the SVMS Encounters file, which contained County DBH follow-up service data, as a supplemental data source for MY2025 HEDIS rate generation.

Key Learnings:

- The collaboration facilitated the provision of medical data, including real-time admissions, discharges, and transfers, from participating hospitals.
- Some counties implemented opt-in procedures for data sharing, which have limited the number

of beneficiaries included in the data.

- Substance use disorder data has not yet been included in the exchange due to varying levels of regulatory uncertainty across counties.

DHCS Mandated Non-Clinical PIP: Improving Provider Notifications and Follow-Up for Members with Serious Mental Health Diagnoses: The Department of Health Care Services (DHCS) has mandated a non-clinical Performance Improvement Project (PIP) focused on enhancing the timeliness and consistency of provider notifications for members with Serious Mental Health (SMH) diagnoses following emergency department (ED) visits. The primary goal of this initiative is to improve the percentage of notifications sent to providers within seven days of an ED visit, thereby increasing the likelihood of timely follow-up care for affected members.

In 2024, the QI team at Partnership identified a tool with the potential to significantly improve provider notification processes: PointClickCare. Partnership subscribes to this platform, which serves as a centralized hub for real-time Admission, Discharge, and Transfer (ADT) messages from EDs and hospitals across California. To operationalize this data, Partnership launched a targeted intervention in the Eureka Region, routing daily PointClickCare reports to a large provider organization. These reports flag assigned members with recent ED visits for SMH diagnoses. In response, the provider organization is developing integrated clinical and operational workflows across its sites to proactively conduct outreach, schedule appointments, and ensure follow-up care is completed within 30 days of the ED event. This approach supports engagement for members less likely to seek care due to stigma or other barriers. The pilot will continue through 2026, with expansion planned based on promising results.

Key Learnings:

- Regular data exchange to promote shared learning, pattern recognition, and continuous quality improvement.
- Real-time data analysis to support agile adjustments and maintain program responsiveness.
- Focused efforts on increasing the rate of timely notifications and achieving compliance with follow-up targets.

DHCS 2025–27 DMC ODS Clinical and Non-Clinical Performance Improvement Projects (PIPs):

The California Department of Health Care Services (DHCS) requires all Drug Medi-Cal Organized Delivery System (DMC-ODS) plans to conduct two Performance Improvement Projects (PIPs) per contract period—one clinical and one non-clinical. The current PIP cycle began in 2025, with annual submissions due each July, and will conclude in 2027 (final submission due July 2028). Participating counties include Humboldt, Lassen, Mendocino, Modoc, Shasta, Siskiyou, and Solano.

Within this framework, Partnership is implementing PIPs focused on improving follow-up after Emergency Department (ED) visits for substance use and increasing the number of members receiving Peer Support Services. Together, these efforts aim to strengthen engagement and continuity of care for members with behavioral health and substance use needs.

The Clinical PIP focuses on improving follow-up rates after ED visits for substance use. Root cause analysis is underway to identify barriers to timely follow-up, and targeted interventions are being implemented and monitored for effectiveness. Findings from this work will inform process improvements for upcoming reporting periods.

The Non-Clinical PIP focuses on expanding access to Peer Support Services. To support this, counties have been offered up to \$10,000 per individual through HCAI funding to train and develop Peer Support Specialists, increasing workforce capacity.

Key Learning:

- Accurate and up-to-date member contact information is critical to enhance outreach effectiveness and increase successful linkage to care.

Community Health Worker (CHW) & Emergency Department: Partnership HealthPlan of California:

To bridge the gap between existing Substance Use Navigation (SUN) grants and the implementation of community health workers (CHWs), Partnership offered a grant of up to \$100,000 to promote the use of CHWs in emergency departments. A total of 24 hospitals expressed interest, and 17 followed through during the grant year.

Key Learnings:

- The project achieved its primary objective of expanding CHW presence in acute care settings and concluded at the end of calendar year 2025. It also advanced the foundation for longer-term sustainability by aligning services with CHW billing pathways.
- Strengthening documentation will support accurate billing, enable reimbursement for CHW services, and ensure the long-term sustainability of this model of care.

10.2 Pediatric Medicine Measure Activities

State-Mandated Performance Improvement Project (PIP) Focused on Early Well-Care in Black/African American Members in Solano County: This PIP's initial intervention addressed delays in Medi-Cal enrollment, which have a significant impact on all families, including African American families. In 2024, the team launched a six-week phone outreach pilot project in collaboration with NorthBay Health, with

outstanding reach rates and outcomes. In 2025, the pilot expanded to Fairchild Medical Center, the primary labor and delivery hospital in Siskiyou County. The initial reach rate was lower than expected.

Key Learning:

- Overall, findings suggest that while the intervention model has potential, its effectiveness is highly dependent on consistent operational execution, data-sharing infrastructure, and strong partner accountability.

Educating Practices about Developmental Screening in the First Three Years of Life: This initiative focused on improving completion of three developmental screenings in the first three years of life by conducting one-on-one training for PCP practices with scores significantly below the MPL. The Pediatric QSMI workgroup reviewed MY2025 HEDIS rates and worked with an Associate Medical Director to set up one-on-one interventions for select practices with especially low scores and larger denominators. Practices that receive coaching will be monitored and offered additional training if their scores do not improve after 3 months.

Key Learnings:

- The current data set relies on claims submitted with code 96110. Six of the lowest performing practices were compared against a list of site audits by the Medical Record Review team and two of those sites had fully compliant charts during their last site visit so it appears at least some practices are conducting screenings but not billing correctly for them.
- Some practices discuss elements of the screenings during the actual visit and document those discussions in the EHR but may not complete the actual screening tool or correctly bill for the screening.
- Even among pediatric-only practices, some are performing well and others are far below the MPL. Proper billing and documentation appears to be an issue regardless of practice type.

Improve Data Capture of Topical Fluoride Application: Partnership launched a multi-pronged messaging campaign to providers to evangelize the use of the Z29.3 ICD code to indicate fluoride varnish application in FQHC, RHC, and Tribal Health Dental Centers. Following the messaging campaign, QI coaches and Partnership's new Dental Liaison followed up with practices during coaching calls to see if the codes had been implemented. In November 2025, DHCS released guidance to the Denti-Cal network that use of the Z29.3 ICD is now mandated for payment on claims that include fluoride varnish services.

Key Learning:

- Sustained focus on data exchange pathways, data validation exercises with provider partners, and partnership with external stakeholders including DHCS is crucial for success on measures

with less straightforward coding and claims pathways

10.3 Chronic Disease Measure Activities

Colorectal Cancer Screening: Cologuard: In 2023 Partnership conducted a pilot project with Exact Sciences who produces the Cologuard Fit DNA colorectal cancer screening product. During the pilot Partnership observed notable improvements in colorectal cancer screening rates with participating providers. Partnership has turned this effort into an ongoing program and has worked closely with Exact Sciences to spread awareness and access to the bulk ordering program. Partnership has created a Cologuard Care-gap Orders page with information and resources. Exact Sciences has a minimum number of patients required for bulk orders since it is resource intensive for them to do outreach and messaging for patients with an order. Partnership has offered to help facilitate bulk orders for smaller practices who do not have large enough denominators to do bulk orders on their own, with orders going out twice annually.

Key Learning:

- Tracking screening rates by screening type helped the team find opportunities where Cologuard bulk order might be appropriate based on availability of other screening methods.

Diabetes Management Offerings From Telemed2U: In 2025-26, Partnership monitored, evaluated, and enhanced utilization of the TeleMed2U diabetes management program through analysis of utilization and engagement data, with the goals of assessing program effectiveness, identifying participation gaps, and informing decisions regarding the continued prioritization of this intervention relative to other strategies. The workgroup partnered with Provider Relations and supported outreach and member education efforts by promoting available nutrition services as an integral component of diabetes management, developing and disseminating fax communications to the provider network to increase program awareness and encourage referrals. The collaboration also extended to engagement with Care Coordination to further expand awareness of the program among members and providers who may benefit from additional diabetes support services.

Key Learning:

- Collaboration between Quality Improvement, Care Coordination, and Provider Relations was crucial for building awareness of available diabetes support services.

10.4 Women's Health and Perinatal Care Measure Activities

PPC Pre Timeliness of Prenatal Care Alignment: A multidisciplinary team review identified opportunities to improve consistency of PPC-Pre measurement support across the organization. The initiative focused on reducing variation in coding and documentation practices, standardizing best practices for qualifying perinatal encounters, and identifying allowable care models (telehealth

pathways) that support timely access to prenatal care. This was a multifaceted quality improvement effort that included targeted research, root-cause analysis, claims review, cross-departmental meetings, workflow and policy document review, and implementation of standardized guidance to improve organizational alignment and measure performance.

Key Learnings:

- Adding validated HEDIS codes to the P-QIP Value Set Directory improves clarity, reduces variation in prenatal care coding and documentation, and supports more reliable HEDIS performance monitoring.
- The PPC-Pre measure best practice resource provides a standardized, evidence-based framework for improving perinatal care delivery and operational performance. Translating measure requirements into actionable workflows can improve quality of care and patient outcomes without organizations reinventing the wheel.
- PPC-Pre Telehealth visits in both administrative and hybrid data collection methods are eligible for use in HEDIS reporting. The visit must be with an appropriate provider, within the applicable timeframe, and include a confirmation/diagnosis of pregnancy, and a visit component such as discussion of screening or lab results or last menstrual period with Obstetric (OB) history.
- Primary care, FQHC, rural, and Tribal health providers play a critical role in early pregnancy and should be included in performance visibility and improvement strategies.
- Integrating provider education efforts into existing structures strengthens the program allowing wider visibility, the prioritizing of providers based on performance data, and inclusion of improvement advisors.

Increase PPC-Pre Timeliness of Prenatal Care Awareness: This initiative focused on improving performance for the Prenatal and Postpartum Care: Timeliness of Prenatal Care (PPC-Pre) measure by partnering with improvement advisors who had established relationships with providers in effort to strengthen awareness of measure timing requirements and identify barriers to timely first prenatal visits.

Key Learnings:

- Clear, repeated messaging on PPC-Pre requirements is needed to build and sustain staff awareness.
- Site-specific performance and access data supports more focused coaching and helps prioritize outreach to practices with the greatest opportunity for improvement.
- Medi-Cal Managed Care plans require first prenatal visits within 10 business days.
- Documentation of initial prenatal visit completed within four weeks of entry to prenatal care. Optimally within the first trimester.

- First prenatal visit access is a site review standard for PCPs who provide obstetric care and missed appointments and referrals require documented outreach and follow-up. Failure to follow up on missed specialty referrals results in a zero score under coordination criteria.
- If prenatal visit periodicity does not meet current ACOG standards, OB providers must document missed visits and outreach efforts.
- Established relationships through Improvement Advisors offers a valuable entry point and provides knowledge of clinics, counties, and regions, as well as insight into local barriers. This can improve provider's engagement and aid in identifying and addressing both site specific and local performance barriers.

Tribal Perinatal Program: This initiative focused on supporting Tribal entities in developing and expanding Tribal Perinatal Programs to improve access to timely prenatal and postpartum care. The Tribal Perinatal Program Tribal Birth Equity Initiative was designed to build culturally informed perinatal care capacity through training, case management, peer support, doula development, and implementation of reimbursement pathways that support sustainable services in Tribal communities. The program goal is to support Tribal communities achieve the best possible outcomes for pregnant American Indians in Northern California.

Key Learnings:

- Culturally grounded training and program design are central to building Tribal perinatal care capacity.
- Trusted entry points and sustained subject matter support, including outreach from the Tribal Liaison and education from a Medical Director champion, can strengthen engagement, improve understanding of program requirements, and support movement from interest to implementation.
- Aligning training, ECM, and PHPS within a shared implementation approach can strengthen care coordination and support long-term sustainability of Tribal perinatal services.
- Baseline performance suggests Tribal providers may be better positioned to support postpartum follow-up than timely first prenatal care, highlighting a need for continued focus on earlier pregnancy identification, access to initial prenatal visits, and stronger prenatal workflow support to improve PPC-Pre performance.

High-risk Human Papillomavirus Self-Collect Support and Education: This initiative focused on improving performance in the Cervical Cancer Screening measure by expanding and standardizing use of the high-risk HPV (hrHPV) self-collect option in healthcare settings. Work centered on strengthening network-wide awareness, updating best-practice guidance, and ensuring clinics had consistent instructions and education materials to support appropriate implementation.

Key Learnings:

- Provider and patient education materials are foundational for scaling hrHPV self-collect consistently across the network.
- Equity-centered material review is important to ensure patient instructions are accessible across threshold languages and usable by patients with different literacy levels and care access needs.
- Targeted provider education informed by site level performance data and improvement advisor insights was an efficient way to prioritize education.
- hrHPV self-collect can be integrated successfully when clinics have clear instructions, laboratory access, and practical examples of staffing, outreach, and visit workflows.