PARTNERSHIP HEALTHPLAN OF CALIFORNIA
PHYSICIAN ADVISORY COMMITTEE ~ MEETING NOTICE

Members: (21)

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

Partnership Executive Staff:

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

Regional Medical Directors	Region	Region Directors
Jeffrey Ribordy, MD	Eureka - Del Norte, Humboldt, Mendocino & Lake	Vicky Klakken
Bradley Cox, DO	Redding - Siskiyou, Modoc, Shasta, Lassen, Trinity & Tehama	Tim Sharp
Colleen Townsend	Fairfield - Napa, Yolo & Solano	Kathryn Power
Lisa Ward, MD	Santa Rosa - Marin & Sonoma	Leigha Andrews
R. Doug Matthews, MD	Chico - Glenn, Butte, Sutter, Colusa & Yuba	Rebecca Stark
Matthew Morris, MD	Auburn - Plumas, Sierra, Nevada & Placer	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
Heather Esget, RN, Director of Utilization Management
Vacant, Director, Health Analytics
Kristine Gual, Director, Quality Measurement
Priscila Ayala, Director, Network Services
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
James Cotter, MD, Associate Medical Director

cc: Partnership Commission Chair
Kim Tangermann, Partnership Board Chair

FROM: PAC@partnershipHP.org
DATE: February 6, 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, February 11, 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
2760 Esplande, Suite 130
Chico, CA 95973

Sutter-Roseville
6 Medical Plaza
Roseville, CA 95661

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

Sutter-Lakeside
5176 Hill Rd. East
Lakeport, CA 95453

Please contact Partnership's Executive Assistant to the Chief Medical Officer with additional questions at (707) 863-4228, or e-mail pac@partnershiphp.org.

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

Date: February 11, 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
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Redding, CA

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San Rafael, CA 94901

Sutter-Lakeside
5176 Hill Rd. East
Lakeport, CA 95453

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. Barresi**		**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 January 14, 2026 PAC Minutes**	**Dr. Brennan**	**5**	**7:55**
B.	**A**	**Consent Review: Agenda Items II. B.1, B.2, B.3, B.5 and B.6** *Consent review allows multiple agenda items to be approved with one motion.	**Dr. Brennan**	**14-97**	**7:58**

1	**C**	**Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – January 21, 2026**
		Acceptance of Draft Meeting Minutes:
		• Q/UAC Agenda
		• Q/UAC Activities & Motion Summary
		• Internal Quality Improvement Meetings January 13, 2026
		  • Agenda
		  • Minutes
		Quality Improvement Update – January 2026
		
		Special Presentations (not included in the packet, for reference only)
		• *2024-2025 Hospital Quality Incentive Program Evaluation*
		• *2025 CG-CAHPS® Survey of Large Primary Care Organizations' Access and Communication Performance Summary*
		• *December 2025 CHA/CHIP Update*
			Dr. Brennan	**14**
				16
				
				19
				21
				33
					7:58

II.B	C	Consent Review: Agenda Items II. B.1, B.2, B.3, B.5 and B.6 *Continued*	LEAD	PG	TIME
2	C		Dr. Brennan	42 44	7:58

Policies/Procedures/Guidelines for Action	
Behavioral Health	
MPBP8003	Mental Health Services
Care Coordination	
MCCP2025	Pediatric Quality Committee Policy
MCCP2035	Local Health Department (LHD) Coordination
MPCP2006	Coordination of Services for Members with Special Health Needs (MSHCNs) and Persons with Developmental Disabilities
MCCP2031	Private Duty Nursing under EPSDT
MPCP2018	Advice Nurse Program
Enhanced Health Services	
MCAP7001	CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)
MPAP7003	CalAIM Community Supports (CS)
Health Equity	
MCEP6002	Quality Improvement and Health Equity Committee (QIHEC)
Member Services	
MP300	Member Notification of Provider Termination or Change in Location
Pharmacy Operations	
MCRP4068	Medical Benefit Medication TAR Policy
MPRP4001	Pharmacy & Therapeutics (P&T) Committee
Quality Improvement	
MPQP1018	Preventive Health Guidelines
MPQP1053	Peer Review Committee
Utilization Management	
MCUG3022	Incontinence Guidelines
MCUP3034	PCP-to-PCP Transfers & Assignments of New Members to PCP
MCUP3041-A	TAR Requirements List
MCUP3052	Medical Nutrition Services
MCUP3104	Transplant Authorization Review
MCUP3113	Telehealth Services
MPUP3006	Appropriate Service & Coverage (Over/Under Utilization)
MCUP3044	Urgent Care Services
MPUP3014	Emergency Services
MPUP3129	Podiatry Services

All policies linked in Policy Summary, see page 42

- Policy Summary
- Detailed Synopsis of Changes

II.B	C	Consent Review: Agenda Items II. B.1, B.2, B.3, B.5, and B.6 *Continued*	LEAD	PG	TIME
3	**C**	**Pharmacy & Therapeutics Committee** • Meeting Summary, January 15, 2026 • Approved Criteria	**Dr. Stan Leung**	**50** **67**	**7:58**
4	*C*	*Provider Education & Networking (PEN) Meeting*	*Ms. Kerlin*		
5	**C**	**Credentials Committee Meeting** • Summary, December 10, 2025 • Credentialed List, December 10, 2025	**Dr. Netherda**	**87** **91**	**7:58**
6	**C**	**Pediatric Quality Committee** • Meeting Minutes, November 5, 2025	**Dr. Ribordy**	**94**	
7	*C*	*Quality Improvement Health Equity Committee*	*Dr. Jalloh*		
C.	**A**	**Physician Advisory Committee Membership** • Nomination of Dr. Betza Kunkel • Resignation of Dr. Mustafa Ammar	**Dr. Brennan**	**98** **99**	**8:00**
III.	**I**	**REGIONAL MEDICAL DIRECTOR REPORTS**	**LEAD**		**TIME**
A.	**I**	**Napa, Yolo & Solano**	**Dr. Jones**		**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. Cox**		**8:17**
F.	**I**	**Plumas, Sierra, Nevada & Placer**	**Dr. Morris**		**8:21**
IV.	**I**	**PARTNERSHIP LEADERSHIP INTRODUCTION**	**LEAD**	**PG**	**TIME**
A.	**I**	• **Aaron Brincko, Director of Provider Relations**	**Mr. Brincko**	*N/A*	**8:25**
V.	*I*	*Old Business*	*LEAD*	*PG*	*TIME*
VI.	**I**	**SPECIAL PRESENTATIONS**	**LEAD**	**PG**	**TIME**
A	**I**	**QI Initiative: DataLink Pilot**	**Ms. Gual**	**100**	**8:30**
VII.	**I**	**ADJOURNMENT**	**LEAD**		**9:00**
		Next PAC on March 11, 2026 at 7:30 a.m.	**Dr. Brennan**		

This agenda contains a brief description of each topic for consideration. 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 is available for review from 8:00 AM to 5:00 PM, Monday through Friday at all Partnership regional offices (see locations under the Meeting Notice). It can also be found online at the Physician Advisory Committee webpage, linked below.

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 the agenda, meeting notice, agenda packet or other writings that may be distributed at the meeting, should contact the Executive Assistant to the Chief Medical Officer at least two (2) working days before the meeting at (707) 863-4228 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: **January 14, 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)* Steven Gwiazdowski, MD *(FF)* Michele Herman, MD, *(FF)* Karen Sprague, MSN, CFNP *(FF)* Teresa Shinder, DO *(FF)* Zoe Cappe, MD *(FF)*	Chris Myers, MD *(E)* Candy Stockton, MD *(E)* Karina Gookin, MD *(AU)* Chester Austin, MD *(C)* Darrick Nelson, MD *(R)*	Christina Lasich, MD *(SL)* Mills Matheson, MD *(OMM)* Vanessa Walker, DO *(SH)*	*FF Fairfield* *SR Santa Rosa* *E Eureka* *R Redding* *C Chico* *AU Auburn*	*MCC Marin Community Clinics* *OMM Office of Dr. Matheson* *SH Sutter Health Roseville* *SL Sutter Health Lakeside* *A Aliados Health*
Members Excused:	Brian Montenegro, MD	Malia Honda, MD	Derice Seid, MD *(MCC)*	Danielle Oryn, DO	
Members Absent:	Mustaffa Ammar, MD	John McDermott, FNP	Matthew Zavod, MD		
Visitor:	Dr. Betza Kunkel, Psychiatrist & Family Physician, Communicare+Ole				
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 Heather Esget, 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	14/21 – PAC	Committee quorum requirements met (14).	01/14/26

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.

I.A. Chief Executive Officer (CEO) Report	**Partnership's Chief Executive Officer provided the following report for Partnership activities**
	
	• **State Budget**
	  • Governor Newsom released the proposed 2026-2027 state budget on January 9, 2026, which was less transparent in terms of health care than in years' past.
	  • One line item indicated $125M will be saved through efficiencies in Medi-Cal managed health care, but efficiencies were not defined making it a challenge to prepare.
	  • There were no mentions of additional cuts to benefits or specific populations within the release.
	  • California Advancing and Innovating Medi-Cal (CalAIM) remained unchanged but continues to operate under waivers afforded by CMS.
	• **MediCal Eligibility Changes**
	  • Changes to Medi-Cal eligibility for those who have uncertain immigration status (UIS) went into effect on January 1, 2026.
	  • Those who have UIS and were not already enrolled as of January 1, 2026 are now ineligible to enroll.
	  • Those who have UIS and were previously enrolled may keep full MediCal benefits.
	  • Partnership is working closely with members, provider networks, and county leadership to ensure enrolled members do not lose their eligibility, in which case those members would not be able to reenroll.
	  • Partnership launched the "Keep Your MediCal" campaign and made materials available to all.
	  • Partnership receives weekly and monthly data files from California Department of Health Care Services (DHCS) showing when members are due for redetermination, which Partnership shares with the care providers to assist with documentation.
	  • Many UIS members have chosen not to reenroll over concerns about data sharing between DHCS and other government agencies.
	  • Every county in Partnership's network has experienced a loss in membership.
	  • County Medical Services Programs (CMSP) assisting uninsured individuals may see an increase in applications for assistance which will be a large expense to account for as budgets are being planned.
	  • Federally Qualified Health Centers (FQHC), rural health centers, and tribal health centers often provide care for a reduced cost or through charity for those who lack health coverage.
	  • There are discussions at the state level of potential copays for UIS enrolled, which may place a financial burden on families and put them at rick of losing MediCal. Partnership is collaborating with counties to see what options are available for financial assistance either through grants or community reinvestment initiatives.
	• **Federal Changes to Medicaid**
	  • Planned Parenthood has been designated as a prohibited provider at the federal level. Contracts for care between Partnership and prohibited providers have removed federal dollars for payment and will be paid solely through state funding. Long-term solutions to ensure continued operations are being discussed.
	  • Centers for Medicare and Medicaid Services (CMS) have proposed a rule to disallow federal funds to pay for gender-affirming care. Proposed rules must allow 60 days for comments to be made before becoming effective. The of the comment period is February 16, 2026.
	  • Partnership has workgroups in place to brainstorm ways members can continue to receive gender-affirming care through state funding and alternate pathways.
	• **Quality Incentive Program (QIP) Contracts**
	  • DHCS required all terms for QIPs be updated in amended provider contracts before December 31, 2025 for continued participation.
	  • Almost all participants were able to sign the amended contracts and participate.
	  • Those who missed the deadline will not be able to participate this year and cannot be granted an exception by federal law, but they may participate in future years.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.

I.A. Chief Executive Officer (CEO) Report, continued	• **CalAIM Community Supports**
	  • Benefits under CalAIM will continue to be utilized to the full extent.
	  • Asthma Remediation is a new Community Support that will allow members with asthma to obtain symptom-mitigating items such as home air filters and hypoallergenic linens.
	  • Providers are still in the contracting process. Referrals will need to wait until that process is complete. Information will be shared with the provider network in February.
	  • Assisted Living Facility Services are available to assist those who were in the hospital transitioning to a long term care facility or home with many supports.
	  • Partnership will pilot these services for six months in selected counties where services are available and evaluate future actions based on results.
	• **MediCal Enrollment Assistance**
	  • Assisting members with eligibility is a covered benefit for which Partnership can be billed.
	  • Community Health Workers and other designated clinic support staff can aid members who may express concerns about eligibility for MediCal upon receiving notice of redetermination.
	  • Members identifying as Alaska Natives/American Indian are exempt from future work requirements for eligibility.

I.B. Chief Medical Officer (CMO) Health Services Report	**Partnership's Chief Medical Officer presented a brief update for Health Services.**
	
	• **DHCS Updates**
	  • DHCS assigned financial sanctions to Partnership for a number of clinical measures falling below the minimum performance level (MPL).
	  • DHCS reduced the sanction for one measure after meeting.
	  • Some measures were considered low performance due to a lack of data from the state, but Partnership has evidence of measures reporting greater than the MPL and has appealed the sanctions for those measures.
	  • Major changes were made to the Measured Care Accountability Set (MCAS) measures for 2026 including many depression screening and treatment measures which must be coded to meet the electronic data submission (ECDS) measures as well.
	  • All adults and adolescents are required to be screened for depression. Every patient must be given the screening and have the information entered into the chart.
	  • Referrals must also be accounted for electronically.
	  • Screening data must be captured by extracting data from the electronic health record (EHR).
	  • Partnership has been working with a company called DataLink which specializes in extracting data from the chart and has had success with electronic medical records (EMRs) such as E Clinical Works and Athena Health. Epic users are slowly coming on board.
	  • In planning for the 2027 Primary Care Provider (PCP) QIP, Partnership intends to only accept the uploaded data that is captured by DataLink.
	  • Providers are strongly encouraged to evaluate workflows for charting depression screening to ensure readiness.
	  • Penalties and fines will be levied against managed care plans (MCP) falling below the MPL.
	• **Pediatric Vaccine Coverage**
	  • The U.S. Department of Health and Human Services (HHS) eliminated several pediatric vaccines from recommendation.
	  • Despite the HHS recommendations, those vaccines are still covered and available per DHCS guidance.
	  • Quality measures with DHCS and the National Coalition for Quality Assurance (NCQA) have not been able to respond, but changes are anticipated in the future.
	  • CMS implemented measures based on Childhood Immunization Status (CIS) Combination 10 (CIS-10), some of which are no longer HHS recommended.
	  • Providers experiencing issues with vaccine coverage are encouraged to reach out to Partnership for advocacy and accessibility.
	• **Staffing Update**
	  • Dr. Michael George has joined Partnership as a new Associate Medical Director.

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.A.	**November 12, 2025 PAC minutes were presented for approval.**	**MOTION:** Dr. Herman moved to approve Agenda III.A as presented, seconded by, seconded by Dr. Gwiazdowski **ACTION SUMMARY:** [13] yes, [0] no, [1] abstentions.	01/14/26 Motion carried.
II.B. II.B.1 II.B.2 II.B.5 II.B.7	**Consent Calendar Review** • Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – November 2025 • Policies, Procedures, and Guidelines for Action Policy Summary January 2026 • Credentials Committee Meeting Minutes and Credentialed List, October 8, 2025 Minutes and Credentialed List, November 12, 2025 • Quality Improvement Health Equity Committee Meeting Summary, November 18, 2025	**MOTION:** Nurse Sprague moved to approve Agenda III.B.1, III.B.2, III.B.5 and III.B.7 with the exception of MPQG1011, Non-Physician Medical Practitioners & Medical Assistants Practice Guidelines, which was pulled to point out language needing to be amended pursuant to Assembly Bill 1501, effective January 1, 2026. MPQG1011 will return to Internal Quality Improvement Committee for review. Motion to approve Consent Calendar Review was seconded by Dr. Lasich. **ACTION SUMMARY:** [14] yes, [0] no, [0] abstentions.	01/14/26 Motion carried.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III.A Status Update, Regional Medical	**Partnership's Regional Medical Director for Napa, Solano, and Yolo Counties presented a brief update on activities.** • Pediatric care in Napa has been affected by staffing changes but are expected to be met through physician direct clinical care and supervision of mid-level team. • Union strikes in Solano County have impacted family health practices and public health offices. Area practices anticipated the need and were able to minimize the impact by accommodating same-day appointments when available. • Self-swab cervical cancer screening may be available for home testing in the near future as manufactures develop the test for approved home use. Self-screening tests are currently available in the clinic setting.

III.B.
Status Update, Regional Medical
	Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities.
	• Area stakeholders continue to meet to discuss vaccine hesitancy.
	• Providence Santa Rosa Memorial will be closing its inpatient pediatric unit and transferring patients to USCF Benioff Children's Hospital.
	  • The closure of the unit will force families to receive care in San Francisco or Oakland.
	  • Sutter has proposed to open pediatric beds to bridge the gap in access.
	• Partnership is working closely with Sonoma County Health Services Director to strategize and prepare for MediCal enrollments and redeterminations. Exploring opportunities for Marin County to share best practices with Sonoma County to overcome some constraints.
	• Dr. Deanna Lomax joined Marin City Health and Wellness as an associate medical director.
	• Dr. Jing Zhao has been appointed CMO at Sonoma Valley Community Health Center after departure from Alexander Valley.
	• Partnership Santa Rosa staff volunteered and donated at The Redwood Empire Food Bank.

III.C. Status Update, Regional Medical	**Partnership's Regional Medical Director for Lake, Mendocino, Humboldt, and Del Norte Counties presented a brief update on activities.** • Providence St. Joseph is having a celebration of their birth center after delivering 1,000 babies in 2025. • Klamath Indigenous Land Trust (KILT) has acquired 10,000 acres of land along the Klamath River. • Partnership Eureka supported two local food banks with a check for $22,500 through community reinvestments. • Partnership Eureka staff volunteered to sponsor a family through the Arcata House providing gifts and other items during the holiday season.
III.D Status Update, Regional Medical	**Partnership's Regional Director for Glenn, Butte, Sutter, and Colusa Counties presented a brief update on activities.** • Congressman LaMalfa's passing creates the need for a special election to fill the seat shortly before midterm elections will be held. LaMalfa left a legacy of strong advocacy for rural hospitals. • Oroville Hospital filed for Chapter 8 bankruptcy and are in process of reorganizing and searching for a financial partner or buyer. • Dr. Edward Kalpus joined Peachtree Health as CMO. • Feather River is reevaluating plans for expansion in Yuba City based on building limitations imposed by the area. • Emmy Johnson joined Healthy Rural California as new CEO. • Healthy Rural California was awarded $500,000 through the University of California Grow Grants.
III.E Status Update, Regional Medical	**Partnership's Regional Director for Siskiyou, Modoc, Shasta, Lassen, Trinity, and Tehama Counties presented a brief update on activities.** • Primary Care Provider access has been affected due to the closure of Tarichi Primary Care in Corning, California. The Chico location is also expected to close in the near future. • The Redding Endoscopy Center will continue to see Partnership members for care. • Dr. Joby Morrow joins Redding Hill Country as Medical Director for substance use disorder (SUB) program. • Dr. Shafqat Akhtar, hematology and oncology, joins St. Elizabeth in Red Bluff, California in addition to Dr. Adams and Dr. Wong, dermatology. • Dr. Matthew Edmonds, CMO at Modoc Medical Center, has retired. A replacement has not been named.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III.F Status Update, Regional Medical	**Partnership's Regional Director for Plumas, Sierra, Nevada & Placer presented a brief update on activities.** • Sierra Nevada Memorial Hospital received their mobile unit and hope to be going live with care later this year. • Dr. John Lillegraven has started providing care at Eastern Plumas Health Care. • Partnership and Placer County HHS director and deputy director visited the Placer County Jail to see the health care provided and understand the transition to care under CalAIM Justice Involved. There is a building expansion being finalized for psychiatric patients. All were impressed with the care and facilities. • Partnership Auburn staff members volunteered and served more than 800 families at Grass Valley Food Bank. • Dr. Cook, Nevada County Public Health Officer, has reported rates of mushroom poisoning have risen sharply. More than 200 cases have been reported throughout the state, leading to three fatalities and three liver transplants. • Mushroom poising symptoms include nausea and vomiting and can occur anywhere from six hours after ingestion up to three days.
IV. Office Practice Update	*None*
V. Old Business	*None*

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
VI.A Community Supports: Transitional Rent Implementation	**Community Supports: Transitional Rent Implementation** **Beginning Jan. 1, 2026** **What is it?** Up to six months of rent for Medi-Cal members experiencing or at-risk of homelessness and meet specific eligibility criteria for county serious mental illness (SMI) and/or SUD. Counties must sign off and attest to housing support plan developed by the transitional rent provider. Partnership can only cover the first six month of rent, after which time funding would shift to county behavioral health dollars. **Who is this for?** Transitional Rent is designed to provide a time-limited opportunity to help those who meet all of the following criteria: • Meet clincal risk factors • Experiencing or at risk of homelessness or experiencing trasition out of the hospital or institution across care settings. • Transitioning populations or unsheltered or FSP **Clinical Risk Factors** • Meet criteria for County MH or Drug Medi-Cal services • Future clinical risk factors maybe expanded to include: 1 or more chronic conditions **Behavioral Health Integration** • In each county, Partnership must offer a contract for TR, and work closely with the county's Behavioral Health Dept. • County Behavioral Health must sign off on the Housing Support Plan (HSP) for the member **Provider Network** • County / County Behavioral Health • Community Based Organization – CoC affiliated entities • Other: Flex Pools, Affordable Housing Providers, Supportive Housing Providers, Social Services Agencies, etc. **Providers will:** • Identify an appropriate setting/unit • Ensure the housing unit is habitable • Help the Member review, understand and execute the lease agreement • Structure rent payment agreement with landlord • Issue timely payments to the housing provider • Coordinate with the supportive services providers Glenn County is the first provider to be contracted with Partnership for Transitional Rent.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
VI.A Community Supports: Transitional Rent Implementation	**Transitional Rent FAQs** 1. **Will Partnership require a TAR for Transitional Rent?** Yes 2. **How will rent be paid for after 6 months?** This will be identified on the member's Housing Support Plan. The TR provider will be responsible for documenting the plan, obtaining necessary signatures (including the member's acknowledgement) and submitting a copy with the TAR to Partnership. 3. **Will the member still qualify for other services like ECM and/or CS?** Yes! Members who are referred for Transitional Rent will also automatically be referred to an ECM provider. Member may also receive other housing related CS if they qualify (e.g. Housing Tenancy, Housing Deposits, etc.) 4. **Is there a dollar limit on how much rent can be covered?** Yes. DHCS has identified market rates for rent in accordance with Small Area Fair Market Rents (SAFMR) through HUD. • Transitional Rent is a mandatory Community Support unaffected by waiver programs within DHCS. • Transitional rent cannot cover back rent and arrears, and it cannot cover eviction. • Transitional rent can only be used once within a waiver period, but all six months do not have to be used consecutively. **Provider Partnerships** • Referral pathway – under development • Close coordination with County Behavioral • Careful messaging to patients; limited affordable housing supply in California • An opportunity for members who are transitioning where housing may be a barrier (ex: out of hospital, carceral settings, MH facility, substance use facility, etc.) Partnership is being very careful with intentional messaging within call centers, care management teams, and the provider network to set proper expectations. Housing shortages are expected to impact the program. Transitional Rent relies on obtaining stable housing, connecting members with appropriate clinical care and services, and also connected by proxy to social services within the MediCal delivery system. **Questions & Resources** DHCS Policy Guide – Vol. 2 *(The policy guidance for transitional rent nor the referral requirements have been finalized).* Partnership CalAIM Page **Contact** CalAIM@partnershipHP.org

VII.	ADJOURNMENT
PAC adjourned at 9:07 a.m.	**Next Physician Advisory Committee announced for February 11, 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
QUALITY/UTILIZATION ADVISORY COMMITTEE (Q/UAC)
MEETING AGENDA

Date: Jan. 21, 2026 **Time: 7:30 – 9:10 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
2760 Esplanade Ave., Ste 130, Chico 95973 | Temp Conf Room

Other Locations:
Open Door Community Health Center, 770 10th St., Arcata
Chapa-de Indian Health: 11670 Atwood Road, Auburn
H&HS Dept.,5730 Packard Ave., Suite 100, Marysville
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* Nov. 19, 2025 Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	5 – 21
2	*Acknowledgment and acceptance of draft minutes of the* • Nov. 11 Internal Quality Improvement (IQI) Committee • Nov. 18 Quality Improvement & Health Equity Committee (QIHEC) • Nov. 13 Substance Use Internal Quality Improvement (SUIQI) Committee • Nov. 20 Member Grievance Review Committee (MGRC)			23 – 102
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isacc Brown, MHA/MBA	7:36	103 – 111
2	HealthPlan Update	Robert Moore, MD	7:41	--
III.	**Old Business – None**			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:46	112
	2025 Referral Follow-ups: Data Analysis for Jan. 1 – June 30, 2025 – *direct questions to Tony Hightower, CPhT*			113 – 124
Health Services Policies	**Behavioral Health**			
	MPBP8003 – Mental Health Services *links to Attachments A-C (DHCS forms) can be found on p. 112*			125 – 140
	Care Coordination			
	MCCP2025 – Pediatric Quality Committee Policy			141 – 142
	MCCP2035 – Local Health Department (LHD) Coordination			143 – 181
	MPCP2006 – Coordination of Services for Members with Special Health Needs (MSHCNs) and Persons with Developmental Disabilities			183 – 190
	Enhanced Health Services			

	Item	Lead	Time	Page #
	MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)			191 – 205
	Health Equity			
	MCEP6002 – Quality Improvement and Health Equity Committee (QIHEC)			207 – 211
	Quality Improvement			
	MPQP1018 – Preventive Health Guidelines			213 – 215
	MPQP1053 – Peer Review Committee			217 – 221
	Utilization Management			
	MCUG3022 – Incontinence Guidelines			223 – 233
	MCUP3052 – Medical Nutrition Services			235 – 243
	MCUP3104 – Transplant Authorization Review			245 – 250
	MCUP3113 – Telehealth Services			251 – 261
	MPUP3006 – Appropriate Service & Coverage (Over/Under Utilization)			263 – 266
	MPUP3129 – Podiatry Services			267 – 269
Non HS	**Member Services**			
	MP300 – Member Notification of Provider Termination or Change in Location			271 – 274
V.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	275 – 280
Health Services Policies	**Care Coordination**			
	MCCP2031 – Private Duty Nursing under EPSDT	Aryana Cunningham	7:50	281 – 286
	MPCP2018 – Advice Nurse Program – *previously MCCP2018*		7:53	287 – 290
	Enhanced Health Services			
	MPAP7003 – CalAIM Community Supports (CS)	Lisa O'Connell, MHA	7:56	291 – 319
	Quality Improvement			
	MCQP1022 – Site Review Policy – *Attachments A-E are unchanged and are not included in this packet*	Rachel Newman, RN	8:00	321 – 461
	Utilization Management			
	MCUP3041-A TAR Requirements List	Tony Hightower, CPhT	8:04	463 – 470
	MCUP3034 – PCP-to-PCP Transfers & Assignments of New Members to PCP		8:07	471 – 473
	MCUP3044 – Urgent Care Services		8:10	475 – 484
	MPUP3014 – Emergency Services		8:14	485 – 492
VI.	**Presentations**			
1	QI Initiative: DataLink Pilot	Kristine Gual, PMP, CPHQ	8:17	493 – 507
2	2024-2025 Hospital Quality Incentive Program Evaluation – *summary page included as p. 521*	Troy Foster	8:40	509 – 521
VI. FYI & Close	2025 CG-CAHPS® Survey of Large Primary Care Organizations' Access and Communication Performance Summary	*Questions?: Robert Moore, MD*	--	523 – 525
	December 2025 CHA/CHIP Update	*Greg Allen Friedman*	--	527-528
	Adjournment scheduled for 9:00 a.m. Q/UAC next meets 7:30 a.m. Wednesday, Feb. 18, 2026			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PARTNERSHIP)
MOTION SUMMARY

Committee: Quality/Utilization Advisory Committee (Q/UAC)
Date / Time: January 21, 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: Choudhry, Sara, MD; Gwiazdowski, Steven, MD, FAAP; Hackett, Emma, MD, FACOG; Murphy, John, MD; Luu, Phuong, MD; Montenegro, Brian, MD; Mulligan, Meagan, FNP-BC; Thomas, Randolph, MD; Wilson, Jennifer, MD, MPH; Quon, Robert, MD, FACP

Members Absent: Lane, Brandy, PHC Consumer Member; Strain, Michael, PHC Consumer Member; Swales, Chris, MD

Visitor:

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; Mary Kerlin, 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; Vacant, Sr. Dir., Quality & Performance Improvement; Isaac Brown, Director, Quality Management; Kristine Gual, Director, Quality Measurement; Amy McCune, Manager of QI Programs; Sue Quichocho, Mgr., Quality Measurement; Megan Shelton, Project Manager, Quality Improvement; Heather Esget, 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	QUAC Chairperson asked for any public comments. None presented.	N/A	N/A
Quorum	10/13 – Q/UAC	Committee quorum requirements met (10).	01/21/26

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
I.1.	**November 19, 2025 Q/UAC minutes were presented for approval.**	Dr. Gwiazdowski moved to approve Agenda item I.1.A as presented, seconded by, seconded by Dr. Wilson. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions.	01/21/26 Motion carried.
I.2	**Acknowledgment and acceptance of draft minutes of the** • Nov. 11 Internal Quality Improvement Committee • Nov. 18 Quality Improvement & Health Equity Committee • Nov. 13 Substance Use Internal Quality Improvement Committee • Nov. 20 Member Grievance Review Committee	Dr. Gwiazdowski moved to approve Agenda item I.2. as presented, seconded by Dr. Hackett. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions.	01/21/26 Motion carried.
IV.	**New Business - Consent Calendar Review** • 2025 Referral Follow-ups: Data Analysis • **Health Services Policies** • Behavioral Health • MPBP8003 – Mental Health Services • Care Coordination • MCCP2025 – Pediatric Quality Committee Policy • MCCP2035 – Local Health Department (LHD) Coordination • MPCP2006 – Coordination of Services for Members with Special Health Needs (MSHCNs) and Persons with Developmental Disabilities • Enhanced Health Services • MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) • Health Equity • MCEP6002 – Quality Improvement and Health Equity Committee (QIHEC) • Quality Improvement • MPQP1018 – Preventive Health Guidelines • MPQP1053 – Peer Review Committee • Utilization Management • MCUG3022 – Incontinence Guidelines • MCUP3052 – Medical Nutrition Services • MCUP3104 – Transplant Authorization Review • MCUP3113 – Telehealth Services • MPUP3006 – Appropriate Service & Coverage (Over/Under Utilization) • MPUP3129 – Podiatry Services • **Non Health Services Policies** • Member Services • MP300 – Member Notification of Provider Termination or Change in Location	Dr. Montenegro moved to approve Agenda item IV. as presented, seconded by Dr. Gwiazdowski. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions.	01/21/26 Motion carried

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
V.	**New Business – Discussion Policies**		
	• Synopsis of Changes	Dr. Quon and Dr. Gwiazdowski approved the Synopsis of Changes as presented. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions.	01/21/26 Motion carried
	• Care Coordination • MCCP2031 – Private Duty Nursing under EPSDT	Dr. Quon and Dr. Gwiazdowski approved MCCP2031 as presented. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions.	01/21/26 Motion carried
	• MPCP2018 – Advice Nurse Program	Dr. Wilson and Dr. Murphy approved MPCP2018 as presented. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions.	01/21/26 Motion carried
	• Enhanced Health Services • MPAP7003 – CalAIM Community Supports (CS)	Dr. Gwiazdowski and Dr. Murphy approved MPAP7003 as presented. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions.	01/21/26 Motion carried
	• Quality Improvement • MCQP1022 – Site Review Policy – Attachments A-E are unchanged and as not included in this packet	Dr. Quon and Dr. Montenegro approved MCQP1022 with modification to add urgent care definitions and references. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions.	01/21/26 Motion carried
	• Utilization Management • MCUP3041-A TAR Requirements List	Dr. Wilson and Dr. Thomas approved MCUP3041-A with modification to remove TAR for TMS. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions.	01/21/26 Motion carried
	• MCUP3034 – PCP-to-PCP Transfers & Assignments of New Members to PCP	Dr. Gwiazdowski and Dr. Wilson approved MCUP3034 with modification to clarify language regarding continuity of care for pregnant members from 33 weeks gestation through eight weeks postpartum and placement in Direct Member status. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions.	01/21/26 Motion carried
	• MCUP3044 – Urgent Care Services	Dr. Wilson and Dr. Montenegro approved MCUP3044 with modification to add language and define urgent care tiers, member roles and responsibilities, and oversight and utilization language. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions.	01/21/26 Motion carried
	• MPUP3014 – Emergency Services	Dr. Gwiazdowski and Dr. Thomas approved MPUP3014 with modification to add urgent care language and outdated contract information in addition to amending addendum A. **ACTION SUMMARY:** [10] yes, [0] no, [0] abstentions.	01/21/26 Motion carried
All motions presented at Q/UAC on January 21, 2026, were carried and will move forward to the Physician Advisory Committee held on February 11, 2026. Meeting adjourned at 9:00 a.m.			

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

Date: Tuesday, Jan. 13, 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 Nov. 11, 2025	Robert Moore, MD, MPH, MBA	1:30	5-18
2	*Acknowledgment and Acceptance of draft minutes of the* • Nov. 13, 2025 Substance Use Internal Quality Improvement (SUIQI) Committee • Nov. 20, 2025 Member Grievance Review Committee (MGRC)			19-64
II.	**Old Business**			
1	Follow-up to November 3NA presentation: Sutter's declination to participate in most recent survey	Aaron Brincko, MPH	1:37	--
2	Modification of rTMS in MCUP3041-A TAR Requirements List approved November 2025	Tony Hightower, CPhT	1:40	65-72
III.	**New Business – Consent Calendar Policies**			
Health Services Department Policies	Consent Calendar	All	1:43	73
	Behavioral Health			
	MPBP8003 – Mental Health Services			75-90
	Care Coordination			
	MCCP2025 – Pediatric Quality Committee Policy			91-92
	MCCP2035 – Local Health Department (LHD) Coordination			93-99
	MPCP2006 – Coordination of Services for Members with Special Health Needs (MSHCNs) and Persons with Developmental Disabilities			101-107
	Enhanced Health Services			
	MCAP7001 CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)			109-123
	Health Equity			
	MCEP6002 – Quality Improvement and Health Equity Committee (QIHEC)			125-129
	Pharmacy			
	MPRP4001 – Pharmacy & Therapeutics (P&T) Committee			131-143
	Quality Improvement			
	MPQP1018 – Preventive Health Guidelines			145-147
	MPQP1053 – Peer Review Committee			148-152
	Utilization Management			
	MCUG3022 – Incontinence Guidelines			153-163

	Item	Lead	Time	Page #
	MCUP3052 – Medical Nutrition Services			165-172
	MCUP3104 – Transplant Authorization Review			173-178
	MCUP3113 – Telehealth Services			179-189
	MPUP3006 – Appropriate Service & Coverage (Over/Under Utilization)			191-194
	MPUP3129 – Podiatry Services			195-197
Non-HS Policies	**Member Services**			
	MP300 – Member Notification of Provider Termination or Change in Location			199-202
	Network Services - Credentialing			
	MPCR11 – Credentialing of Community Health Worker (CHW) Supervising Providers			203-206
	MPCR20 – Medi-Cal Managed Care Plan Provider Screening and Enrollment			207-216
	MPCR100 – Credential and Re-credential Decision Making Process			217-225
IV.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	227-233
Health Services Policies	**Care Coordination**			
	MCCP2031 – Private Duty Nursing under EPSDT	Aryana Cunningham	1:50	235-240
	MPCP2018 – Advice Nurse Program – *previously MCCP2018*		1:55	241-244
	Enhanced Health Services			
	MPAP7003 – CalAIM Community Supports (CS)	Namita Vij	2:00	245-273
	Pharmacy			
	MCRP4068 – Medical Benefit TAR Policy	Stan Leung, Pharm.D	2:05	275-285
	Quality Improvement			
	MCQP1022 – Site Review Policy – *Attachments A-E are unchanged and as not included in this packet*	Rachel Newman, RN	2:10	287-428
	Utilization Management			
	MCUP3034 – PCP-to-PCP Transfers & Assignments of New Members to PCP	Tony Hightower, CPhT	2:15	429-431
	MCUP3044 – Urgent Care Services		2:20	433-442
	MPUP3014 – Emergency Services		2:25	443-450
V.	**Presentations**			
1	Quality Improvement Update	Isaac Brown, MHA/MBA	2:30	451-459
2	QI Initiative: DataLink Pilot	Kristine Gual, PMP, CPHQ	2:35	461-475
3	2024-2025 Hospital Quality Incentive Program Evaluation – *summary page included as p. 489*	Troy Foster	2:55	477-489
4	2025 CG-CAHPS® Survey of Large Primary Care Organizations' Access and Communication Performance Summary	Robert Moore, MD	3:15	491-493
5	2025 Referral Follow-ups: Data Analysis for Jan. 1 – June 30, 2025	Tony Hightower, CPhT	3:22	495-505
	FYI: December 2025 CHA/CHIP Update	*direct questions to Greg Friedman*		507-508
FYI	CY 2026 QI Committees Meeting Schedules and Material Deadlines	*Leslie Erickson will circulate an update of the policy calendar at Feb. 10 IQI*		509
	CY 2026 Health Services and Other External Policies before IQI/QUAC – *last updated Dec. 8, 2025*			510-516
	Adjournment by 3:30 p.m. to 1:30 p.m. Tuesday, Feb. 10, 2026			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Jan. 13, 2026 / 1:32 – 3:29 PM

Members Present:	
Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer	Hightower, Tony, CPhT, Associate Director, UM Regulations
Bides, Robert, RN, BSN, Manager of Member Safety – Quality Investigations, QI	Innes, Latrice, Manager of Grievance & Appeals Compliance
Bontrager, Mark, Sr. Director of Behavioral Health, Behavioral Health	Leung, Stan, Pharm.D, Director of Pharmacy Services
Brincko, Aaron, Director, Provider Relations	Moore, Robert, MD, MPH, MBA, Chief Medical Officer, Committee Chair
Brown, Isaac, MHA/MBA, Sr. Dir. of Q & P Improvement	Netherda, Mark, MD, Medical Director for Quality, Committee Vice-Chair
Brunkal, Monika, RPh, Assoc. Dir., Population Health	Newman, Rachel, RN, BSN, Manager, Clinical Compliance – Quality Inspections
Campbell, Anna, MPH, Policy Analyst, Utilization Management	Randhawa, Manleen, Senior Health Educator, Population Health
Esget, Heather, RN, BSN, ACM, Director of Utilization Management	Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Gast, Brigid, MSN, BS, RN, NEA-BC, Sr. Director, Care Management	Townsend, Colleen, MD, Regional Medical Director (Southeast)
Gual, Kristine, PMO, CPHQ, Director of Quality Measurement, QI	Vaisenberg, Liat, Director of Health Analytics, Finance
Members Absent:	
Andrews, Leigha, MBA, Regional Director (Southwest)	Klakken, Vicki, Regional Director (Northwest)
Ayala, Priscila, Director of Network Services	Matthews, Richard "Doug," MD, Regional Medical Director (Chico)
Bjork, Sonja, JD, Chief Executive Officer	Sharp, Tim, Regional Director (Northeast)
Brundage O'Connell, Lisa, MHA, Director of Enhanced Health Services	Turnipseed, Amy, Senior Director of External and Regulatory Affairs
Davis, Wendi, Chief Operating Officer	Villasenor, Edna, Senior Director, Member Services and G&A
Jalloh, Mohamed "Moe," Pharm.D, Health Equity Officer	Ward, Lisa, MD, Regional Medical Director (Southwest)
Jones, Kermit, MD, JD, Deputy CMO & Medical Director for Medicare Services	YoungStone, Kelly, RN, Director of Care Coordination, Care Coordination
Guests:	Kung, Jen, Senior Health Data Analyst II, Finance
Akintan, Folo, MBBS/MD MPH MBA, Epidemiologist, Population Health	Lee, Donna, Manager of Claims, Claims
Allen, Angier, Senior Data Scientist I, Finance	Ocampo, Andrea, Pharm.D, Clinical Pharmacist, Pharmacy
Arguello, Amanda, Lead Trainer, Network Services	O'Leary, Hannah, Manager of Population Health, Population Health
Bikila, Dejene, Manager of Data Science, Finance	Moore, Jordan, Education Specialist, Provider Relations
Booth, Garnet, Senior Program Manager, Provider Relations	Muncy, Kellie, Mgr of Change Management & Configuration, Configuration
Boyle, Shannon, RN, Manager, Care Coordination Regulatory Performance	Nguyen, Tom, Manager of Health Analytics, Finance
Chiang, Yuen, Program Manager I, Utilization Management	Rathnayake, Russ, Senior Health Data Analyst I, Finance
Clark, Kristen, Manager, Quality & Training, Member Services	Rednic, Hanny, Program Manager I, UM
Devan, James, Sr. Mgr. of Performance Improvement, QI (Redding)	Roach, Erika, Program Manager II, Network Services
DeVido, Jeff, MD, Behavioral Health Clinical Director	Salehi, Tiphanie, Sr. Health Data Analyst I, Finance
Durst, Jennifer, Sr. Mgr. of Performance Improvement, QI (Santa Rosa)	Seale, J'aime, PR Lead, Network Services
Enos, Mary, Director, Member Services Enrollment	Sivasankar, Shivani, Sr Data Scientist, Health Analytics, Finance
Flournoy, Candi, Project Manager II, QI	Smith, Christine, Community Health Needs Liaison, Population Health
Foster, Troy, Program Manager II, QI	Spiller, Bettina, MD, Associate Medical Director
Harris, Vander, Senior Health Data Analyst I, Finance	Stites, Jaylyn, Program Manager II, Provider Relations
Hendrix, Hillary, Exec. Asst. to the Sr. Dir. of Behavioral Health	Thomas, Andrea, Project Manager I, QI
Isola, Brandy, Manager of Performance Improvement, QI (Chico/Auburn)	Thomas, Penny, Senior Health Data Analyst I, Finance
Kim, Amanda, Improvement Advisor, QI (Redding)	Vance, Brooke, Program Manager I, Network Services
Kubota, Marshall, MD, Associate Medical Director	Vij, Namita, Program Manager II, Enhanced Health Services
Kulkarni, Shreya, JD, Policy Analyst, Regulatory Affairs & Compliance (RAC)	Yu, Fei, Senior Data Scientist I, Finance

	Zhao, Li, Senior Health Data Analyst I, Finance

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

I. Call to Order
• Introductions
• Approval / Acceptance of Minutes
	Chief Medical Officer Robert Moore, MD, MPH, MBA called the meeting to order at 1:32 p.m. from the Redding-Airpark office. He congratulated UM Policy Analyst Anna Campbell on receiving her MPH degree in December. He also thanked Amy McCune, who was departing Partnership Jan. 15, for her work ably leading the Quality Incentive Program team, remarking "the QIP team is in a very strong place."
	
	Approval of the Nov. 11, 2025 IQI Minutes
	• Acknowledgment and Acceptance of the draft minutes of the
	  o Nov. 13, 2025 Substance Use Internal Quality Improvement (SUIQI) Committee
	  o Nov. 20, 2025 Member Grievance Review Committee (MGRC)
	
	Anna Campbell noted **an incorrect policy number was cited in the capture of the MCUG3038 discussion. This is now corrected as "Relevant language in *the archiving MPUP3051* is now incorporated in this policy."**
		Motion to **approve IQI Minutes as amended**: Issac Brown
		Second: Kristine Gual
		
		Motion to **accept other minutes**: Mark Netherda, MD
		Second: Kristine Gual
		
		The corrected and approved November 2025 IQI minutes have been submitted to Regulatory Affairs for transmission to the Department of Health Care Services (DHCS).

II. Old Business		
Sutter's Non-Participation in Last 3NA Survey In follow-up to the 3NA (3rd Next Available) Survey presented at November IQI and Q/UAC, Director of Provider Relations Aaron Brincko reported that Sutter representatives told him that they do not object to participating in Partnership's future such surveys; however, they will not agree to cooperate with any Corrective Action Plan (CAP) that Partnership might impose because Sutter is fee-for-service and not capitated. Medical Director for Quality Mark Netherda, MD, commented that local health departments in counties where Sutter operates have reported similar lack of cooperation. Dr. Moore noted that participation in the 3NA is a regulatory requirement and that if this situation persists, the matter may need to be escalated to Legal.		
MCUP3041-A TAR Requirements List Dr. Moore noted that, after thinking about the implications for National Committee for Quality Assurance (NCQA), we have decided to reverse course on one modification made to this list in November: **Repetitive Transcranial Magnetic Stimulation (rTMS) then added as item HH is now removed. Partnership will NOT require a TAR for TMS,** so Configuration will need to undo any related work it may have done.		
III. New Business Consent Calendar (Committee Members as applicable)		
Health Services Policies Behavioral Health MPBP8003 – Mental Health Services Care Coordination MCCP2025 – Pediatric Quality Committee Policy MCCP2035 – Local Health Department (LHD) Coordination – ***pulled*** MPCP2006 – Coordination of Services for Members with Special Health Care Needs (MSHCNs) and Persons with Developmental Disabilities		Motion to **approve the slate without the four pulled policies**: Mark Netherda, MD Second: Anna Campbell Next Steps: All Health Services policies but Pharmacy will go to the Jan. 21 Quality/ Utilization

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Enhanced Health Services MCAP7001 – CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS) Health Equity MCEP6002 – Quality Improvement and Health Equity Committee (QIHEC) Pharmacy MPRP4001 – Pharmacy & Therapeutics (P&T) Committee – ***pulled*** Quality Improvement MPQP1018 – Preventive Health Guidelines – ***pulled*** MPQP1053 – Peer Review Committee Utilization Management MCUG3022 **–** Incontinence Guidelines MCUP3052 – Medical Nutrition Services – ***pulled*** MCUP3104 – Transplant Authorization Review MCUP3113 – Telehealth Services MPUP3006 – Appropriate Service & Coverage (Over/Under Utilization) MPUP3129 – Podiatry Services **Non-Health Services Policies** Member Services MP300 – Member Notification of Provider Termination or Change in Location Network Services - Credentialing MPCR11 – Credentialing of Community Health Worker (CHW) Supervising Providers MPCR20 – Medi-Cal Managed Care Plan Provider Screening and Enrollment MPCR100 – Credential and Re-credential Decision Making Process **Anna Campbell pulled** MCCP2035, MPRP4001, MPQP1018, MCUP3052 to comment or ask clarifying questions. • MCCP2035: With changing Center for Disease Control guidance, we probably do not want to suggest providers continue to follow the CDC's Advisory Committee on Immunization Practices (ACIP) guidelines. Dr. Moore agreed. **VI.C.5.a. 1) is amended to read "Assess the Member's need for EPSDT medically necessary services using the American Academy of Pediatrics Periodicity Table and childhood vaccination schedule." Dr. Netherda noted Reference E therefore should be struck and IQI agreed.** *Kristine Gual/Katherine Barresi, RN* • Should CDC references in MPRP4001 be altered? Dr. Netherda expressed reluctance to do so at this time, and Dr. Moore agreed. **Approved as presented***: Mark Netherda, MD/Kristine Gual* • Should CDC mention change at in MPQP1018's VI.A.1.b.? Dr. Moore cautioned against getting ahead of ourselves. **Approved as presented:** *Mark Netherda, MD/Kristine Gual* • A new update to MCUP3052 was circulated by email this morning with Dr. Colleen Townsend's approval. The revision includes the additions of MCUG3118 – Prenatal & Perinatal Care to the Related Policies section. Three definitions were also added: the Comprehensive Perinatal Services Program (CPSP), the Partnership HealthPlan Perinatal Services (PHPS), and "Perinatal services are defined as pregnancy-related services given before and during delivery and for a period of 12 months following delivery." Some codes, which Dr. Moore noted were necessary to contract with our Registered Dieticians, were also in the emailed revision. **Approved as amended:** *Kristine Gual/Mark Netherda, MD*	Advisory Committee (Q/UAC) and thereafter to the Feb. 11 Physician Advisory Committee (PAC). MPRP4001 will go to P&T before moving to PAC Feb. 11. Network Services' three policies will finish at the Feb. 11 Credentials Committee.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
IV. New Business – Discussion Policies		
Policy Owner: Care Coordination – *Presenter: Aryana Cunningham, Policy Analyst, Care Coordination*		
MCCP2031 – Private Duty Nursing under EPSDT	**Policy edits due to Annual Review** **Related Policies updated:** MCUG3011 renamed to MPUG3011 **Definition updated:** Whole Child Model (WCM): A comprehensive program 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 pediatric Member with CCS eligible conditions insured by Partnership. **VI.E.7. removed:** Partnership reserves the right to limit hours as follows: a. Limit approved skilled nursing care provided by a Home Health Agency (HHA) to a maximum of 22 hours/day, and/or b. Limit approved skill nursing care provided by an Individual Nurse Provider (INP) to a maximum of 11 hours/day per INP **VI.E.7 added:** In keeping with this requirement, Partnership reserves the right to limit hours based on medical necessity and provider evaluation, inclusive but not limited to skilled nursing care provided by a Home Health Agency (HHA) and/or an Individual Nurse Provider (INP). **References added:** National Committee for Quality Assurance (NCQA) Health Plan Standards. Quality Management and Improvement 3 Continuity and Coordination of Care A word may be missing from the WCM definition as presented, and Shannon Boyle, RN, noted the qualifier may be realigned. **"2025" will be dropped from the NCQA reference as there were no new Health Plan Accreditation (HPA) Standards released in 2025.** A 2026 release is expected any day.	*There were no questions.* **Motion to approve as amended:** Kristine Gual Second: Isaac Brown Next Steps: Jan. 21 Q/UAC Feb. 11 PAC
MPCP2018 – Advice Nurse Program *(previously MCCP2018)*	**Policy edits due to APL 25-006 Timely Access Requirements** **Related Policies added:** MCND9001 – Population Health Management Strategy and Program MCND9002 – Cultural and Linguistic Program Description **Definition added:** Partnership Advantage (PA) **VI.A. added** Partnership Advantage Members **VI.H.5 added:** DHCS verifies the wait times for the Advice Nurse Services line through the Timely Access Survey. DHCS provides the results to Partnership quarterly and compiles the quarterly results into an annual result provided to Partnership by the second quarter of the subsequent measurement year. a. 24/7 Nurse Triage Line: All inquiries must receive a response within 30 minutes. A minimum performance threshold of 90% compliance is required. **References added:** CalAIM Dual Eligible Special Needs Plans Policy Guide – Contract Year 2026 (September 2025)	**Motion to approve as presented:** Mark Netherda, MD Second: Brigid Gast, RN Next Steps: Jan. 21 Q/UAC Feb. 11 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	DHCS APL 25-006 Timely Access Requirements (*Revised* 11/18/2025) Anna Campbell asked if any timely access policy in Provider Relations should be referenced in this policy. Dr. Moore said no.	
Policy Owner: Enhanced Health Services – *Presenter: Namita Vij, Senior Program Manager, EHS*		
MPAP7003 – CalAIM Community Supports (CS)	**This policy was last at PAC on Nov. 11, 2026. The Policy Guide called for new updates that went live Jan. 1, 2026. This policy will come back again in 2026** with a new Partnership policy for Transitional Rent **after DHCS approves its new CalAIM Policy Guide Volume 2 in development. It will also include final referral requirements, which may change the eligibility updates made today.** The Related Policies section is updated. **VI.F.1-5:** Updated eligibility requirements for "Housing Trio" – Housing Transition Navigation Services (HTNS), Housing Deposits, and Housing Tenancy and Sustaining Services (HTSS) – Short-Term Post-Hospitalization Housing (STPHH), and Recuperative Care (Medical Respite – Room and Board Service) per the DHCS Policy Guide, Vol 2 (April 2025). **VI.F.6:** Eligibility criteria are moved to the beginning of the Medially Tailored Meals/Groceries (MTH/G) section. **References:** DHCS Policy Guides Volumes 1 and 2 are separated for ease of hyperlinked access.	*There were no questions.* **Motion to approve as presented:** Isaac Brown Second: Mark Netherda, MD Next Steps: Jan. 21 Q/UAC Feb. 11 PAC
Policy Owner: Pharmacy – *Presenter: Andrea Ocampo. Pharm.D, Clinical Pharmacist*		
MCRP4068 – Medical Benefit Medication TAR	**Policy edits due to APL 25-013 Medi-Cal Rx Pharmacy Benefits, and Cell and Gene Therapy (CGT) Coverage** (09/18/2025 *superseding* APL 22-012) **and NCQA UM 10 Element E.** **Section III.D**: Added definition of CGT Access Model. **Section III.K**: Added definition of PAD (Physician-Administered Drug) Formulary Exception. **Section VI.C** Added that Members can coordinate with their practitioner to send Partnership a request for physician-administered drugs that are not on the list of covered pharmaceuticals or exceptions to utilization management requirements based on medical necessity. Practitioners may submit the request on behalf of the member and should include information with the request that explains why an exception is requested along with appropriate clinical information to support the request. **Section VI.D:** Updated to include that Partnership has specific criteria used to determine medical necessity and clinical appropriateness for PAD TAR review. **Section VI.D.1**: Added examples of clinical documentation to be furnished to establish medical necessity for TAR review. **Section VI.D.4.d**: Added that only Clinical Pharmacists, the CMO or a Physician Designee have the authority to deny a TAR or exception request for PADs where the determination requires clinical judgement. **Section VI.D.6.g**: Added examples of member characteristics that are considered during TAR review. **Section VI.D.6.h**: Added "Based on consideration of available services in the local delivery system and their ability to meet the member's specific health care needs, when Partnership criteria are applied."	**Motion to approve as presented:** Kristine Gual Second: Colleen Townsend, MD Next Steps: Jan. 15 P&T Committee Feb. 11 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.E: Added language to clarify that the time frames also apply to exception requests. Updated time frames to 24 hours for all types of requests. **Section VI.G**: Added that all Adverse Benefit Determinations (ABDs) due to medical necessity (regardless if the request is for a PAD that requires a TAR or a PAD formulary exception request) have the same internal and external appeal processes as denials for other services. Added that the notification includes the reason for the denial and an explanation of the appeal process. **Section VI.I.e.:** Added the following changes as pursuant to APL 25-013-CGT therapy coverage: • Therapies pursuant to the CGT Access Model are excluded from the Partnership medical drug benefit. • Partnership will be responsible for care coordination and assisting members with accessing CGT sickle cell disease medications, all associated outpatient or inpatient medical services and non-medical ancillary services that support members through their CGT treatments, • Partnership will be responsible for Non-Emergency Medical Transportation (NEMT) and Non-Medical Transportation (NMT) services and related travel expenses to the CGT Access Model as applicable **Section VII References**: Added references for DHCS APL 25-013 Anna Campbell questioned changes in some decision time frames as this has not been done in UM. Director of Pharmacy Stan Leung, Pharm.D, noted the change is to accommodate NCQA and is only for PADs, not UM medical decisions; however, Dr. Moore said that eventually UM and Pharmacy docs will need to sync. He suggested that UM make the change when it next updates its Program Description.	
Policy Owner: Quality – *Presenter: Rachel Newman, RN, Manager, Member Safety – Quality Inspections Team*		
MCQP1022 – Site Review Requirements and Guidelines *– there are no changes to Attachments A-E, so for brevity they were not included in the packet except by hyperlink*	This policy is coming back ahead of its annual review in large part to accommodate UM's MCUP2033 – Urgent Care Services policy changes on today's agenda. Accordingly, MCQP1022's attachments will now include review tools relevant to urgent care. Additional changes have been made to improve the workflow of the policy and be more inclusive of the additional reviews performed by the Site Review team. **Section III Definitions added:** "Supplemental Facility," and Free-Standing Urgent Care Center **Attachment F –** the Non-Accredited Facility Site Review Tool – has minor updates on questions for flow and process. **Note: this Tool will no longer be used for Urgent Care.** **Old Attachments J and L** – Master Trainer Certification and Provider Certificate, respectively **– are being archived. Others are being reordered and thus relettered** (e.g., the old K – Interim Compliance Self-Assessment – is now the new N). **Attachments G-K below are new additions:** G. Free Standing Urgent Care Clinic Facility Site Review Tool H. Urgent Care Medical Record Tool I. PCP Providing Urgent Care Facility Site Review Tool J. Palliative Care Facility Site Review Tool K. Palliative Care Medical Record Review Tool M. Supplemental Tool *(previously Attachment I)* **Section VI Policy /Procedure is entirely reformatted for ease of reading**. Therein, these additions or changes have been made: • "Supplemental Sites" added as language to be more inclusive in required site reviews. (p.1)	**Motion to approve as amended:** Kristine Gual Second: Isaac Brown Next Steps: Jan. 21 Q/UAC ~~Feb. 11 PAC~~ *Meeting Postscript:* After Q/UAC met, Rachel agreed with Staff that more work needs to be done aligning the attachments, so this policy will come back to February IQI and Q/UAC before going to March 11 PAC. Rachel also agreed to reformat Section VI according to the usual outline, so the policy will be presented both in redline and clean copies.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Sites with a failed review will be placed on an annual review. • "Any site review concerns that reveal significant quality of care issues will be forwarded to the Chief Medical Officer or the Quality Medical Director for Quality for further guidance." (p. 3) • Partnership expanding to a new service area. Language is removed and now points to APL 20-017 for guidance. • Facility Site Review (FSR) Scoring language on Critical Elements (CEs) is updated (p. 4) • Medical Record Review (MRR) Scoring language is updated (p. 5): "If the minimum number of records is not available, Partnership will document the rationale and complete the MRR with the available records." • Partnership's Certified Master Trainer (CMT) will recertify CSRs every three years. Upon certification and recertification, Site Reviewers will receive written verification of certification from Partnership. (p. 8) • Obstetric Specialists and Non-Accredited Sites have been bundled and FSR and MRR language augmented under section "Specialized Site Reviews" (pp. 9-10) These are followed by additional MMR language pertaining to Free Standing Urgent Care Clinics (p. 10), and "PCP providing Urgent Care Services" (p. 10) "A Palliative Care report is run monthly by the Inspections Site Review Team." (p. 10) Removed section under Non-Accredited site reviews. These reviews do not fit within the Site Review scope. Sites removed include Hospitals, Skilled Nursing Facilities, Ambulatory Behavioral Health Facilities, Free Standing Surgical Centers. Originally was going to place a "rural section" but felt it was more accurate to completely remove. These sites will require accreditation. Rachel went through the synopsis, saying she rearranged Section VI, Policy/Procedure for better flow. Anna Campbell asked if MPCR17 and MPCR700 should not be added as Related Policies. Rachel had no objections, but no such amendment was made. In answer to a question from Dr. Townsend, **Rachel agreed to amend the Non-Accredited Site Review examples in the policy itself to include free-standing birthing centers, and to likewise amend p. 1 of Attachment F. "Free-standing urgent care center" is defined in the policy and will be added to policy section Specialized Reviews.**	
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*		
MCUP3034 – PCP-to-PCP Transfers & Assignment of New members to PCP	During the annual review of this policy at the department level, there was discussion regarding continuity of services for pregnant Members. Dr. Moore recommended seeking comments at IQI for language at VI.A.3. **Section III. B. and C.** Definitions of Medical Home and Whole Child Model were updated to match recent updates made by Member Services for "Medical Home" and Care Coordination for "Whole Child Model." **Section IV.** Appendix A was removed and the language was brought into the body of the policy at VI.A.3. instead. **Section V.** The Purpose section was updated to specify "Primary Care Provider" transfers **Section VI.A.3.** Guidelines for Determining Medical Stability Prior to PCP Transfer that were previously shared in Appendix A were brought into the body of the policy at this section. When doing so, it was noticed that we had a discrepancy in our recommendations for pregnant Members with one recommendation being 28 weeks and the other being 32 weeks as the threshold for when a pregnant Member is considered "unstable" for PCP transfer. The policy was updated to reflect that a Member would be considered unstable for PCP transfer from the 33rd week of pregnancy until 8 weeks postpartum.	**Motion to approve as amended:** Kristine Gual Second: Isaac Brown Next Steps: Jan. 21 Q/UAC Feb. 11 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.A.5. Redundant language was deleted here regarding pregnant Members because the language is now included at VI.A.3. **Section VI.B.4.** Clarified that new Members who are at least 28 weeks pregnant when they become a Partnership Member may be granted Direct Member status for continuity of care "upon their request." Associate Medical Director Marshall Kubota, MD was curious from where the time frames mentioned in VI.A.3 derive: he had thought 36 weeks was the threshold for PCP to OB transfer. Dr. Moore noted there was no citation made for this timeframe. Ensuing discussion between Anna and doctors Moore, Netherda and Kubota also covered some exceptions that may occur wherein a Medical Director could make an exception that Member Services could not. **VI.A.3.b. is amended to read "Pregnant Members from the 33rd week of pregnancy until 8 weeks postpartum."**	
MCUP3044 – Urgent Care Services	This policy was updated to reflect current access to urgent care services for Partnership Members. Attachment A – Application to be a Contracted Urgent Care Services Provider – is new and may yet be revised. **Section I.C. – K.** Several policies were added as Related Policies for this topic: C. MPUP3006 Appropriate Service and Coverage Policy D. MCUP3113 Telehealth Services E. MCCP2018 Advice Nurse Program F. MCQP1022 Site Review Requirements and Guidelines G. MPQP1016 Potential Quality Issue Investigation and Resolution H. MPCR700 Assessment of Organizational Providers I. MPCR17 Standards for Contracted Primary Care Providers and Urgent Care Physicians J. MPCR301 Non-Physician Clinician Credentialing and Recredentialing Requirements. K. MPNET100 Access Standards and Monitoring **Section II.** Provider Contracting and Network Services were both specified as Impacted Departments **Section III.** The Definition of Direct Member was updated and four new Definitions were added for "Free-Standing Urgent Care Center," "Partnership Urgent Care Tiers," "Primary Care Providers," and "Urgent Care Services." **Section V.** The Purpose section was updated to reflect that this policy describes "access to" urgent care services for Partnership Members and is not specific only to facility standards. **Section VI.A.** This first section in the body of the policy specifies that there is no prior authorization required for urgent care visits for Partnership Members. **Section VI.B.** This section outlines the two primary ways Members can access urgent care services: Through Primary Care Offices or through Free-Standing Urgent Care Centers. **Section VI.C.** This section was added to specify that Partnership conducts site review for all Urgent Care Services. **Section VI.D.** This section was added to describe Members' Roles and Responsibilities in Accessing Urgent Care Services. **Section VI.E.** This section was added to describe Provider Responsibilities when offering Urgent Care Services. **Section VI.F.** The existing language in this section was updated to clarify standards for free-standing urgent care centers. **Section VI.F.** At the end of this section, the previous language describing "Claims Issues" was deleted.	**Motion to approve as amended:** Robert Bides, RN Second: Brigid Gast, RN Next Steps: Jan. 21 Q/UAC Feb. 11 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.G. This new section was added to describe Oversight and Monitoring of urgent care services to monitor for any patterns of over-utilization. **Section VII.B. and C.** Two new References were added as follows: B. California Code of Regulations (CCR) Title 28 §1300.67.2.2 (c) (5) C. DHCS Contract Exhibit A, Attachment III 5.2.5 Network Adequacy Standards Tony commented that this policy outline both member and provider roles and responsibilities while emphasizing member access. Dr. Moore thanked everyone ho worked on this update. Anna noted that the policy does not yet instruct anyone how or when to use the new Attachment A application to become a UC provider. Dr. Moore commented that the criteria for approval is more a credentialing process and perhaps should be noted in relevant Network Services policies, such as MPCR700 when it next comes to IQI (possibly Feb. 10). Rachel Newman, RN, wondered if one section's Medical Record Review (MRR) mention was sufficient, and it was agreed it was. Brigid Gast, RN, wondered if Definition D on PCPs shouldn't reference "walk-in appointment" rather than "work-in appointments": Dr. Moore said "work-in" is the broader term and is correct. Dr. Netherda concurred. **It was suggested that provider Tax ID and NPI fields be added to the new Attachment A so claims may be looked at if need be, and IQI agreed with this amendment.**	
MPUP3014 – Emergency Services	This policy was updated to reflect current access to urgent care services for Partnership Members. **Section III.F.** A new Definition was added for Urgent Care Services and the previous definition of Urgent Conditions was deleted. **Section IV.** The Addenda listed in the Attachments section were deleted. **Section VI.A.** "Payment for Services" language was deleted from this section. **Section VI.G.** This section regarding Emergency Department Contracts was deleted. **ADDENDA A – C:** Deleted three Addenda that listed Non-Urgent Medical Conditions, Urgent Medical Conditions, and Emergency Medical Conditions. Dr. Moore asked if anyone was concerned with the removal of the addenda as noted above. No one expressed a concern.	**Motion to approve as presented:** Kristine Gual Second: Aaron Brincko Next Steps: Jan. 21 Q/UAC Feb. 11 PAC
V. Presentations		
QI Update – *Isaac Brown, MPH/MBA, Senior Director, Quality Improvement and Performance*		
• New federal requirements stipulate that we have a signed contract from every Provider that participates in any Quality Incentive Program (QIP): that is, if one provider participates in three QIPs, three separate contracts must be executed. We are fortunate that we had a 98% return rate by the Dec. 31, 2025 deadline. (Only nine of 582 contracts were not returned on time.) We are shifting both the Hospital and the Perinatal QIPs from fiscal year to calendar year cycles to accommodate the extra workload and developing six-month "bridge" program proposed measure sets for July-December 2026. These proposals will be presented in spring meetings. • The Preventive Care Dashboard went live Jan. 12 and will be refreshed weekly. • 2026 Improvement Academy trainings are posted on our website. The Spring Cohort Training Series will run Feb. 24 through May 5. Eighty participants have registered, and a waiting list now exists.	1.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• DHCS calculates that Partnership has earned back $10,637,870or $14,300,221 of Plan revenue withheld in 2024 based on Measurement Year 2024 Healthcare Effectiveness Data Information Set (HEDIS®) performance. Regional Medical Director Colleen Townsend, MD, added that the Women's Health and Perinatal Workgroup continues to integrate hrHPV self-collection across the network and provider one-on-one provider education. In 2025, 30 parent organizations with 111 total sites completed training. Dr. Townsend commented that widespread use of cervical cancer screening kits is largely aspirational at present but has great potential to improve health outcomes.	
QI Initiative: Datalink Pilot – *Kristine Gual, PMO, CPHQ, Director of Quality Measurement*		
	Kristine led off with a brief summation of the drivers affecting high performance in quality measures but then concentrated on the data completeness components, for if our network is completing services but Partnership does not receive the data, we cannot improve our Healthcare Effectiveness Data Information Set (HEDIS®) rates. We are always looking for new data sources, and Datalink is one to allow us to more completely understand our clinical data. This dovetails with NCQA's mandate that, by 2029, all measures will be converted from hybrid – where we take a random sample of charts to have our nurse review them – to a new electronic clinical data systems (ECDS) methodology. We must use the entire eligible population for rate generation. We will no longer be able to do manual overreads of a random sample of charts for measure rate generation. This change will affect many of our withhold measures, such as controlling blood pressure and the glycemic status assessment for patients with diabetes. Prenatal/postpartum visits and vaccination measures for children will also be transitioning. We must be ready for anything depending on point-of-care tests such as controlling blood pressure and performing vitals. This will not easily fit into a coding solution. We know that some of our providers are doing CPT coding but this is not feasible for those who haven't supporting technology. We need something like Datalink to maintain and improve rates. The other big development is that DHCS has added several new ECDS measures to the Managed Care Accountability Sets (MCAS) measure set starting in 2026, including four depression screening measures. There is prenatal/postpartum depression screening. The largest one is DSF-E - Depression Screening and Follow-Up for Adolescents and Adults. The size of the eligible population is almost 400,000 members, really every adult member in our network. This will be sanctionable. Since member impact is a factor, the sanctions could be sizeable. There is no way to code for this. You can't code that a depression screen was warranted and that it merited a follow-up visit. We need clinical data to receive this information and generate our rates. Datalink is an NCQA Validated Data Aggregator. There is no charge for implementing Datalink to our network practices (Partnership is bearing all the costs), "contract" really means "data sharing agreement." Datalink works with a contracted practice directly and will extract chart data from the practice's electronic medical record (EMR) in a structured format. It then uploads the date and hands it off to Partnership. And now that we have this data, we cannot just treat it for HEDIS® generation; it's an organizational asset that belongs to the entire network. It can impact things like our Population Health interventions, the patient experience, and utilization management. This could be a time and resource savings for the entire network. We are about halfway into our second year of our pilot. We began in the summer of 2024 (after abandoning another, resource intensive, pilot dependent on being manually sent files). When we began, we worked with a few practices on depression screens because we knew they were going to be added to the measure set. We also wanted to know what additional measures would be impacted by extracting these charts. For this first cycle of the pilot, we contracted with just six parent-level practices of the more than 100 in our network. We were able to get significant numerator hits for the depression screen measures, so we have our proof of concept. We got more than 9,000 hits for depression screening in all adults. We also got results for the follow-up for positive screen, as well as the prenatal and postpartum screen. With just six practices, we were able to exceed the benchmark for both areas of the depression screen for all ages. For three of the four measures, Datalink was the sole source of data for MY2024. That was an exciting success. In addition, we saw a positive impact on several other measures important to us, several MCAS measures, particularly controlling blood pressure, from a fiscal standpoint probably one of our highest priority measures: it is a withhold measure, is heavily weighted in our health plan accreditation; it's important for the coming Medicare	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

product. From just six practices, we got almost 1,500 numerator hits. For every hit that's potentially a chart our nurses don't have to overread. It also sets us up well for when this measure becomes an ECDS measure. We also saw positive, if smaller, impacts on other measures, including cervical cancer screening (CCS) and glycemic status measurement for patients with diabetes.

We had a good first year on this pilot. Now, we are about halfway into Year 2 of the pilot. We will end with the fiscal year (June 30, 2026) when the HEDIS® rates are complete. We knew in year two that we wanted to expand the pilot, have more practices involved and additional EMRs. We were particularly interested in OCHIN Epic because we know that many of our practices are moving there. In the first round for those six practices, we requested every single member that was assigned to that practice, and what we realized is that, for the HEDIS® effort, some charts are valuable than others. There are many members who aren't part of a measure-eligible population. So, in the second pilot year 2025-2026, we decided to focus on CCS and chlamydia because that also included women who are of child-bearing age, and we would also get the prenatal postpartum measure, our prenatal/postpartum depression screening. We wanted to see if there was an impact on our childhood vaccination measure. We also included our chronic conditions measures: controlling blood pressure and our diabetes A1c measure. We also finally included our Dual-eligible Special Needs Program populations in the counties launching in D-SNP in 2027 to see if there is an impact on those measures as well.

Kristine went briefly through a slide showing the five steps each practice will go through with Datalink: contracting, data extraction and handoff, Partnership data ingestion, analysis and validation at the practice-level, and application to Partnership programs. Right now, we have 46 practices engaged with Datalink. About 17 are now in the data ingestion step where the iterative mapping occurs. We are in the analysis and validation process with six practices who use eClinicalWorks as their EMR.

Kristine showed a slide with the December 2025 rates for the five-county Chico region. Datalink was able to extract about 20,000 charts from eClinicalWorks EMR, getting a total of nearly 7,500 numerator hits for seven high-priority MCAS/withhold measures. "That's a very healthy ratio," she said. For the Chico region we are over the 50th percentile benchmark for all four depression screening measures. Kristine pointed out other rates in other measures, crediting Datalink numerator hits for pushing the benchmark results. She added that when we go to validation on CCS ECDS, those numbers might improve too. Across the board, however, there was a smaller impact on our childhood vaccination measures as we get most of that data from the California Immunization Registry (CAIR).

Goals for the remainder of pilot year 2 (June 30, 2026) include contracting perinatal QIP practices with Datalink. Kristine noted that Troy Foster is actively working with those who have not yet contracted. Per our HEDIS® auditor, the data needs to be extracted by Feb. 27, 2026 to be able to be included in our 2025 measure calculations. Ahead of that, we need to be able to wrap up our iterative mapping by Jan. 31. We will be reaching out to practice that we are already working with to validate specific data by June 30.

Practices may reach out to the QIP@partnershiphp.org inbox to start the Datalink contracting process. Those in the Perinatal QIP must contract by June 30.

Time ran out before three other scheduled topics could be presented. These will be included in Q/UAC's Jan. 21 agenda packet as follows:

1. QI Program Manager Troy Foster will present the 2024-2025 Hospital Quality Incentive Program Evaluation.
2. Tony Hightower's data analysis on 1st and 2nd Qtr 2025 Referral Follow-ups will be on the Consent Calendar.
3. Dr. Moore's 2025 Clinician Group Consumer Assessment of Healthcare Providers & Systems (CG-CAHPS) Survey of Large PCPs' Access and Communication Performance Summary will be included as FYI.

VI. Adjournment

Dr. Moore adjourned the meeting at 3:29 p.m. IQI will meet next Tuesday, Feb. 10, 2026.

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

Approval Signature: *Date:*

Robert Moore, MD, MHA, MBA

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Chief Medical Officer and Committee Chair		

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

QUALITY INCENTIVE PROGRAMS (QIPS)

PROGRAM	UPDATE
PRIMARY CARE PROVIDER QUALITY INCENTIVE PROGRAM (PCP QIP)	• Contract amendments have been distributed and executed for 2026 • 2026 PCP QIP specifications have been posted to the public facing webpage. These specifications are abridged. Detailed specifications will be available in eReports upon launch in March. Please send the PCP QIP team an email if you wish to receive the detailed specifications by secure email. • January is Grace Period. eReports is down for the application of Relative Improvement and Continuous Enrollment, but will come back up on Monday, January 12, 2026. • January 30, 2026 at 5 pm is the last day to upload any measure data for dates of service in 2025. At 5 pm on the 30th eReports data will be frozen and final for 2025. • Small denominator exclusion and Unit of Service measure submissions are due by January 30, 2026. For the complete list of dates and submission templates, please review the 2025 detailed specifications available on eReports.
PALLIATIVE CARE QUALITY INCENTIVE PROGRAM (PALLIATIVE CARE QIP)	• 2026 specifications have been published on the public facing webpage • Contract amendments have been distributed and executed for 2026
PERINATAL QUALITY INCENTIVE PROGRAM (PQIP)	• Contract amendments have been distributed and executed for FY2025/2026 • This program will transition to a calendar year program in 2027. • A 6-month bridge program is in development for July - December 2026
ENHANCED CARE MANAGEMENT QUALITY INCENTIVE PROGRAM (ECM QIP)	• Contract amendments have been distributed and executed for 2026 • 2026 specifications have been published on the public facing webpage • Q4 2025 payment will be distributed by end of January
HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)	• Contract amendments have been distributed and executed for FY2025/2026 • This program will transition to a calendar year program in 2027. • A 6-month bridge program is in development for July - December 2026
EXTENDED CARE CENTER QUALITY INCENTIVE PROGRAM (EXT QIP, FORMERLY LTC QIP)	• Contract amendments have been distributed and executed for 2026 • 2026 specifications have been published on the public facing webpage

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	• 2025 PQD will remain available with frozen data as of 12/31/2025 through May 2026 • 2026 PQD will launch between May-July 2026 • 2026 Preventive Care Dashboard will go-live, Monday January 12th and will be refreshed weekly
EREPORTS	• 2026 eReports is in development with launch early March 2026

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE

STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	• The **2025 Clinical PIP**: Focused on improving W30-6 rates among the Black/African American population in Solano County. Accepted by HSAG with scores of 100% in all sections.
	• The **2025 Non-Clinical PIP**: DHCS has approved the resubmission of the QI plan for the 2026–2027 non-clinical PIP.
	  o A new collaboration with CommuniCare+Ole has been started to enhance FUM rate, with the first meeting scheduled for January 8, 2026
	• **State Mandated P-D-S-As**
	  o Final submissions for 2025 activities were submitted in October.
	  o Awaiting DHCS instructions regarding 2026 mandated areas of focus.

QUALITY MEASURE SCORE IMPROVEMENT	• **Pediatrics:**
	  o WCV, CIS, and IMA: The workgroup has completed the data analysis phase and is moving on to site interviews to identify best practices and common challenges. The workgroup will use this information to develop targeted activities in early 2026.
	  o DEV: Working with Data Analytics to enhance the functionality and reporting of the Developmental Screening dashboard in Tableau. Continuing work on developing and implementing one-on-one education for low performing providers.
	  o TFL: Continuing with data investigation and feedback to DHCS. Still not receiving good data back from the state.
	  o LSC: Continuing focus on provider education and POC grants. 5 machines delivered in 2025 and additional 6 approved. More applications currently under review.
	  o W30+6: Fairchild agreed to continue the newborn pilot project at least through the end of Feb 2026. This project is a replica of the project previously completed with North Bay Health to test for scalability and spreadability.
	  o W30+2: Continuing to promote the Growing Together Program. Evaluating effectiveness of the additional $25 gift card for 2 visits between 15-30 months.
	• **Women's Health & Perinatal:**
	  o The Women's Health and Perinatal workgroup continues to integrate hrHPV self-collection across the network and provide one-on-one provider education. In 2025, 30 parent orgs with 111 total sites have completed trainings. Training and health education materials are being reviewed and updated to reflect current screening options.

	○ New Improvement Academy 2026 Improving Measure Outcome series webinars are scheduled for April 2026, including "Improving Perinatal Outcomes" and "Sexual and Reproductive Health". • **Chronic Disease:** ○ The workgroup, together with Dr. Matthews, are in talks with the Communications team and are proposing to create a resource corner around colorectal cancer screening modalities. This would be member and provider facing. • **Behavioral Health:** ○ Depression Screening for Adolescents and Adults (DSF-E) is a new accountable MCAS measure for MY 2026. ○ BH Workgroup selected the DSF-E as a focus measure in addition to FUA and FUM for 2026 & 2027. This measure relies heavily on data captured through DataLink so Partnership is encouraging practices to explore the Unit of Service measure to get connected. • **Elder Care:** ○ Wakely has been chosen as the Software vendor for our DSNP HEDIS reporting and predictive analytics for Medicare Stars reporting. ○ Proposed changes to the 2026 DSNP Measure set were released in November. Notably, the Statin Control Measure was removed.
IMPROVEMENT ACADEMY	**QI Project Training Program** The training schedule for the first cohort program launching in Spring 2026 has been finalized. • Pilot cohort training series concluded on 11/19/25 and a final evaluation of the pilot is in progress, which will be completed by 12/31/25, • Spring Cohort Training Series will run from 02/24/26-05/05/26. • Registration Flyer was sent to PCP QIP List and County and Community Partners on 12/8/25 with an enrollment due date of 02/17/25. External newsletters and regional meetings will remain active marketing channels as well. 2026 Improvement Academy trainings are posted on Partnership's website. Offerings include: • The **ABCs of Quality Improvement** training. Designed to teach the basic principles of quality improvement using the Model for Improvement. In-person trainings offered in February, March, and May. • The **Improving Measure Outcomes** Webinar Series. Designed to help providers improve on specific measures by offering strategies to close care gaps and sharing of best practices. Virtual trainings offered February through April.
JOINT LEADERSHIP INITIATIVE (JLI)	• The 2026 Joint leadership Initiative meetings are currently being scheduled.
REGIONAL IMPROVEMENT MEETINGS	• **Santa Rosa Region** – The fourth quarter Regional Quality Improvement meetings focused on the topic of vaccine hesitancy and best practices for improving vaccine measures with a Voices of the Field presentation showcasing one health center's promising practice for vaccine inventory management and workflows. The meeting had 15 attendees from 5 organizations.

	• **Fairfield Region** – The fourth quarter Regional Quality Improvement meeting focused on topics included Perinatal Early Access to Care and best practices for improving Chlamydia screening rates with Voices of the field showcasing workflows for improved screening. The meeting had 32 attendees from 9 organizations. • **Chico Region** – Scheduled 01/14/2026 • **Auburn Region** – Scheduled 01/14/2026 • **Redding Region** – The fourth quarter Regional Quality Improvement meeting was held on 12/09/2025 and had 29 attendees from 14 organizations. Topics included: a blood pressure project from Mountain Valleys, review of 2025 data, preparing for 2026, important measure updates on new DHCS measures 2026, and prenatal care best practices. • **Eureka Region** – The fourth quarter Regional Quality Improvement meeting was held on 12/04/2025 and had 35 attendees from 21 organizations. Topics included: a blood pressure project from Mountain Valleys, review of 2025 data, preparing for 2026, important measure updates on new DHCS measures 2026, and prenatal care best practices.

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
CAHPS SURVEY PROGRAM - MEDI-CAL PRODUCT LINE AND FY 25/26 ORG GOALS	**CAHPS® Regulated Measurement Year (MY) 2025 / Report Year (RY) 2026 Survey** • The CAHPS® regulated survey for Measure Year (MY) 2025 / Report Year (RY) 2026 will start in February and conclude in May 2026. • Partnership will formally submit the Child population for the National Committee for Quality Assurance (NCQA) Health Plan Rating in MY 2025 / RY 2026. **Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)** • Fiscal Quarter 2 (On-Track): Goal activities continue, led by champions from four departments: Transportation, Member Services, Population Health, and Quality Improvement. o Milestone updates will be posted internally on the OpEx|PMO goal dashboard the week of January 5.
EQUITY & PRACTICE TRANSFORMATION PROJECT	**PDPP Participation and Deliverables** • We currently have 23 provider organizations enrolled in the EPT Program. • To continue participating in the EPT program, provider organizations must complete the following by May 2026: o 2026 PhmCAT and successfully submit the following deliverables: ▪ Data Policy & Procedure ▪ Empanelment Policy & Procedure ▪ Data Implementation Plan ▪ Disparity Reduction Plan ▪ One Model of Care deliverable

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- DHCS is expected to issue payments to MCPs for May 2025 deliverables in December 2025, with the goal of MCPs distributing payments to providers by January 2026.

EPT MCP Reporting Requirements

In accordance with the APL 25-015 published on 10/02/2025, DHCS is asking Managed Care Plans (MCPs) to produce quarterly rolling quality measure rates using the California Technical Specifications (CaTS) so that performance can be tracked for all EPT deliverables that include HEDIS-like measures. .

- The first CaTS report was submitted to PHLC on 10/31/2025 for MY 2024.
- The next report for MY 04/01/24 - 03/31/2025 is due on 01/31/2026.
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<tr><td>Preventive Care Bridge Project (Formerly: Locum Pilot Initiative)</td><td>

- All participating providers have completed the 12-week intervention and submitted their close-out questionnaires. Distribution of final installment payments has begun. The comprehensive project evaluation, featuring results and recommendations for next steps, is in its final drafting stage, and a companion resource to support providers is currently in development.
</td></tr>
<tr><td>Mobile Mammography Program</td><td>

- Current Event Days for FY 25/26 Q2 (October – December)

<table>
<tr><th colspan="4">Current Event Days
10/01/2025 – 12/30/2025</th></tr>
<tr><th>Region</th><th># of Provider Organizations</th><th># of Provider Sites</th><th># of Event Days</th></tr>
<tr><td>Auburn</td><td>1</td><td>1</td><td>1</td></tr>
<tr><td>Chico</td><td>1</td><td>3</td><td>4</td></tr>
<tr><td>Eureka</td><td>6</td><td>6</td><td>6</td></tr>
<tr><td>Fairfield</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>Redding</td><td>6</td><td>6</td><td>6</td></tr>
<tr><td>Santa Rosa</td><td>2</td><td>2</td><td>2</td></tr>
<tr><td>Plan Wide</td><td>16</td><td>20</td><td>21</td></tr>
</table>
</td></tr>
<tr><td>Partnering for Pediatric Lead Prevention Program</td><td>

- 5 devices were distributed to 4 provider practices in 2025 through the Partnering for Pediatric Lead Prevention program.
</td></tr>
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QI TRILOGY PROGRAM	• Mid-year status initial notices for the 2025-2026 QI Work Plan were sent to Business Owners on 12/09/2025. Submissions are due 01/14/2026. • Initial notices for the 2026-2027 QI Program Description will be emailed to Business Owners on 02/10/2026. Submissions are due 03/03/2026. • QI Trilogy trainings, both live and virtual, are currently in progress to be updated for 2026.
SAGE GRANT	• 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.

D-SNP

ACTIVITY	UPDATE
D-SNP	• In December, baseline measurement analysis was completed in collaboration with Pharmacy and Health Analytics for four Medicare Stars Part D measures. The data provides an estimate of member performance in these measures and potential intervention areas of focus for members and providers. • An analysis of existing California D-SNP plans with available Star ratings in MY2024/SY2026 was reviewed to understand challenges in Star performance among similar county-based dual special needs plans.

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	UPDATE
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD:10/24/25-12/30/25	• 60 PQI referrals were received with 47 coming from Grievance and Appeals, 5 from Utilization Management, 3 from Care Coordination, 3 from a Regional Medical Director, 1 from an Associate Medical Director and 1 from an outside source (other). • 40 PQI cases were processed and closed. • 103 cases are currently open. • One case was discussed at the Peer Review Committee on 12/17/2025 and there are three awaiting PRC. • 6 cases were sent to a Subject Matter Expert for review.

FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR THE PERIOD: 10/19-12/31/2025

Region
Reporting period – Oct 19 – Dec 31, 2025

Primary and OB Reviews:

Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued
Auburn	6	3	2	2
Chico	9	8	0	6
Eureka	10	10	3	6
Fairfield	9	8	2	7
Redding	4	5	0	3
Santa Rosa	6	5	2	3

New sites opened this period

- Auburn – 5 Rivers Health, Sierra Care Physicians,
- Santa Rosa – Marin Health Medical Network, Santa Rosa Community Health-Parkway Campus

Total County of PCP/OB and 2nd check-ins

- As of 12/31/2025, we have a total of 532 reviews including PCP, OB, Multiple check-in's and delegated reviews

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	
Annual HEDIS® Projects	
HEDIS® Program Overall	• Partnership received a final report from DHCS on earnbacks from MY2024 Quality Withholds in December 2025. In 2024, DHCS withheld 0.5% of Partnership's revenue for the 14 legacy counties, to be earned back using two (2) methodologies: 1) High performance on ten (10) prioritized HEDIS measures in MY2024; and 2) Significant improvement on reducing disparities for low-performing racial communities for the Child and Adolescent Well-Care Visits (WCV) measure in MY2024. • DHCS calculates that Partnership earned back $10,637,870 of $14,300,221 of Plan revenue withheld in 2024, based on MY2024 HEDIS performance in the two areas described above. Details about the MY2024 Quality Withhold earnback are in the table below.

Category	Quality Withhold from Plan Revenue (0.5%)	Quality Withhold Earnback	Quality Withhold Earnback %	Balance
North Bay Withhold	$ (8,574,063)	$ 7,171,346	83.64%	$ (1,402,717)
Rural Upper North Withhold	$ (5,726,158)	$ 2,134,139	37.27%	$ (3,592,019)
WCV Incentive Earned (Reducing disparities)	n/a	$ 1,332,385	n/a	$ 1,332,385
Total	**$ (14,300,221)**	**$ 10,637,870**	**74.4%**	**$ (3,662,351)**

	• Partnership also received DHCS's Final Notice of Sanctions for MY2024 HEDIS performance on November 24, 2025. Based on information shared with DHCS by Partnership during a Meet and Confer meeting on November 4, 2025, DHCS reduced Partnership's sanction for the Topical Fluoride for Children measure by 50%. Requested reductions in sanctions for other measures, including Follow-Up After ED Visit for Mental Illness—30 days, Follow-Up After ED Visit for Substance Use—30 days, and Developmental Screening in the First Three Years of Life, were denied. The total MY2024 sanction was reduced from $260,000 to $199,000. • On December 17, 2025, Partnership communicated via counsel to DHCS that the Plan will appeal the MY2024 sanctions for the four (4) measures listed above.

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	Santa Rosa
NCQA Health Plan Accreditation	• The HPA Mock Renewal Survey was held 10/27-10/30/2025 with our NCQA Consultant, Managed Healthcare Resources (MHR). Our consultant prepared a gap assessment report, which identified opportunities for improvement. Documents with MHR's comments, including required edits and recommended annotations, are also available for review. o Based on the assessment from MHR and scoring adjustments in alignment with the target timeline of the outstanding requirements, the estimated status is Provisional at this time. Partnership obtained 80% of applicable points in the standards category of QI, PHM, NET, CR, and ME. The UM category is below the 80% threshold, which is due to new requirements under the 2026 HPA Standards and Guidelines, and evidence not yet being developed for requirements with a shorter look-back period. The NCQA Program Management created an NCQA HPA compliance dashboard, that will be updated monthly to capture the most up-to-date compliance status based on revised/new evidence or any required edits because of NCQA FAQs and Triannual Policy Updates. All Business Owners should inform the NCQA Program Management Team if any modifications are made to previously approved evidence that affects the NCQA requirements, prior to the effective/production date. o On 11/24/2025, the NCQA Program Management Team distributed Action Plans (APs) to Business Owners, as applicable, to address improvement recommendations. Business Owners were asked to outline the actions or activities that will take place to address the findings, which should correspond to the applicable look-back period, timelines, and/or expectations by NCQA. All Business Owners submitted their AP by the due date, 12/10/2025. Activities to address the gaps identified during the mock survey are in progress; a subset requires additional discussion tied to business ownership, processes, data sources and timeline. The submission of the completed AP completed Milestone 4 of the FY 25-26 HPA Key Activities. • NCQA released updates to the 2026 HPA Standards and Guidelines on 11/17/2025. Updates include modifications of the existing requirements and an error identified from the existing standards. Additional edits to existing documentation may be required due to

	the policy updates. The November 2025 updates have been shared with applicable Business Owners for review and assessment. The updated 2026 HPA Standards and Guidelines and a summary table of all changes are available in the Y:Drive. • NCQA invited public comments on its new proposed Artificial Intelligence (AI) Standards for the 2027 Health Plan Accreditation. The AI standards will address critical domains including AI program structure, governance, pre-deployment evaluation, and ongoing monitoring and intervention. The NCQA Program Management Team solicited input from Partnership key stakeholders and submitted a summary of responses to NCQA on 12/4/2025. These updates will ultimately impact the scope of review for Partnership's HPA Renewal Survey in 2029, with a 24-month look-back period starting in 2027.
NCQA Health Outcome Accreditation	• Effective January 15, 2026, Health Equity Accreditation will be renamed Health Outcomes Accreditation. Effective January 15, 2026, NCQA's Report Card will list Partnership as Accredited in Health Outcomes. Updated seals will be available on the NCQA website. Partnership may continue to use the Health Equity Accreditation seal through our next renewal, which is scheduled for May 2028. • NCQA released the 2026 Health Outcomes Accreditation (HOA) Standards and Guidelines on December 12, 2025, which included expanded content and enhancements that will help organizations sustain long-term strategies for improving outcomes based on member, patient, and community needs. The NCQA Program Management Team is preparing a summary of changes and gap analysis to share with Business Owners in January 2026. The NCQA Program Management Team will facilitate any discussion needed with the impacted Business Owners based on the new and/or updated requirements.

Partnership Policy & Procedure Updates

February 2026

Policy Number	Policy/Procedures/Guidelines	Version Links
*The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in **January 2025.*** ***All policy versions hyperlinked for review.* *Highlighted policies have significant changes, new attachments, or were amended during the Q/UAC meeting. Redline versions contain attachments.* *Please review all drafts and the detailed **Synopsis of Changes**.*		
Behavioral Health		
MPBP8003	Mental Health Services	C CD RD
Care Coordination		
MCCP2025	Pediatric Quality Committee Policy	C CD RD
MCCP2035	Local Health Department (LHD) Coordination	C CD RD
MPCP2006	Coordination of Services for Members with Special Health Needs (MSHCNs) and Persons with Developmental Disabilities	C CD RD
MCCP2031	Private Duty Nursing under EPSDT	C CD RD
MPCP2018	Advice Nurse Program	C CD RD
Enhanced Health Services		
MCAP7001	CalAIM Service Authorization Process for Enhanced Care Management (ECM) and/or Community Supports (CS)	C CD RD
MPAP7003	CalAIM Community Supports (CS)	C CD RD
Health Equity		
MCEP6002	Quality Improvement and Health Equity Committee (QIHEC)	C CD RD
Member Services		
MP300	Member Notification of Provider Termination or Change in Location	C CD RD
Pharmacy Operations		
MCRP4068	Medical Benefit Medication TAR Policy	C CD RD
MPRP4001	Pharmacy & Therapeutics (P&T) Committee	C CD RD

Quality Improvement				
MPQP1018	Preventive Health Guidelines	C	CD	RD
MPQP1053	Peer Review Committee	C	CD	RD
Utilization Management				
MCUG3022	Incontinence Guidelines	C	CD	RD
MCUP3034	PCP-to-PCP Transfers & Assignments of New Members to PCP	C	CD	RD
MCUP3041-A	TAR Requirements List	C	CD	RD
MCUP3052	Medical Nutrition Services *(changes to attachments)*	C	CD	RD
MCUP3104	Transplant Authorization Review	C	CD	RD
MCUP3113	Telehealth Services	C	CD	RD
MPUP3006	Appropriate Service & Coverage (Over/Under Utilization)	C	CD	RD
MCUP3044	Urgent Care Services *(New attachment A)*	C	CD	RD
MPUP3014	Emergency Services	C	CD	RD
MPUP3129	Podiatry Services	C	CD	RD

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Jan. 21, 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: Care Coordination – *Presenter: Aryana Cunningham, Policy Analyst, Care Coordination*			
MCCP2031 Private Duty Nursing under EPSDT	281 – 286	**Policy edits due to Annual Review** **Related Policies updated:** MCUG3011 renamed to MPUG3011 **Definition updated:** Whole Child Model (WCM): A comprehensive program 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 pediatric Member with CCS eligible conditions insured by Partnership. **VI.E.7. removed:** Partnership reserves the right to limit hours as follows: a. Limit approved skilled nursing care provided by a Home Health Agency (HHA) to a maximum of 22 hours/day, and/or b. Limit approved skill nursing care provided by an Individual Nurse Provider (INP) to a maximum of 11 hours/day per INP **VI.E.7 added:** In keeping with this requirement, Partnership reserves the right to limit hours based on medical necessity and provider evaluation, inclusive but not limited to skilled nursing care provided by a Home Health Agency (HHA) and/or an Individual Nurse Provider (INP). **References added:** National Committee for Quality Assurance (NCQA) Health Plan Standards 2025. Quality Management and Improvement 3 Continuity and Coordination of Care	Health Services Provider Relations Member Services Claims
MPCP2018 Advice Nurse Program *(previously MCCP2018)*	287 – 290	**Policy edits due to APL 25-006 Timely Access Requirements** **Related Policies added:** MCND9001 – Population Health Management Strategy and Program MCND9002 – Cultural and Linguistic Program Description **Definition added:** Partnership Advantage (PA) **VI.A. added** Partnership Advantage Enrollees **VI.H.5 added:** DHCS verifies the wait times for the Advice Nurse Services line through the Timely Access Survey. DHCS provides the results to Partnership quarterly and compiles the quarterly	Health Services Member Services Claims

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)
		results into an annual result provided to Partnership by the second quarter of the subsequent measurement year. a. 24/7 Nurse Triage Line: All inquiries must receive a response within 30 minutes. A minimum performance threshold of 90% compliance is required. **References added:** CalAIM Dual Eligible Special Needs Plans Policy Guide – Contract Year 2026 (September 2025) DHCS APL 25-006 Timely Access Requirements (*Revised* 11/18/2025)	
Policy Owner: Enhanced Health Services – *Presenter: Lisa O'Connell, Director of EHS*			
MPAP7003 – CalAIM Community Supports (CS)	291 – 319	**This policy was last at PAC on Nov. 11, 2025. The Policy Guide called for new updates that went live Jan. 1, 2026. This policy will come back again in 2026** with a new Partnership policy for Transitional Rent **after DHCS approves its new CalAIM Policy Guide Volume 2 in development. It will also include final referral requirements, which may change the eligibility updates made today.** The Related Policies section is updated. **VI.F.1-5:** Updated eligibility requirements for "Housing Trio" – Housing Transition Navigation Services (HTNS), Housing Deposits, and Housing Tenancy and Sustaining Services (HTSS) – Short-Term Post-Hospitalization Housing (STPHH), and Recuperative Care (Medical Respite – Room and Board Service) per the DHCS Policy Guide, Vol 2 (April 2025). **VI.F.6:** Eligibility criteria are moved to the beginning of the Medically Tailored Meals/Groceries (MTH/G) section. **References:** DHCS Policy Guides Volumes 1 and 2 are separated for ease of hyperlinked access.	Health Services Claims Finance Member Services Provider Relations Administration
Policy Owner: Quality Improvement – *Presenter: Rachel Newman, RN, Manager, Member Safety – Inspections*			
MCQP1022 – Site Review Requirements and Guidelines – *there are no changes to Attachments A-E, so for brevity they*	321 – 461	This policy is coming back ahead of its annual review in large part to accommodate UM's MCUP2033 – Urgent Care Services policy changes on today's agenda. Accordingly, MCQP1022's attachments will now include review tools relevant to urgent care. Additional changes have been made to improve the workflow of the policy and be more inclusive of the additional reviews performed by the Site Review team. IQI on Jan. 13 added Free-standing Birthing Center to the types of Non-Accredited Sites that are reviewed (top of policy page 10) and also added it to the "clinic type" list found on p. 1 of Attachment F.	Provider Relations Network Services Health Services Compliance Grievance and Appeals

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)
are not included in this packet		**Section III Definitions added:** "Supplemental Facility," and Free-Standing Urgent Care Center **Attachment F –** the Non-Accredited Facility Site Review Tool – has minor updates on questions for flow and process. **Note: this Tool will no longer be used for Urgent Care.** **Old Attachments J and L** – Master Trainer Certification and Provider Certificate, respectively **– are being archived. Others are being reordered and thus relettered** (e.g., the old K – Interim Compliance Self-Assessment – is now the new N). **Attachments G-K below are new additions:** G. Free Standing Urgent Care Clinic Facility Site Review Tool H. Urgent Care Medical Record Tool I. PCP Providing Urgent Care Facility Site Review Tool J. Palliative Care Facility Site Review Tool K. Palliative Care Medical Record Review Tool M. Supplemental Tool *(previously Attachment I)* **Section VI Policy /Procedure is entirely reformatted for ease of reading**. Therein, these additions or changes have been made: • "Supplemental Sites" added as language to be more inclusive in required site reviews. (p.1) • Sites with a failed review will be placed on an annual review. • "Any site review concerns that reveal significant quality of care issues will be forwarded to the Chief Medical Officer or the Quality Medical Director for Quality for further guidance." (p. 3) • Partnership expanding to a new service area. Language is removed and now points to APL 20-017 for guidance. • Facility Site Review (FSR) Scoring language on Critical Elements (CEs) is updated (p. 4) • Medical Record Review (MRR) Scoring language is updated (p. 5): "If the minimum number of records is not available, Partnership will document the rationale and complete the MRR with the available records." • Partnership's Certified Master Trainer (CMT) will recertify CSRs every three years. Upon certification and recertification, Site Reviewers will receive written verification of certification from Partnership. (p. 8) • Obstetric Specialists and Non-Accredited Sites have been bundled and FSR and MRR language augmented under section "Specialized Site Reviews" (pp. 9-10) These are followed by additional MMR language pertaining to Free Standing Urgent Care Clinics (p. 10), and "PCP providing Urgent Care Services" (p. 10) "A Palliative Care report is run monthly by the Inspections Site Review Team." (p. 10)	

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)
		• Removed section under Non-Accredited site reviews. These reviews do not fit within the Site Review scope. Sites removed include Hospitals, Skilled Nursing Facilities, Ambulatory Behavioral Health Facilities, Free Standing Surgical Centers. Originally was going to place a "rural section" but felt it was more accurate to completely remove. These sites will require accreditation.	
Policy Owner: Utilization Management – *Presenter: Tony Hightower, CPhT, Associate Director, UM Regulations*			
MCUP3041-A TAR Requirements List	463 – 470	The TAR Requirements List was updated from that Q/UAC approved in November 2025. Now *excluded* is **Section HH:** Added Repetitive Transcranial Magnetic Stimulation (rTMS) Now *included*: **Pain Management CPT Code List:** **62290, 62291:** Clarified that these two codes are for "Injection procedure" for discography **63661, 63663, 63688:** Added these three codes for "Insertion or revision of spinal neurostimulator" **72285, 72295:** Clarified that these two codes are for "Radiological supervision and interpretation for" for discography	Provider Relations
MCUP3034 - PCP-To-PCP Transfers & Assignment of New Members to PCP	471 – 473	During the annual review of this policy at the department level, there was discussion regarding continuity of services for pregnant Members. Dr. Moore recommended seeking comments at IQI for language at VI.A.3. **Section III. B. and C.** Definitions of Medical Home and Whole Child Model were updated to match recent updates made by Member Services for "Medical Home" and Care Coordination for "Whole Child Model." **Section IV.** Appendix A was removed and the language was brought into the body of the policy at VI.A.3. instead. **Section V.** The Purpose section was updated to specify "Primary Care Provider" transfers **Section VI.A.3.** Guidelines for Determining Medical Stability Prior to PCP Transfer that were previously shared in Appendix A were brought into the body of the policy at this section. When doing so, it was noticed that we had a discrepancy in our recommendations for pregnant Members with one recommendation being 28 weeks and the other being 32 weeks as the threshold for when a pregnant Member is considered "unstable" for PCP transfer. The policy was updated to reflect that a Member would be considered unstable for PCP transfer from the 33rd week of pregnancy until 8 weeks postpartum. **Section VI.A.5.** Redundant language was deleted here regarding pregnant Members because the language is now included at VI.A.3. Language was made consistent to describe exceptions for	Member Services Provider Contracting Population Health

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)
		pregnant Members wishing to transfer after "from the 33rd week of pregnancy" and before 8 weeks postpartum. **Section VI.B.4.** Clarified that new Members who are at least 28 weeks pregnant when they become a Partnership Member may be granted Direct Member status for continuity of care "upon their request."	
MCUP3044 - Urgent Care Services	475 – 484	This policy was updated to reflect current access to urgent care services for Partnership Members. Attachment A – Application to be a Contracted Urgent Care Services Provider – is new and was revised at Jan. 13 IQI to include new fields for Tax ID and NPI numbers. **Section I.C. – K.** Several policies were added as Related Policies for this topic: C. MPUP3006 Appropriate Service and Coverage Policy D. MCUP3113 Telehealth Services E. MCCP2018 Advice Nurse Program F. MCQP1022 Site Review Requirements and Guidelines G. MPQP1016 Potential Quality Issue Investigation and Resolution H. MPCR700 Assessment of Organizational Providers I. MPCR17 Standards for Contracted Primary Care Providers and Urgent Care Physicians J. MPCR301 Non-Physician Clinician Credentialing and Recredentialing Requirements. K. MPNET100 Access Standards and Monitoring **Section II.** Provider Contracting and Network Services were both specified as Impacted Departments **Section III.** The Definition of Direct Member was updated and four new Definitions were added for "Free-Standing Urgent Care Center," "Partnership Urgent Care Tiers," "Primary Care Providers," and "Urgent Care Services." **Section V.** The Purpose section was updated to reflect that this policy describes "access to" urgent care services for Partnership Members and is not specific only to facility standards. **Section VI.A.** This first section in the body of the policy specifies that there is no prior authorization required for urgent care visits for Partnership Members. **Section VI.B.** This section outlines the two primary ways Members can access urgent care services: Through Primary Care Offices or through Free-Standing Urgent Care Centers. **Section VI.C.** This section was added to specify that Partnership conducts site review for all Urgent Care Services. **Section VI.D.** This section was added to describe Members' Roles and Responsibilities in Accessing Urgent Care Services. **Section VI.E.** This section was added to describe Provider Responsibilities when offering Urgent Care Services.	Administration Configuration Claims Provider Contracting Network Services

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.F. The existing language in this section was updated to clarify standards for free-standing urgent care centers. **Section VI.F.** At the end of this section, the previous language describing "Claims Issues" was deleted. **Section VI.G.** This new section was added to describe Oversight and Monitoring of urgent care services to monitor for any patterns of over-utilization. **Section VII.B. and C.** Two new References were added as follows: B. California Code of Regulations (CCR) Title 28 §1300.67.2.2 (c) (5) C. DHCS Contract Exhibit A, Attachment III 5.2.5 Network Adequacy Standards	
MPUP3014 - Emergency Services	485 – 492	This policy was updated to reflect current access to urgent care services for Partnership Members. **Section III.F.** A new Definition was added for Urgent Care Services and the previous definition of Urgent Conditions was deleted. **Section IV.** The Addenda listed in the Attachments section were deleted. **Section VI.A.** "Payment for Services" language was deleted from this section. **Section VI.G.** This section regarding Emergency Department Contracts was deleted. • **ADDENDA A – C:** Deleted three Addenda that listed Non-Urgent Medical Conditions, Urgent Medical Conditions, and Emergency Medical Conditions.	Administration Claims Provider Contracting Network Services

Partnership HealthPlan of California
Meeting Minutes

COMMITTEE	Pharmacy and Therapeutics Committee Meeting (P&T)
DATE / TIME:	Thursday, January 15, 2026 / 7:30am – 10:00am PT

Practicing Members Present:

PHC Members Present:

Deputy Chief Medical Officer, Committee Chair:
Kermit Jones, MD

Director of Pharmacy, Committee Secretary & Acting Chair:
Stan Leung, PharmD

Medical Directors:
Jeffery Ribordy, MD, MPH
Mark Glickstein, MD
Mark Netherda, MD
James Cotter, MD, MPH
Matthew Morris, MD
Richard Matthews, MD
Marshall Kubota, MD
Aaron Thornton, MD
Bettina Spiller, MD
Lisa Ward, MD
Michael George, MD
Colleen Townsend, MD

Pharmacists:
Erin Montegary, PharmD
Susan Becker, PharmD, BCPS
Kathleen Vo, PharmD
Andrea Ocampo, PharmD
Angela Keough, PharmD
Lisa Ooten, PharmD
Michael Perez, PharmD

Invited Guests Present:
Donell Colvin, CPhT

Department AA's:
Jacquelyn Brackett

IT Ops & Systems:
Jose Puga
John Lemoine

Practicing Members Absent:
Kirsten Balano, PharmD
Michael Majeski, PharmD
Jay Shubrook, DO
Phillip Nguyen, PharmD, BCACP, BCGCP
Antonio Olea, PharmD
Lilia Vargas-Toledo, RN

PHC Members Absent:
Robert Moore, MD, MPH, MBA
Dave Katz, MD
Bradley Cox, DO
Jeffrey DeVido, MD
Teresa Frankovich, MD

AGENDA ITEM	DISCUSSION / CONCLUSIONS	SPEAKER, APPROVED ACTION ITEMS	EFFECTIVE DATE
Opening Comments	○ Introductions ○ Housekeeping (Announcement: Meeting is being recorded)	*Presented by Stan Leung, PharmD*	
I. Approval of minutes	Quorum: Not met. A post-meeting email has been sent to the external committee members for approval. Minutes: Approved	*Presented by Stan Leung, PharmD*	N/A
II. Standing Agenda			
1. PHC Update	PHC Updates provided by Dr. Jones: I want to start with the top line organizational updates before getting a little more granular. I would say that the high-level picture is that the legal and economic uncertainty created by the federal government's kind of assaults toward states with which it has some ideological differences are likely to continue. Governor Gavin Newsom closed out his State of the State address last week, and the administration released its proposed January budget for fiscal year 2026–2027, emphasizing that this budget should be viewed as a snapshot. The proposed spending plan is balanced for now, but long-term sustainability will be addressed in the May Revision, after April tax receipts are received, and the administration has a clearer sense of the fiscal outlook. As a quick summary of the budget, it includes a $4.5 billion discretionary reserve and a projected deficit of between $18 to $22 billion anticipated for 2027–2028. The budget includes roughly $340 billion for Health and Human Services programs for 2026–2027, with about $196 billion allocated to Medi Cal for 2025–2026 and $224 billion for 2026–2027. The effects of H.R. 1 is estimated to have a reduction of about $373 million in 2026 to 2027 and $13 billion by 2029 to 2030. The Affordable Care Act update, and more specifically for the Affordable Care Act Adult expansion population, changes are going to come into effect January 1, 2027. Effective October 1, 2026, the new federal policy will exclude individuals with certain immigration statuses from federal eligibility for full scope Medi-Cal, and if the state were to otherwise step in this gap and provide full scale Medi-Cal for this population of full	*Presented by Kermit Jones, MD JD*	N/A

	scope, the cost was estimated to be about $786 million to the general fund in 2026 to 2027. The Managed Care Organization (MCO) tax is projected to generate $4.5 billion in 2025 to 2026 and $2.5 billion in 2026 to 2027, this MCO tax revenue is to support the state's Medi-Cal program. This includes additional $1.6 billion across 2025 to 2026 and 2026 to 2027 to support increases in managed care payments relative to the calendar year 2024. But of note, which many of you probably already know, the current MCO tax is not consistent with the H.R. 1 requirement that prohibits taxing Medicaid providers at higher rates than non-Medicaid providers. So, under the recent federal guidance, the state will receive a transition period to get into compliance, but that will end June 30, 2026, and I believe the state has applied for an extension to the end of 2026. For the Rural Health Program State Project Awards that we applied for as a state, the federal government, through its rural health program state project grants, awarded California $233 million. This may seem like a big number on paper but on a per capita basis compared to red States it is actually pretty low. It's about $5.80 per person in California compared to $39 per person in Alabama because they received $203 million and believe it or not almost $300 per capita in Alaska because of the amount that they received. CMS (Centers for Medicare & Medicaid Services) has proposed a new rule for the condition of participation in Medicare. If you break this condition, then they can kick you out of the Medicare program. Their proposed rule states that hospital providers who provide gender affirming care which they label as sex rejecting procedures will be barred from participating in Medicare. There's a 60-day waiting period from the proposed rule to the rule takes effect for the collection of online comments. The rule was proposed in the latter half of December, so that means after that 60-day waiting period it will take effect February 17. The catch 22 with this rule is that providers and plans in California are legally mandated under state law and interpretation of state case law, to provide access to gender affirming care based on states and statutes in this case law interpretation. California Civil Code 1798.301 declares that gender affirming health care and mental health services are rights secured by the constitution of laws of California. This rock and a hard place situation that some health plans and providers are going to find themselves in will likely result in lawsuits once the rule is finalized, with California likely joining other states in suing the federal government. Some of the possible lines of argument is the anti-commandeering document,		

	which states the federal government can set conditions for its own money, but it cannot commandeer state officials or state based programs to enforce federal policy. California may argue in that instance that the federal government is using Medicare to effectively overturn state healthcare laws, which can be seen as overstepping federal authority under the 10th amendment. Also, with spending clause power, the federal government can set conditions on programs but these conditions cannot be coercive. Ironically, the Supreme Court held this particular ruling in a case against secretary Civilius of the Affordable Care Act, I believe it was in 2015. Finally, there is the doctrine of unconstitutional conditions, which holds that the government cannot require a person or organization to give up a constitutional right—such as equal protection—in exchange for a government benefit like Medicaid participation. Stay tuned on that. There are several high-level regional updates to Partnership plan specifically. We had a regional strategy meeting day before yesterday, where each region provided updates of things going on in their areas. I won't go through all of them, but I'll highlight a few of the most notable. In the Chico region, the Glenn Medical Center's closure has been noted to be impacting ground ambulance transportation times. There has been a near 100% increase in ambulance transport times. Previously, it averaged 18 minutes to get a patient from their home to the hospital center; now, it is averaging 35 minutes, as ambulances must carry patients to other healthcare centers that are farther away. In the Fairfield region, the proposed federal rescinding of what is called the bright line clarity policy and the public charge rule that was put in place in the Biden administration is believed to likely negatively impact the UIS Medi-Cal members there. County eligibility offices are projected to get overwhelmed and are already getting overwhelmed with snap work requirement mandates that are rolling into effect in 2026, and they also anticipate problems with the Medicaid work requirements in 2027. Lastly, last week, January 5, 2026, the CDC underwent a historic shift by reducing the number of diseases that they target by universal childhood immunization schedules, decreasing this from 17 down to 11. This has triggered a significant rift between federal health officials and the Medicare and medical establishment. CDC has reclassified several vaccines from routine and universal to high risk only or shared clinical decision making, meaning that the parents can discuss with their own providers whether they decide to get the vaccine. Some of these		

	changes involve the influenza vaccine, the COVID-19 vaccine, hepatitis A, hepatitis B, and meningococcal. RSV is now recommended only for infants with specific underlying health conditions exposure risks. The West Coast Health Alliance, which involves California, Oregon, Washington, and Hawaii, have announced that they will continue to recommend the pre 2025 evidence-based schedule. The CDC did note that there should not be any changes with respect to insurance coverage for these vaccinations. The VFC system, should be unchanged from before, in terms of providers access to these vaccines. That is all the updates I have. **Question**: With all the federal changes and ongoing state budget issues, is there an estimate of potential membership losses for Partnership? **Response**: Projections indicate a potential membership reduction of 8–10%. What is fueling these estimates are the increased re-eligibility requirements and a higher number of individuals who may no longer qualify for full scope coverage. It is a pretty significant number.		
2. Additional Updates	<u>PHC and Medi-Cal Rx Updates:</u> Dr. Leung started off the meeting informing everyone of the conflict of interest form attached in the meeting invite, which was provided to our external committee members for their attestation for any conflict of interests. He requested they sign and return the form. Welcome to the team, Dr. Michael George! Joining us as Medical Director, Dr. George brings a wealth of experience as a family physician and longtime hospitalist. His specialized background in hospital-based care is a fantastic addition to our medical leadership. There are a couple things happening with Medi-Cal Rx, which is the State run pharmacy benefit. The first is with the PAD (Physician Administered Drug) benefit change. Last October, DHCS attempted to change the policy by having certain medications restricted to the plan's medical benefits, they weren't allowing certain drugs to be furnished by the home infusion pharmacies. This caused severe access issues because there was not much information about the change. So, when they tried to activate this, it caused quite a bit of chaos and disruption. As a result, they suspended this policy and in January they held a meeting to talk about the reinstatement of this PAD policy change. The policy change will require certain medications to be billed under the plan's medical benefit. Right now, the real	*Presented by Stan Leung, PharmD*	N/A

	disconnect for this policy change is with the reimbursement model. Currently for PAD drug that are billed through the medical benefit, they are paid the Medi-Cal rate, which is set at the benchmark of ASP (Average Sales Price). But with pharmacy billing, the reimbursement usually occurs at the wholesale acquisition costs or an average wholesale price minus the discount. These different models of reimbursement can vary greatly and for some of the pharmacies it would be unsustainable for them if they were to be reimbursed at the medical benefit methodology. In the January meeting, there were physicians in attendance that attested they do not have the financial resources to buy and bill these medications, and they do rely on home infusion pharmacies to furnish these medications. These comments were taken back to the State and over the next year there will be monthly meetings to discuss how they will operationalize and finance this change. One of the other points is that they will need to meet with the managed care plan's finance departments to talk about how they will be reimbursed for paying these medications under the medical benefits. There is certainly a lot of discussions in terms of pharmacy reimbursement, physician reimbursement, and the rate setting process for the managed care plans. The second bigger update is with the weight loss GLP-1 coverage change. Starting January 1st, the weight loss GLP-1 medications: Wegovy, Saxenda and Zepbound, were taken off of the Medi-Cal Rx formulary. With these medications regardless of, previous years or continuity of care, or if they had a previous prior authorization, they will now require a prior authorization for use. And not only that, Medi-Cal will review these prior authorizations case by case and it has to align with the medication's FDA approved indications. For example, Zepbound is approved for OSA (Obstructive Sleep Apnea), but if a provider tried to submit Zepound for MACE reduction or fatty liver disease, Medi-Cal will deny the prior authorization. Just to provide some context, on a seven-day average last year looking at October, November and December, we had about 2,300 claims over a seven-day period. For January, for the first seven days, we only had about 50 claims. So there has been a dramatic reduction in GLP-1 use, and additionally what we are seeing is half of those were for pediatrics. I should mention in addition to covering the weight loss GLP-1 for FDA indications for adults, they will also consider coverage of these weight loss GLP-1s for pediatrics under the EPSDT benefit. Looking at these first couple of weeks of claims, about half of these medications are covered under EPSDT benefit and the other half for the adults.		

	Further, when we look at the actual approved TAR (Treatment Authorization Request) itself in terms of the documentation, what needs to be documented at least for MACE reduction for major adverse cardiovascular events, is that the patient has had an event and have established cardiovascular disease. So for a lot of the TARs that we see approved, they usually have documentation of previous MI (Heart Attack), TIAs (Mini-strokes), Strokes or some type of Revascularization events. For OSA, what we see in terms of denial is a lack of sleep studies. If the provider's only justification is that patient cannot tolerate or tried and failed a CPAP, then the reviewer will note a need for additional information about sleep studies and sleep score AHI index for approval. We do see TARs for OSA being approved, but again, they would have to demonstrate that either the CPAP did not work, or the patient was not compliant on a CPAP (e.g. the mask doesn't fit , can't put on the mask and be adherent to CPAP) and then third is the sleep study with the AHI score. What we have not seen so far is any approvals for MASH (Metabolic Dysfunction-Associated Steatohepatitis liver disease or hepatitis. Based on what we see for MASH, the TAR will probably get approved if the patient has a fibro scan to stage fibrosis at F2 and above. They probably won't require a biopsy to confirm MASH, but their approval will align with the ASLD guideline of having MASH, and a fibrosis stage the F2 or above. We will continue to monitor the GLP-1 utilization and approvals. And continue the message out to the providers the documentation that they should provide to support approval. The other relevant update with regards to GLP-1 coverage is that CMS has now negotiated with Eli Lilly and Novo Nordisk to lower the price of GLP-1. They are planning to implement what they call the BALANCE initiative, which is for the manufacturers to provide the GLP-1s at a much reduced cost. It is a voluntary participation from the State and Medicare. The addition to this is, the manufacturer will also offer lifestyle coaching for the members who are on these medications. So, not only is there going to be a reduction in price, but also lifestyle coaching by the manufacturer. The program is expected to launch later this year, probably second quarter for Medicare. They have a bridge program in July for Medicaid and they are allowed to participate sometime in May and June. As far as prices, it will be about $245 for an injectable GLP-1 and $150 for the newly approved Wegovy tablets. Once again, this is voluntary, and it will be interesting to see how the State will decide on participation because with the GLP-1 coverage that got implemented January 1, 2026, it was based on the approved		

	budget for 2025 to2026, where they forecasted $80 million savings for this current fiscal year and then a $700 million savings by fiscal year 2028 and 2029. When asked about the rationale or justification for excluding GLP-1 coverage, the State cites the state policy. As you know, the state budget draft was released recently and in that draft there is no mention of GLP-1s. So, at this time, the exclusion for GLP-1 coverage still stays, but it will be interesting to see with the new price, if there is reconsideration for the State to add GLP-1s back to the budget. That is all for the Medi-Cal Rx update. **Questions:** Regarding GLP-1s, a provider asked for a patient who had done well, had lost a significant amount of weight and had obstructive sleep apnea at the onset of using the medication. The provider was asked to provide an updated sleep study. The provider stated that it will most likely not show as much OSA at this point. For continuation of treatment requests, will they be asking for the original sleep study or will they be asking for a repeat sleep study for the OSA indication? **Response:** Good question, this actually came up at a meeting with Community Medical Centers in Dixon, a very similar case was brought up. They asked, how current does the sleep study have to be? They submitted the original sleep study and it passed. It seems what they are looking for is that some type of work up was done and a sleep study with a score to confirm OSA diagnosis.		
3. DUR Update	**Psychotropic Medications in Youth: Monitoring for concomitant use of antipsychotics with antidepressants and mood stabilizers** Talking Points <u>Overview</u>: • DHCS requires managed care plans to monitor the appropriate use psychiatric drugs in members under the age of 18. • The monitored medication classes include antipsychotics, mood stabilizers, and anti-depressants. • The monitoring also includes evaluating whether overutilization of psychotropic drugs occurred among our youth and foster care population.	*Presented by Kathleen Vo, PharmD*	N/A

	• Partnership implemented a process to identify potential psychotropic medication overutilization and to notify the prescribers when concerns are identified.
	•
	
	<u>Method</u>:
	
	• 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 concurrent fills of 2 or more antipsychotic medications, additional claims analysis was conducted to assess concomitant use of mood stabilizers, antidepressants, stimulants, benzodiazepines, and sedatives.
	• Members with 3 or more psychotropic medications, including at least 2 antipsychotics, were evaluated to determine prescriber specialty and to assess the appropriateness of their psychotropic regimen. Concerning findings were referred to PHC medical directors with pediatric and psychiatric expertise to determine whether follow-up or intervention was warranted.
	
	<u>Results</u>:
	
	A review of Medi-Cal Rx claims for antipsychotic medication among members under 18 years of age, between 3/1/25 through 8/31/25, identified the following:
	
	• 75 members were receiving ≥3 psychotics medications, meeting PHC' definition of psychotropic overutilization and warranting a detailed review of medical and pharmacy claims.
	  o For these 75 members, focused on:
	  ▪ Regimens managed by only mid-level prescribers
	  ▪ members 9yrs and under
	  ▪ concurrent use of 6 or more psychotropics
	  ▪ use of 3 or more second generation antipsychotics
	  ▪ prescribed doses that exceeds the max recommended doses based on indication		

	• 19 of the 75 members were referred to PHC medical directors for further review and evaluation; most of these members had overlapping areas of concerns. • Analysis showed that ~3.1% of Partnership's youth receiving antipsychotic medications were prescribed ≥3 psychotics medications, suggesting that psychotropic overutilization was low during the 6 month review period. • The rate of psychotropic overutilization was comparable between youth in foster care and non-foster care youth, at 3.1% respectively. <u>Case Referral Update:</u> • A member case was referred to our PQI workgroup for investigation and review. This member was prescribed 5 psychotropic medications, including 3 second generation antipsychotics, and was managed by a mid-level provider. • PQI workgroup recommended that this case be forwarded to the Peer Review Committee (PRC) for discussion regarding the appropriateness of care and oversight of the practitioner providing the treatment. • Provider outreach and communication was conducted by Dr. DeVido, our Behavioral Health Clinical Director. • Follow-up of on this case showed that member's care transitioned to another provider, and their medication regimen was adjusted and simplified. • In addition, the facility involved reviewed its protocols and updated its processes to improve care coordination and information sharing among behavior health providers.		
4. Managing Pain Safely Report	As part of the requirements from the State, we have to monitor opioid utilization and potential FWA (Fraud, Waste and Abuse). Reports were pulled with data extracted from our Tableau dashboards to look at opioid utilization-how many prescriptions are filled monthly- and it is pretty stable in terms of quarter by quarter. Next, we look at dose escalation, broken down in terms of the daily MED-those who are escalating, those who are dose stable and those who are deescalating. The reports show that at least for those who are escalating, the MED is still below 50. There are about 15 members who appear to be dose escalating above 200 MED, we will be taking a closer look at those members to ensure their dose is not continually escalating	*Presented by Stan Leung, PharmD*	N/A

	beyond the appropriate daily MED and they are not obtaining prescriptions from multiple prescribers and multiple pharmacies. We also monitor new starts and reports show stability in terms of the new starts for each month. In addition, we look at members co-prescribed opioids and benzodiazepines/muscle relaxants and these reports show they are stable. Certainly, if there is a spike in any one of these metrics, we would do further investigation to see the cause of the spike. Lastly, is MAT (Medications Assisted Treatment Utilization) and reports show we were slightly trending up in terms of our MAT utilization. There are a couple reasons this could be, one being due to the new regulations that allow more primary care providers to provide MAT, as well as pharmacies. Some pharmacies are now able, based on the regulations, to furnish MAT without a prescription from the doctor. All this updated information and report tables will be posted on our Partnership external site under the MPS-Managing Pain Safely page. **Question:** Does the State have specific protocols for MEDs for max use? **Response:** Yes, the State has a tablet restriction of 75 tablets over 90 days as well as a MED restriction and if the member goes over that restriction, then a TAR would be required. The State has been decent in terms of maintaining control for opioid utilization. This may be reason as to why they require the managed care plans to monitor opioid use, concurrent use of benzodiazepines and opioids as well as any suspected fraud, waste and abuse. There is a shared responsibility with the State, Managed Care Plans and Pharmacies for the safety and health outcomes for the members. It is also part of the drug utilization review to detect and identify FWA and address those issues. **Question:** Is there an opportunity to get a one page GLP-1 changes document that can be shared at Quality meetings or Provider Practice Meetings to show what we know and give guidance for TARs and what documentation is needed. **Response:** Yes, we did provide this information to Dr. Moore for his newsletter and we can certainly have a one pager for the Medical directors to share with your counterparts at clinics and health centers.		

5. Annual Review of Member Language for PADs	Dr. Ocampo presented an overview of PHC'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. **Recommendation for PAD Coverage Member Language:** A recommendation was made to update the language for member materials pertaining to PAD coverage (see page 61 of the packet). The proposed revision adds the word "***prescribed***" as follows: While most medications ***prescribed*** by your provider are dispensed at a pharmacy, Partnership covers certain drugs that you get from your doctor at the doctor's office or hospital. **Response:** Suggestion will be taken back to be approved by Communications and DHCS. Once approved the member language will be updated. Language approved by the committee with the recommended addition of "***prescribed***".	*Presented by Andrea Ocampo, PharmD*	N/A
6. Drug Benefit Review	The classes for this quarter's review are: o ADHD, Narcolepsy, Obesity o Analgesic, Anti-inflammatory, Migraine, Gout, Anesthetics o Cardiovascular Agents o Central Nervous System Agents o Neuromuscular Agents No changes proposed to the ADHD, Narcolepsy, Obesity Class and Central Nervous System Agents. All actions at right were approved by the committee as presented, unless otherwise noted as "*approved as modified*". All changes will be effective 4/01/2026 unless otherwise noted.	*Presented by Susan Becker, PharmD, BCPS and Erin Montegary, Pharm*	

Class Reviews:

- Analgesic, Anti-Inflammatory, Migraine, Gout
  - Updates to the following were presented, with approved action shown at right.
    - tocilizumab, IV use (Actemra™)
    - tocilizumab-anoh, biosimilar, (Avtozma™)
    - tocilizumab-bavi, biosimilar, (Tofidence™)
    - tocilizumab-aazg, biosimilar, (Tyenne™)

Presented by Erin Montegary, Pharm D

Analgesic, Anti-Inflammatory, Migraine, Gout Agents Class Review, Approved Actions:	
HCPCS	**Drug**
TAR Criteria Updates (see attached criteria for details)	
J3262	Injection, tocilizumab, 1 mg for IV use (Actemra™)
Q5156	Injection, tocilizumab-anoh, biosimilar, 1 mg (Avtozma™)
Q5133	Injection, tocilizumab-bavi, biosimilar, 1 mg (Tofidence™)
Q5135	Injection, tocilizumab-aazg, biosimilar, 1 mg (Tyenne™)

4/1/2026

- Cardiovascular Agents
  - Updates to the following were presented, with approved action shown at right.
    - evinacumab-dgnb, 5 mg (Evkeeza™)
    - inclisiran, 1 mg (Leqvio™)
  - Updated Pharmacy MDL search tool to reflect TAR required. (Note: These drugs are TAR required by default since any NOC code not specifically on claims valid with J3490/Z7610 workbook requires a TAR.)
    - angiotensin II acetate, (Giapreza™)
    - ephedrine hydrochloride, (Rezipres™)
    - Mannitol, (Osmitrol™)
    - Long Grove 505(b)(2) norepinephrine-sodium Chloride
    - epinephrine (auto-injector), (Auvi-Q™)
    - epinephrine (auto-injector), (EpiPen™)
    - furosemide, (Lasix Onyu™)
    - epinephrine (nasal spray), (Neffy™)
    - landiolol, (Rapiblyk™)
    - sotatercept-csrk, (Winrevair™)
    - alirocumab, Praluent™

Presented by Susan Becker, PharmD, BCPS

Cardiovascular Agents Class Review, Approved Actions:	
HCPCS	**Drug**
TAR Criteria Updates (see attached criteria for details)	
J1305	Injection, evinacumab-dgnb, 5 mg (Evkeeza™)
J1306	Injection, inclisiran, 1 mg (Leqvio™)
Addition of Claim Limits &/or Requirements *TAR required*	
J3490	angiotensin II acetate, (Giapreza™)
J3490	ephedrine hydrochloride, (Rezipres™)
J3490	Mannitol, (Osmitrol™)
J3490	Long Grove 505(b)(2) norepinephrine-sodium Chloride
J3490	epinephrine (auto-injector), (Auvi-Q™)
J3490	epinephrine (auto-injector), (EpiPen™)
J3490	furosemide, (Lasix Onyu™)
J3490	epinephrine (nasal spray), (Neffy™)
J3490	landiolol, (Rapiblyk™)
J3490	sotatercept-csrk, (Winrevair™)
J3490	alirocumab, (Praluent™)

4/1/2026

- Neuromuscular Agents
  - Updates to the following were presented, with approved action shown at right.
    - delandistrogene moxeparvovec-rokl, per therapeutic dose (Elevidys™)
    - onasemnogene abeparvovec-brve, per treatment, up to 5x10^15 vector genomes (Itvisma™)
  - Updated Pharmacy MDL search tool to reflect TAR required. (Note: These drugs are TAR required by default since any NOC code not specifically on claims valid with J3490/Z7610 workbook requires a TAR.)
    - midazolam nasal spray, (Nayzilam™)
    - diazepam (rectal), (Diastat Pediatric™; Diastat™; Diastat AcuDial™)
    - dantrolene sodium, (Dantrium IV™; Revonto™; Ryanodex™)
    - pyridostigmine bromide (injectable), (Regonol™)
    - rotigotine, (Neupro™)

Presented by Susan Becker, PharmD, BCPS and Erin Montegary, Pharm D

Neuromuscular Agents Class Review, Approved Actions:	
HCPCS	**Drug**
TAR Criteria Updates (see attached criteria for details)	
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose, (Elevidys™)
New TAR Criteria (see attached criteria for details)	
J3590	Injection, onasemnogene abeparvovec-brve, per treatment, up to 5x10^15 vector genomes, (Itvisma™)
Addition of Claim Limits &/or Requirements *TAR required*	
J3490	midazolam nasal spray, (Nayzilam™)
J3490	diazepam (rectal), (Diastat Pediatric™; Diastat™; Diastat AcuDial™)
J3490	dantrolene sodium, (Dantrium IV™; Revonto™; Ryanodex™)
J3490	pyridostigmine bromide (injectable), (Regonol™)
J3490	rotigotine, (Neupro™)

4/1/2026

- *Ad Hoc* Drug Review: In addition to the scheduled class reviews, PHC presented the following:
  - Antineoplastic Agents and Adjunctive Therapies:
    - lisocabtagene maraleucel (Breyanzi™)
    - pembrolizumab and berahyaluronidase alfa-pmph (Keytruda Qlex™)
    - nivolumab, 2 mg and hyaluronidase-nvhy (Opdivo Qvantig™)
    - atezolizumab, 5 mg and hyaluronidase-tqjs (Tecentriq Hybreza™)
  - Updates to Dermatological, Anorectal, Mouth – Throat, Dental, Eye – Ear Agent:
    - Topical administration, prademagene zamikeracel, per treatment (Zevaskyn™) - Discussion brought forth by Dr. Glickstein and Dr. Matthews to include an additional requirement for ***photographic documentation***

Presented by Susan Becker, PharmD, BCPS

Ad hoc Updates		
HCPCS	**HCPCS Description (brand)**	**Approved Action**
Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose (Breyanzi™)	Updates to current CAR-T criteria (see attached criteria for details)
J3490	pembrolizumab and berahyaluronidase alfa-pmph (Keytruda Qlex™)	Updates to current criteria (see attached criteria for details)
J9289	Injection, nivolumab, 2 mg and hyaluronidase-nvhy (Opdivo Qvantig™)	Updates to current criteria (see attached criteria for details)

4/1/2026

of the wound area. This change will be helpful in reviews, especially MD reviews of TARs for the medication. Committee agrees with change. The change has been made to the drug specific criteria (see attached criteria, Approved as Modified).

J9024	Injection, atezolizumab, 5 mg and hyaluronidase-tqjs (Tecentriq Hybreza™)	Updates to current criteria (see attached criteria for details)
J3389	Topical administration, prademagene zamikeracel, per treatment (Zevaskyn™)	New Drug Specific Criteria (Approved as Modified with additional requirement for photographic documentation of the wound area.)

- New HCPCS code review – listed at right, listed in 2 sections:
  - 1st 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 12/30/2025, with an effective date of 1/1/2026.

Presented by Susan Becker, PharmD, BCPS
NTR = No TAR Required

New HCPCS codes (no prior code or was previously unclassified		
HCPCS	HCPCS Description	Requirements
J1736	Injection, meloxicam (delova), 1 mg	TAR
J1737	Injection, meloxicam (azurity), 1 mg	TAR
J1837	Injection, posaconazole, 1 mg	TAR
J9184	Injection, gemcitabine hydrochloride (avyxa), 200 mg	TAR
J9282	Mitomycin, intravesical instillation, 1 mg (Zusduri)	TAR
Q5160	Injection, bevacizumab-nwgd (jobevne), biosimilar, 10 mg	TAR
J0013	Esketamine, nasal spray, 1 mg	TAR
J3389	Topical administration, prademagene zamikeracel, per treatment	TAR
J0654	Injection, liothyronine, 1 mcg	TAR
J2596	Injection, vasopressin (long grove), not therapeutically	NTR
J7299	Intrauterine copper contraceptive (miudella)	NTR
J2711	Injection, neostigmine methylsulfate 0.1 mg and glycopyrrolate 0.02 mg	Covered with limits (no UA/UB)
J3379	Injection, valproate sodium, 5 mg	NTR

1/1/2026

J3387	Injection, elivaldogene autotemcel, per treatment	TAR
Q0155	Dronabinol (syndros), 0.1 mg, oral, fda approved prescription anti-emetic, for use as a complete therapeutic substitute for an iv anti-emetic at the time of chemotherapy treatment, not to exceed a 48 hour dosage regimen	TAR
Q5148	Injection, filgrastim-txid (nypozi), biosimilar, 1 microgram	TAR
J9174	Injection, docetaxel (beizray), 1 mg	TAR
J9275	Injection, cosibelimab-ipdl, 2 mg (Unloxcyt)	TAR

NTR = No TAR Required

New HCPCS codes replacing a prior code for same drug		
HCPCS	**HCPCS Description**	**Requirements & prior code**
J2516	Injection, pentamidine isethionate, 1 mg	NTR *(same as prior code S0080)*
J3376	Injection, vancomycin hcl (hikma), not therapeutically equivalent to J3373, 10 mg	NTR *(same as prior code J3373)*
J9326	Injection, telisotuzumab vedotin-tllv, 1 mg (Emrelis)	TAR *(changed from previous code: case by case criteria to drug specific criteria)*
J0162	Injection, epinephrine (fresenius), not therapeutically equivalent to J0165, 0.1 mg	NTR *(same as prior code J0165)*
J1073	Testosterone pellet, implant, 75 mg	ICD-10 Requirements: E29.1, E29.8 or E29.9
J3291	Injection, tranexamic acid in sodium chloride, 5 mg	NTR *(same as prior code J3290)*
J7528	Mycophenolate mofetil, for suspension, oral, 100 mg	NTR *(same as prior code J7517)*
J9256	Injection, nipocalimab-aahu, 3 mg (Imaavy)	TAR *(same as prior code C9305)*
J0166	Injection, epinephrine (bpi), not therapeutically equivalent to J0165, 0.1 mg	NTR *(same as prior code J0173)*

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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.

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<table>
<tr><th colspan="3">Consent Items</th></tr>
<tr><th>HCPCS</th><th>HCPCS Description</th><th>Changes to Biling Requirements</th></tr>
<tr><td>J9309</td><td>Injection, polatuzumab vedotinpiiq, 1 mg (Polivy)</td><td>Added diagnosis restrictions to mirror the State (C83.30-C83.39) to prevent off label use.</td></tr>
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<td>N/A</td>
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<tr>
<td><u>III. Old Business</u>

a. Policy Updates</td>
<td>
1) MPRP4001: Pharmacy & Therapeutics (P&T) Committee

a. Presented for consent with no substantive edits. Added language stating how members and providers are notified of any negative changes, 60 days before the change is implemented.

2) MCRP4068: Medical Benefit Medication TAR Policy

a. Added language to comply with APL 25-013 Cell and Gene Therapy Coverage.
b. Added language to comply with NCQA UM 10 Element E requirements for Exception requests.
c. Updated time frames to 24 hours for all types of requests.

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<td>Presented by Andrea Ocampo, PharmD</td>
<td>2/11/2026</td>
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<td><u>IV. New Business</u></td>
<td>None</td>
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<tr>
<td><u>V. Additional Items</u></td>
<td>None</td>
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<tr>
<td><u>VI. Adjournment</u></td>
<td>Meeting adjourned at 9:50am</td>
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APPROVED

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 Duchenne muscular dystrophy (DMD) in patients who are ambulatory and have a confirmed mutation in the DMD gene.
Exclusion Criteria	1. Treatment or use for anything other than DMD. 2. Prior administration of delandistrogene moxeparvovec-rokl (Elevidys™). 3. Deletions in exon 8 and/or exon 9 in the DMD gene. 4. Preexisting liver impairment defined as gamma-glutamyl transferase (GGT) >2 x upper limit of normal (ULN), or total bilirubin > ULN (and not due to Gilbert's syndrome). 5. Active viral hepatic infection. 6. Concurrent use with exon skipping therapies.
Required Medical Information	1. Documented diagnosis of Duchenne muscular dystrophy with medical records detailing the clinical course and confirming a mutation of the DMD gene. a. Genetic mutation test results must be submitted with request. b. Skeletal muscle biopsy results characterizing dystrophin by western blot and immunohistochemistry may be required, such as in the case of genetic testing showing a variant of uncertain significance, or a clinical course and laboratory findings deviating from the traditional trajectory of DMD. c. For mutations in exons 1-17, provider must attest that they are aware of the increased risk for severe myositis associated with these mutations. 2. Baseline Serum Creatine Kinase level with laboratory reference range. 3. Documentation of ambulatory status in the medical records AND as evidenced by North Star Ambulatory Assessment (NSAA) score of ≥1 (or equivalent on another recognized scale) completed within the 3 months prior to TAR submission. 4. Documentation of anti-AAVrh74 total antibody titers <1:400 using a Total Binding Antibody enzyme linked immunosorbent assay (ELISA) completed within the 30 days prior to TAR submission. 5. Documentation of baseline liver function tests, platelet counts, left ventricular ejection fraction (LVEF) and troponin I levels completed within the 30 days prior to TAR submission. Elevidys is not recommended in patients with pre-existing liver impairment (GGT >2x ULN) or total bilirubin >ULN. Elevidys administration should be postponed until acute liver disease has resolved or been controlled. 6. Documentation that the member does not have any signs or symptoms of infection currently or within 4 weeks of receiving Elevidys. 7. Concurrent use corticosteroids (prednisone, prednisolone, deflazacort (Emflaza™), vamorolone (Agamree™) etc.) at a stable dose for at least 12 weeks, unless contraindicated or intolerant. 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	Ages 4 years and older
Prescriber Restriction	Prescribed by, or under supervision and monitoring of a neurologist or a provider who specializes in the treatment of Duchenne muscular dystrophy
Coverage Duration	Once per lifetime
Other Requirements & Information	Requests for use in members who are considered non-ambulatory: See PHC criteria document ***Case-by-Case TAR Requirements and Considerations.*** Prescriber must attest or otherwise document member will receive prophylactic prednisolone (or glucocorticoid equivalent) (in addition to baseline corticosteroid dose) one day prior to Elevidys™ infusion and for 60 days following therapy to monitor liver function.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J1413	Injection, delandistrogene moxeparvovec-rokl, per therapeutic dose (Elevidys™)	$1.33x10^{14}$ vector genomes per kg (vg/kg) of body weight (or 10mL/kg) Supplied in 10ml vials packaged into single dose kits ranging from 10 to 70 vials per kit.

APPROVED

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PA Criteria	Criteria Details
Covered Uses	Homozygous familial hypercholesterolemia (HoFH)
Exclusion Criteria	• Pregnancy • Diagnosis other than HoFH
Required Medical Information	Clinical note documenting: 1) Diagnosis of homozygous familial hypercholesterolemia (HoFH) by genetic test to confirm mutation(s) in the LDLR, PCSK9, or APOB gene. 2) Treatment history confirming compliant trial and treatment failure, intolerance, or contraindication to maximally tolerated high dose statin therapy (atorvastatin ≥ 40mg or rosuvastatin ≥ 20mg), ezetimibe, and PCSK9 inhibitor. 3) Cholesterol lab confirming LDL-C level drawn within the past 90 days. 4) Confirmation of treatment plan to include continued use of current LDL-C lower therapies along with evinacumab. 5) Current weight.
Age Restriction	1 year of age and older
Prescriber Restriction	Cardiologist, diabetologist or endocrinologist
Coverage Duration	Initial: 6 months. Renewal: 12 months with documentation of positive treatment response as evidenced by reduction of LDL-C from baseline with cholesterol lab drawn within 90 days of request.
Other Requirements & Information	Use based on clinical presentation may be considered on a case-by-case basis if genetic testing cannot confirm diagnosis of HoFH. Clinical presentation: 1) Untreated total cholesterol > 500mg/dL AND cutaneous or tendon cholesterol deposits before age 10 years; OR 2) Documentation of untreated total cholesterol ≥ 250mg/dL in both parents. Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J1305	Injection, evinacumab-dgnb, 5mg	15mg/kg every 4 weeks

APPROVED

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	As an adjunct to diet and exercise to reduce low-density lipoprotein cholesterol (LDL-C) in adults with hypercholesterolemia, including heterozygous familial hypercholesterolemia (HeFH).
Exclusion Criteria	Concurrent use of other PCSK9 inhibitors [i.e. Repatha™ (evolocumab) or Praluent™ (alirocumab)]
Required Medical Information	Clinical notes and laboratory values documenting the member is within one of the following categories for which the use of Leqvio is supported by medical guidelines: <u>Baseline LDL-C level of ≥190mg/dL</u>: 1) Documentation of baseline LDL-C level of ≥190mg/dL 2) LDL-C ≥100mg/dl (drawn within the past 3 months) despite compliant therapy with ALL of the following taken at the same time at the maximum tolerated doses: a) Maximally tolerated high dose statin therapy (atorvastatin ≥ 40mg or rosuvastatin ≥ 20mg), AND b) Ezetimibe (Zetia), AND c) Evolocumab (Repatha) or Alirocumab (Praluent). <u>Atherosclerotic cardiovascular disease (ASCVD)</u>: 1) History of clinical ASCVD. 2) LDL-C ≥70mg/dl (drawn within the past 3 months) despite compliant therapy with ALL of the following taken at the same time at the maximum tolerated doses: a. Maximally tolerated high dose statin therapy (atorvastatin ≥ 40mg or rosuvastatin ≥ 20mg), AND b. Ezetimibe (Zetia), AND c. Evolocumab or Alirocumab (Praluent).
Age Restriction	18 years and older
Prescriber Restriction	Cardiologist, Diabetologist or Endocrinologist
Coverage Duration	Initial: 9 months. Renewal: 12 months with documentation of positive treatment response as evidenced by reduction of LDL-C from baseline with cholesterol lab drawn within 90 days of request.
Other Requirements & Information	Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.* Inclisiran should be administered by a healthcare professional.

Medical Billing:

Dose limits & billing requirements (approved TAR is required)

HCPCS	Description	Dosing, Units
J1306	Injection, inclisiran, 1mg	284mg SC initially, again at 3 months, and then every 6 months thereafter

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PA Criteria	Criteria Details
Covered Uses	1) Cytokine Release Syndrome (CRS) 2) Polyarticular Juvenile Idiopathic Arthritis (PJIA) 3) Systemic Juvenile Idiopathic Arthritis (SJIA) 4) Moderate to severely active Rheumatoid Arthritis (RA) 5) Giant Cell Arteritis (GCA)
Exclusion Criteria	• Active, serious infection, latent (untreated) tuberculosis • Combination with another monoclonal antibody/biologic therapy.
Required Medical Information	<u>For all indications:</u> • 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. • Disease Activity Score. • 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). • General dosing considerations for all indications, should include evaluation of baseline labs for ANC >2,000/mm3, Platelets >100,000/mm3) and ALT or AST <1.5 times ULN and throughout treatment of ensure safety. • General dosing consideration in addition (to ANC, platelets, LFTs) specifically for Giant Cell Arthritis & Rheumatoid Arthritis, should also include evaluation of baseline labs for alkaline phosphate and total bilirubin and throughout treatment to ensure safety. <u>Cytokine Release Syndrome (CRS):</u> • Documentation that the request is for treatment for chimeric antigen receptor (CAR) T-cell induced cytokine release syndrome. • Notes: (1) Studies have shown that the combination of tocilizumab and corticosteroids may be more effective than either agent is alone, depending on the affected organs/systems. (2) Although tocilizumab is FDA approved only for severe or life-threatening CRS, there are treatment guidelines that include tocilizumab in less-severely rated CRS, especially when a member is at risk for progression to severe CRS or is not responding to the usual treatments for mild to moderate CRS. Requests for use in scenarios other than severe CRS should include the clinical information necessary to document medical necessity for an off-label case-by-case review. <u>Polyarticular Juvenile Idiopathic Arthritis (PJIA)</u>: • Documented therapeutic failure to induce remission with a TNF inhibitor (TNFi): Adalimumab (Humira), etanercept (Enbrel), or intravenous golimumab (Simponi Aria). • IL6i: Subcutaneous Tocilizumab (Actemra) or reason(s) why intravenous infusion is required. <u>Systemic Juvenile Idiopathic Arthritis (SJIA):</u> • Documentation of confirmed diagnosis of SJIA. • IL6i: subcutaneous tocilizumab (Actemra) or reason(s) why intravenous

	infusion is required.
	
	Rheumatoid Arthritis (RA):
	• Documentation of trial and failure of, or contraindication to, a minimum 3-month trial each of:
	  ○ Methotrexate, or other oral DMARD if member is unable to take methotrexate AND
	  ○ TNFi: Adalimumab (Humira), etanercept (Enbrel), subcutaneous golimumab (Simponi), or certolizumab (Cimzia) AND
	  ○ IL6i: subcutaneous tocilizumab (Actemra) or reason(s) why intravenous infusion is required.
	
	Giant Cell Arteritis (GCA):
	• Documentation regarding need for adjunctive therapy for glucocorticoid-sparing agent due to:
	  ○ Preexisting conditions where long-term treatment with glucocorticoids cannot be used, such as diabetes or osteoporosis,
	  ○ Significant glucocorticoid related side effects during treatment OR
	  ○ Relapsing disease activity requiring long-term glucocorticoid use.
	• Documentation of trial and failure of, or contraindication to:
	  ○ IL6i: subcutaneous tocilizumab (Actemra) or reason(s) why intravenous infusion is required.
	
	Clinician notes or TAR must clearly indicate why member requires vials with IV administration rather than the less invasive subcutaneous route using prefilled syringes or pens when both subcutaneous and IV administration have the same indications.

Age Restriction	CRS, PJIA, SJIA: 2 years and older RA: 18 years and older
Prescriber Restriction	PJIA, SJIA, RA: Rheumatologist CRS: Oncologist
Coverage Duration	Initial: 6 months. Renewal: 12 months thereafter, with documentation of efficacy to support positive benefit when compared to baseline.
Other Requirements & Information	Requests for off-label use: See Partnership criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing, Units
Actemra IV	J3262	Injection, Tocilizumab, 1 mg, for intravenous use	CRS: ≥30 kg, 8 mg/kg, <30 kg, 12 mg/kg for up to 4 doses total at least 8 hrs apart. PJIA: ≥30 kg, 8 mg/kg every 4 weeks, <30 kg, 10 mg/kg every 4 weeks. RA: 4 mg/kg - 8 mg/kg every 4 weeks.
Avtozma IV	Q5156	Injection, tocilizumab-anoh (avtozma), biosimilar, 1 mg	

Tofidence IV	Q5133	Injection, tocilizumab-bavi (tofidence), biosimilar, 1 mg	SJIA: ≥30 kg, 8 mg/kg every 2 weeks, <30 kg, 12 mg/kg every 2 weeks. GCA: 6 – 8 mg/kg once every 4 weeks Max dose up to 800 mg per dose or 2,400 mg per day
Tyenne IV	Q5135 *(JA modifier for IV)*	Injection, tocilizumab-aazg (tyenne), biosimilar, 1 mg	

APPROVED

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PA Criteria	Criteria Details
Covered Uses	For the treatment of spinal muscular atrophy (SMA) in adult and pediatric patients 2 years of age and older with confirmed mutation in the survival motor neuron 1 (SMN1) gene.
Exclusion Criteria	1. Prior treatment with Zolgensma™ IV or Itvisma™ IT. 2. Concurrent treatment with nusinersen (Spinraza™) or risdiplam (Evrysdi™). 3. Treatment or use for anything other than SMA.
Required Medical Information	1. Diagnosis of spinal muscular atrophy with documentation of genetic testing confirming mutation in survival motor neuron 1 (SMN1) gene. 2. Documentation that member has been evaluated for risk of serious systemic immune response and member is clinically stable in overall baseline health status (e.g., hydration and nutritional status, absence of infection, respiratory status) prior to administration of Itvisma. 3. Member must have an anti-AAV9 antibody titer below or equal to (≤) 1:50 as determined by Enzyme-Linked Immunosorbent Assay (ELISA) binding immunoassay within 90 days of planned administration. 4. Documentation supporting no indication of significant liver injury. Requests should include assessment of liver function (baseline liver function testing to include aspartate aminotransferase (AST), alanine aminotransferase (ALT), albumin, prothrombin time, partial thromboplastin time (PTT), international normalized ratio (INR), and total bilirubin). 5. Documentation that liver function (AST, ALT, total bilirubin) will be monitored following treatment with Itvisma for at least 3 months after injection, and at other times as clinically indicated. 6. Creatinine and complete blood count (including hemoglobin and platelet count) prior to administration of Itvisma and documentation that platelet counts will be monitored weekly for the first month and as clinically indicated after administration until platelet counts return to baseline. 7. Documentation that member will receive the recommended corticosteroid regimen pre- and post- Itvisma injection for a total of 30 days. 8. Documentation of at least one neuromotor assessment, performed within past 12 months with a score used to establish a clinical baseline. 9. Member must not have received this therapy previously with either Zolgensma IV or Itvisma IT. 10. 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 and older (per FDA labeling)
Prescriber Restriction	Neurologist or pediatric neurologist

Coverage Duration	Once per lifetime
Other Requirements & Information	Prescriber must attest or otherwise document member will receive prophylactic prednisolone (or glucocorticoid equivalent) one day prior to Itvisma injection and for 30 days following therapy to monitor liver function. Treatment with nusinersen (Spinraza) or risdiplam (Evrysdi) must be discontinued prior to the administration of onasemnogene abeparvovec-brve (Itvisma).

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3590	Itvsma, 4 x 10^{13} vg per mL	Each carton of Itvisma contains a single-dose vial with an extractable volume of not less than 3 mL, containing 1.2×10^{14} vg (4 x 10^{13} vg/mL)

Approved as Modified

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	• The treatment of wounds in adult and pediatric patients with recessive dystrophic epidermolysis bullosa (R-DEB). • Off-label requests for adult and pediatric patients with severe cases of dominant dystrophic epidermolysis bullosa (D-DEB) will be considered using the D-DEB specific criteria below.
Exclusion Criteria	1. Treatment or use for anything other than dystrophic epidermolysis bullosa (DEB). 2. The use of beremagene geperpavec (Vyjuvek) or birch triterpenes (Filsuvez) on the wound site intended to be treated with prademagene zamikeracel within the 3 months prior to scheduled administration of prademagene zamikeracel, or within the 24 weeks after the administration of prademagene zamikeracel (use of Vyjuvek and Filsuvez on other wound sites is permitted). 3. Current squamous cell carcinoma (SCC) in the area where prademagene zamikeracel will be administered. Note: for wounds that have a history of SCC within the prior 12 months that was excised with complete resolution, clearance for the use of prademagene zamikeracel by dermatology or oncology with confirmatory pathology is required.
Required Medical Information	<u>General requirements for all requests:</u> 1. Negative pregnancy test. 2. Hepatitis B, Hepatitis C, and Human Immunodeficiency Virus (HIV) testing. If positive, additional information may be required such as viral load, treatment status, and evidence of stable or controlled infection. 3. Attestation that the member can undergo the required immobilization and post-operative management. 4. Documentation of current medical therapies for DEB the member is using, such as beremagene geperpavec (Vyjuvek) or birch triterpenes (Filsuvez), including photographs of the specific areas where those treatments are applied and attestation that their use at the target wound(s) site will be discontinued at least 3 months prior to prademagene zamikeracel administration and for at least 24 weeks after. 5. Positive expression of the non-collagenous region 1 of the type 7 collagen protein (NC1+) in the skin, or reason why this testing cannot be performed. 6. Documentation, including photographs, of the wound location(s) where prademagene zamikeracel will be applied. <u>Requests for the treatment of R-DEB:</u> 1. Notes documenting a clinical diagnosis of R-DEB and that the member has at least one clinical feature of R-DEB (for example, blistering, wounds, scarring). 2. Genetic testing documenting two confirmed pathogenic mutations in the collagen type VII alpha 1 chain (COL7A1) gene with recessive inheritance patterns (or confirmation that parents don't have any evidence of dominant disease). a. Note: for mutations classified as variants of uncertain significance, documentation of diagnostic confirmation by additional testing, such as immunofluorescence mapping (IFM) may be required. 3. Target wound(s) meets ALL of the following, according to prescriber attestation (a, b, c, d, and e): a. Target wound(s) is clean in appearance and does not appear to be infected; AND

	b. Target wound(s) has adequate granulation tissue and vascularization; AND c. There is no current evidence or clinical suspicion of SCC identified at the target wound(s) (for wounds that have a history of SCC within the prior 12 months that was excised with complete resolution, clearance by dermatology or oncology with confirmatory pathology is required); AND d. Target wound is (i, ii, or iii): i. Chronic (present ≥ 6 months without healing) and size is ≥20cm^2; OR ii. The wound has had an inadequate response or intolerance to beremagene geperpavec (Vyjuvek); OR iii. reasons why Vyjuvek is not clinically appropriate for the wound have been provided; AND e. Prademagene zamikeracel has NOT been previously applied to the target wound(s) OR the wound meets requirements for retreatment of the same wound site specified under Other Requirements & Information. <u>Requests for the off-label treatment of severe D-DEB</u>: 1. Notes documenting a clinical diagnosis of severe D-DEB, that the member has at least one clinical feature of D-DEB (for example, blistering, wounds, scarring) and that wounds have chronicity, depth and functional impacts similar to R-DEB. 2. Genetic testing documenting one confirmed pathogenic mutation in the collagen type VII alpha 1 chain (COL7A1) gene consistent with dominant disease. a. Note: for mutations classified as variants of uncertain significance, documentation of diagnostic confirmation by additional testing, such as immunofluorescence mapping (IFM) may be required. 3. Target wound(s) meets ALL of the following, according to prescriber attestation (a, b, c, d, and e): a. Target wound(s) is clean in appearance and does not appear to be infected; AND b. Target wound(s) has adequate granulation tissue and vascularization; AND c. There is no current evidence or clinical suspicion of SCC identified at the target wound(s) (for wounds that have a history of SCC within the prior 12 months that was excised with complete resolution, clearance by dermatology or oncology with confirmatory pathology is required); AND d. Documentation that beremagene geperpavec (Vyjuvek) is either not clinically appropriate for the specific wound, or was applied at the target wound(s) for at least 6 months without adequate healing; AND e. Prademagene zamikeracel has NOT been previously applied to the target wound(s) OR the wound meets requirements for retreatment of the same wound site specified under Other Requirements & Information. 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	None

Prescriber Restriction	Dermatologist or wound care specialist with experience in the management of DEB

Coverage Duration	1 treatment per authorization

Other Requirements & Information	<u>Renewal requests R-DEB:</u> 1. Documentation of current medical therapies for DEB the member is using, such as beremagene geperpavec (Vyjuvek) or birch triterpenes (Filsuvez), including photographs of the specific areas where those treatments are applied and attestation that their use at the target wound(s) site will be discontinued at least 3 months prior to prademagene zamikeracel administration and for at least 24 weeks after. 2. Documentation, including photographs, of the wound location(s) where prademagene zamikeracel will be applied. 3. Treatment of a new wound site never previously treated with prademagene zamikeracel: a. Target wound(s) meets ALL of the following, according to prescriber attestation (i, ii, iii, and iv): i. Target wound(s) is clean in appearance and does not appear to be infected; AND ii. Target wound(s) has adequate granulation tissue and vascularization; AND iii. There is no current evidence or clinical suspicion of SCC identified at the target wound(s) (for wounds that have a history of SCC within the prior 12 months that was excised with complete resolution, clearance by dermatology or oncology with confirmatory pathology is required); AND iv. Target wound is (1, 2, or 3): 1. Chronic (present ≥ 6 months without healing) and size is ≥20cm^2; OR 2. The wound has had an inadequate response or intolerance to beremagene geperpavec (Vyjuvek); OR 3. reasons why Vyjuvek is not clinically appropriate for the wound have been provided. 4. Treatment of a wound site previously treated with prademagene zamikeracel: a. Target wound(s) meets ALL of the following, according to prescriber attestation (i, ii, iii, iv, v, vi, and vii): i. ≥24 weeks since the initial prademagene zamikeracel graft; AND ii. Documentation, including photographs, that full epithelial closure was achieved, followed by recurrence; AND iii. Documentation that the member has not developed anti-C7 antibodies following the initial prademagene zamikeracel graft; AND iv. Target wound(s) is clean in appearance and does not appear to be infected; AND v. Target wound(s) has adequate granulation tissue and vascularization; AND vi. There is no current evidence or clinical suspicion of SCC identified at the target wound(s) (for wounds that have a history of SCC within the prior 12 months that was excised with complete resolution, clearance by dermatology or oncology with confirmatory pathology is required); AND vii. Target wound is (1, 2, or 3): 1. Chronic (present ≥ 6 months without healing) and size is ≥20cm^2; OR 2. The wound has had an inadequate response or intolerance to beremagene geperpavec (Vyjuvek); OR 3. reasons why Vyjuvek is not clinically appropriate for the wound have been provided. 5. Negative pregnancy test.

	Renewal Requests D-DEB: 1. Documentation of current medical therapies for DEB the member is using, such as beremagene geperpavec (Vyjuvek) or birch triterpenes (Filsuvez), including photographs of the specific areas where those treatments are applied and attestation that their use at the target wound(s) site will be discontinued at least 3 months prior to prademagene zamikeracel administration and for at least 24 weeks after. 2. Documentation, including photographs, of the wound location(s) where prademagene zamikeracel will be applied. 3. Treatment of a new wound site never previously treated with prademagene zamikeracel: a. Target wound(s) meets ALL of the following, according to prescriber attestation (i, ii, iii, and iv): i. Target wound(s) is clean in appearance and does not appear to be infected; AND ii. Target wound(s) has adequate granulation tissue and vascularization; AND iii. There is no current evidence or clinical suspicion of SCC identified at the target wound(s) (for wounds that have a history of SCC within the prior 12 months that was excised with complete resolution, clearance by dermatology or oncology with confirmatory pathology is required); AND iv. Documentation that beremagene geperpavec (Vyjuvek) is either not clinically appropriate for the specific wound, or was applied at the target wound(s) for at least 6 months without adequate healing. 4. Treatment of a wound site previously treated with prademagene zamikeracel: a. Target wound(s) meets ALL of the following, according to prescriber attestation (i, ii, iii, iv, v, vi, and vii): i. ≥24 weeks since the initial prademagene zamikeracel graft; AND ii. Documentation, including photographs, that full epithelial closure was achieved, followed by recurrence; AND iii. Documentation that the member has not developed anti-C7 antibodies following the initial prademagene zamikeracel graft; AND iv. Target wound(s) is clean in appearance and does not appear to be infected; AND v. Target wound(s) has adequate granulation tissue and vascularization; AND vi. There is no current evidence or clinical suspicion of SCC identified at the target wound(s) (for wounds that have a history of SCC within the prior 12 months that was excised with complete resolution, clearance by dermatology or oncology with confirmatory pathology is required); AND vii. Documentation that beremagene geperpavec (Vyjuvek) is either not clinically appropriate for the specific wound, or was applied at the target wound(s) for at least 6 months without adequate healing. 5. Negative pregnancy test.

Medical Billing:

Dose limits & billing requirements, with an approved TAR:

HCPCS	Description	Dosing, Units
J3389	Topical administration, prademagene zamikeracel, per treatment	1 unit = 1 treatment (up to 12 sheets) Only 1 treatment should be approved per TAR

APPROVED

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	Per FDA approved indications included in the product labeling. CAR-T immunotherapy products included in this criteria: • Idecabtagene vicleucel (Abecma™) • Obecabtagene autoleucel (Aucatzyl™) • Lisocabtagene maraleucel (Breyanzi™) • Ciltacabtagene autoleucel (Carvykti™) • Tisagenlecleucel (Kymriah™) • Brexucabtagene autoleucel (Tecartus™) • Axicabtagene ciloleucel (Yescarta™)
Exclusion Criteria	• CAR-T will not be approved for use as first-line therapy. • Concurrent or prior treatment with another CAR-T immunotherapy. • Concurrent use with a chemotherapy regimen (excluding the necessary lymphodepleting regimen). • CNS disorders or CNS malignancy/metastasis. • Active infectious disease. • ECOG grade 4 or worse.
Required Medical Information	• Histologically confirmed diagnosis of one of the FDA approved indications for which therapy is being requested. • Clinic notes documenting history and course of illness, including response to previous therapies. • Documentation that member does not have active infection, and the recommended screenings in the package labeling, or in treatment guidelines, have been or will be performed for (including but not limited to): Hepatitis B, Hepatitis C, and HIV. • Documentation that member does not have an autoimmune disease or graft-vs-host disease requiring immunosuppression. • Documentation that member will undergo the recommended lymphodepleting regimen prior to CAR-T treatment (cyclophosphamide + fludarabine or appropriate alternative as recommended by package labeling or treatment guidelines). • Documentation that member is able to remain in the vicinity of the certified healthcare facility for at least 2 weeks post-infusion. • Member's current bone marrow, cardiac, pulmonary, liver, and renal function (all organ function must be adequate). • ECOG (Eastern Cooperative Oncology Group) performance status grade. • Policy MCUP3138 External Independent Medical Review will apply, enabling Partnership to obtain a specialist's evaluation of the case prior to both approvals and denials not meeting medical necessity.

Age Restriction	See prescriber information per drug specific approval information. For most indications, CAR-T may be approved for members aged 18 or older. Noted exception for tisagenlecleucel (Kymriah™) when used for the treatment of precursor acute lymphoblastic leukemia which is limited to members aged 25 years and younger on the date of the infusion (date of service), not previously treated with any gene therapy.
Prescriber Restriction	Prescribed by a hematologist or oncologist
Coverage Duration	A 3-month treatment window on the authorization but limited to 1 dose only per lifetime.
Other Requirements & Information	Additional required information per FDA-approved indication, at time of publication. **<u>Multiple myeloma, relapsed or refractory:</u>** FDA-approved CAR-T therapies with this indication**: Abecma™, Carvykti™.** Additional information required with request: • For **Abecma™**: Documentation of treatment failure (either due to intolerable adverse reaction or lack of efficacy) with ≥2 prior lines of therapy, with at least one from each mechanism of action group listed below: a) An anti-CD38 monoclonal antibody: daratumumab (Darzalex™), daratumumab-hyaluronidase (Darzalex Faspro™), or isatuximab (Sarclisa™) b) A proteasome inhibitor: bortezomib (Velcade™), carfilzomib (Kyprolis), or ixazomib (Ninlaro™) c) An immunomodulatory agent: lenalidomide (Revlimid™), thalidomide (Thalomid™, accepted off-label use), or pomalidomide (Pomalyst™) • For **Carvykti™**: Documentation of treatment failure (due to either intolerable adverse reaction or lack of efficacy) with ≥1 prior line of therapy that includes a proteasome inhibitor and an immunomodulatory agent and are refractory to lenalidomide. **<u>Large B-cell lymphoma, relapsed or refractory:</u>** FDA-approved CAR-T therapies with this indication: **Breyanzi™, Kymriah™, Yescarta™.** Additional information required with request: For all: • A confirmed diagnosis of large B-cell lymphoma, including ANY of the following types: ▪ Diffuse large B-cell lymphoma (DLBCL) not otherwise specified (including DLBCL arising from follicular lymphoma or transformed follicular lymphoma-TFL) ▪ Primary mediastinal large B-cell lymphoma ▪ High-grade B-cell lymphoma ▪ Limitations of use: Not indicated for treatment of primary CNS lymphoma. For **Breyanzi™** or **Yescarta™**: • Documentation of treatment of large B-cell lymphoma in adults that is refractory to first-line chemoimmunotherapy or that relapses within 12 months of first-line chemoimmunotherapy OR, • Member has relapsed or refractory disease after two or more lines of systemic therapy OR, • For **Breyanzi™** only: Member is refractory to first-line chemoimmunotherapy or relapses after first-line chemoimmunotherapy and is not eligible for

	hematopoietic stem cell transplantation (HSCT) due to comorbidity or age. For **Kymriah™**: • Documentation of treatment of relapsed or refractory large B-cell lymphoma in adults after two or more lines of systemic therapy. **Follicular lymphoma, relapsed or refractory:** FDA-approved CAR-T therapies with this indication: **Breyanzi™, Kymriah™, Yescarta™.** • Documentation of treatment of relapsed or refractory follicular lymphoma in adults after two or more lines of systemic therapy. **Acute lymphoblastic leukemia (ALL), B-cell precursor, relapsed or refractory:** FDA-approved CAR-T therapies with this indication for children and young adults up to 25 years of age: **Kymriah™**. FDA-approved CAR-T therapies with this indication for adults 18 years and older: **Tecartus™, Aucatzyl™**: For **Kymriah™**: • Documentation of treatment of relapsed or refractory B-cell precursor ALL for member up to 25 years of age. • Member has a confirmed diagnosis of B-cell precursor ALL and the member's condition meets ONE of the additional criteria, as specified below in either item 1 or item 2: 1. Second or later relapse B-cell precursor ALL after failing at least two lines of adequate treatment (with relapse defined as the reappearance of leukemia cells in the bone marrow or peripheral blood after complete remission with chemotherapy and/or allogeneic cell transplant) OR 2. Refractory B-cell precursor ALL with refractory defined as failure to obtain complete response with induction therapy (with second or later bone marrow relapse, bone marrow relapse after allogeneic stem cell transplant, or primary refractory or chemorefractory after relapse). • Members with Ph+ ALL require documentation of failure of 2 tyrosine kinase inhibitors (e.g., imatinib, dasatinib, nilotinib, bosutinib, ponatinib) at up to maximally indicated doses is required, unless contraindicated or clinically significant adverse effects are experienced, PHC prior authorization may be required for tyrosine kinase inhibitors. For **Tecartus™ and Aucatzyl™:** • Documentation of treatment of relapsed or refractory B-cell precursor ALL for member ≥18 years of age. • Members with Ph+ ALL require documentation of failure of tyrosine kinase inhibitors (e.g., imatinib, dasatinib, nilotinib, bosutinib, ponatinib) at up to maximally indicated doses is required, unless contraindicated or clinically significant adverse effects are experienced, PHC prior authorization may be required for tyrosine kinase inhibitors. **Chronic lymphocytic leukemia (CLL), or small lymphocytic lymphoma, relapsed or refractory:** FDA-approved therapies with this indication: **Breyanzi™**. • Documentation of treatment of relapsed or refractory chronic lymphocytic leukemia or small lymphocytic lymphoma after two or more lines of systemic therapy including a Bruton tyrosine kinase (BTK) inhibitor and a B-cell lymphoma 2 (BCL-2) inhibitor (Venetoclax-based regimen per NCCN guidelines).

Mantle cell lymphoma, relapsed or refractory:
FDA-approved CAR-T therapies with this indication: **Breyanzi™**, **Tecartus™.**

- Documentation of treatment of relapsed or refractory mantle cell lymphoma (MCL) in adults after 2 or more lines of systemic therapy, including a Burton tyrosine kinase (BTK) inhibitor.

Marginal Zone Lymphoma (MZL), relapsed or refractory:
FDA-approved CAR-T therapies with this indication: **Breyanzi™**

- Documentation of treatment of relapsed or refractory marginal zone lymphoma in adults after 2 or more lines of systemic therapy.

Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.*

Medical Billing:
Dose limits & billing requirements, with an approved TAR:

Product	HCPCS	Description	Dosing
Abecma™	Q2055	Idecabtagene vicleucel, up to 460 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	300 to 460 x 10^6 CAR-T cells, not to exceed the maximum dose of 460 million cells (may be provided in one or more IV bags)
Aucatzyl™	Q2058	Obecabtagene autoleucel, 10 up to 400 million cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per infusion	410 × 106 CD19 chimeric antigen receptor (CAR)–positive viable T cells administered as a split dose infusion on day 1 and day 10 (±2 days).
Breyanzi™	Q2054	Lisocabtagene maraleucel, up to 110 million autologous anti-cd19 car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	50 to 110 x 10^6 CAR-T cells, not to exceed the maximum dose of 110 million CAR-T cells (may be provided in one or more IV bags).
Carvykti™	Q2056	Ciltacabtagene autoleucel, up to 100 million autologous b-cell maturation antigen (bcma) directed car-positive t cells, including leukapheresis and dose preparation procedures, per therapeutic dose.	0.5-1.0 x 10^6 CAR-T cells per kg of body weight, not to exceed the maximum dose of up 100 million CAR-T cells (provided in a single IV bag).
Kymriah™	Q2042	Tisagenlecleucel, up to 600 million car-positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Recommended dose varies per indication with range: 0.1 to 6 x 10^8 CAR-T cells, not to exceed maximum dose of 600 million CAR-T cells (provided in single IV bag).
Tecartus™	Q2053	Brexucabtagene autoleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	Recommended dose varies per indication with range: 1 to 2 x 10^6 CAR-T cells, not to exceed maximum dose of 200 million CAR-T cells (provided in single IV bag).

Yescarta™	Q2041	Axicabtagene ciloleucel, up to 200 million autologous anti-cd19 car positive viable t cells, including leukapheresis and dose preparation procedures, per therapeutic dose	2 x 10^6 CAR-T cells, not to exceed maximum dose of 200 million CAR-T cells (provided in single IV bag).

PARTNERSHIP HEALTHPLAN OF CALIFORNIA MEETING SUMMARY
(Confidential – Protected by CA. Evidence Code 1157)

Committee:	Credentials Committee
Date:	12/10/2025 7:00 AM
Members Present: by phone conference*	David Gorchoff, MD*; Michele Herman, MD; Bradley Sandler, MD* ; Brian Montenegro, MD
PHC Staff: by phone conference*	Mark Netherda, MD* Medical Director Quality Improvement; Marshall Kubota, 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; 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. a. Voting member reminder.	I. Partnership Medical Director Quality Improvement Mark Netherda, MD called the meeting to order at 7:00AM. Credentials Committee roll call taken by J'aime Seale Credentialing Team Lead. Dr. Netherda reminded everyone that all items discussed are confidential. a. Partnership Medical Director Quality Improvement Mark Netherda, MD, reminded The Credentials Committee of who the voting members are, and voting is restricted to non-PHC staff. Dr. Netherda reminded the committee that all information discussed is confidential in nature.			
II. Review and approval of 11/12/2025 Credentials Meeting Summary.	II. The Credentials Committee meeting Summary for 11/12/2025 was reviewed by the Committee.	II. Summary was reviewed. A motion for approval of the Summary was made by Michele Herman, MD and seconded by David Gorchoff, MD. Meeting Summary was unanimously approved without changes.		12/10/2025
III. Old Business. a. Update on Provider	III. Old Business – a. On 11/12/2025 the Credentials Committee originally reviewed the information presented for the provider. The information reviewed by the Credentials Committee involved sanctions by the Nevada Pharmacy Board. The Nevada Pharmacy Board found the provider submitted 690 controlled substance prescriptions (one every two days estimated) from 3/18/2018-1/12/2022 without checking the Nevada PMP account. Checking the PMP every six months is a requirement of the Nevada	III. Old Business a. The provider's updated information was reviewed. A motion for approval of routine re-credentialing was made by David Gorchoff, MD and seconded by Michele Herman, MD. Unanimously approved without changes.		12/10/2025

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	Pharmacy board. The provider's Nevada Pharmacy board certification was revoked. They were fined $10,000 for violations and $544.55 in attorney fees. A letter from the provider's supervising physician was requested but was not received by the 11/12/2025 Credentials Meeting. The Credentials Committee voted to defer further discussion of provider until the 12/10/2025 Credentials Meeting pending Supervising Physician Letter and proof the provider fully paid the fines implemented by the Nevada Pharmacy Board. On 11/18/2025, Partnership received a letter from the provider's Supervising Physician along with proof of payment of fines from Nevada Office of the State Controller. This information was presented to the Credentials Committee to review. Approval of routine re-credentialing was recommended by Partnership staff.			
b. Update on Provider	b. On 11/12/2025 the Credentials Committee originally reviewed the information presented for the provider. The information reviewed by the Credentials Committee involved a felony conviction for willfully submitting a false income tax return. Medical Board of California revoked and stated the providers' license while they served time along with Probation for seven years thereafter. The Credentials Committee voted to defer further discussion of the provider's sanctions, specifically to further research the timeline of events, confirm Medicare/Medi-cal status and updated statement from the provider. Dr. Netherda presented to the Credentials Committee information requested regarding the providers Medicare and Medi-Cal. Confirmation the provider is currently enrolled with Medical and Medi-Cal. No Medicare & Ineligible List or OIG (Office Inspector General) findings were found. An email from the provider was also presented showing that no charges were brought against the provider. Partnership staff recommended approval of credentialing.	b. The provider's updated information was reviewed. A motion for approval of credentialing was made by Bradley Sandler, MD and seconded by Michele Herman, MD. Unanimously approved without changes.		12/10/2025

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
IV. New Business	IV. New Business	IV. New Business		
a. Review and Approval of Routine Practitioner List.	a. Dr. Netherda referred to the Credentials Committee to review the routine list of practitioners.	a. The Committee reviewed the list of practitioners**.** A motion to approve the list of practitioners was made by Michele Herman, MD and seconded by David Gorchoff, MD. The Committee unanimously approved the routine list.		12/10/2025
b. MPCR200 Clean/Routine Practitioners and Ancillary Practitioners	b. Dr. Netherda referred to 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 list practitioners was made by Michele Herman, MD and seconded by Brian Montenegro, MD. The Committee unanimously approved the MPCR200 Clean/Routine and Ancillary Practitioners list.		12/10/2025
c. CR5 Semi-Annual Evaluation of Practitioner Specific Complaints. *Information Only*	c. Dr. Netherda referred the Credentials Committee to CR5 Semi-Annual Evaluation of Practitioner Specific Member Complaints for the period of July 1, 2025 through September 30, 2025 (3 months). Summary of Findings: Number of Complaints from Perform Quality Improvement (PQI) is 33. Number of Complaints from Grievance and Appeals (G&A) 53. Per Dr. Netherda's review there were a total of 15 practitioners involved with a total of 32 complaints. No trend or significant clinical or service issues were identified. As a result, no further action is needed at this time. *Information Only*	d. *Information Only*		12/10/2025
V. Ongoing Monitoring of Sanctions and Exclusions Report and Practitioner Monitoring List.	V. Ongoing Monitoring of Sanctions and Exclusions Report and Practitioner Monitoring List.	V. Ongoing Monitoring of Sanctions and Exclusions Report and Practitioner Monitoring List.		
a. Review and Approval of Ongoing Monitoring of Sanctions and Exclusions Report.	a. Review and Approval of Ongoing Monitoring of Sanctions and Exclusions Report. The Credentials Committee was asked to review and approve the Ongoing Monitoring of Sanctions Report and Exclusions.	a. The Credentials Committee members reviewed the report. A motion for approval of the Ongoing Monitoring of Sanctions and Exclusions Report was made by David Gorchoff, MD and seconded by Michele Herman, MD.		12/10/2025

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
b. Practitioner Monitoring List. *Information Only*	b. The Credentials Committee was asked to review the Practitioner Monitoring list. Dr. Netherda reminded the committee that the credentialing department monitors these boards for any actions regarding our providers. *Information Only.*	The Committee unanimously approved. b. *Information only*.		12/10/2025
VI. Review and Approval of Consent Calendar Items. a. Report of Long Term Care Facility, Hospital, and Ancillary provider list.	VI. Review and Approval of Consent Calendar Items. a. Dr. Netherda asked the Credentials Committee members to review the report of Long-Term Care Facility, Hospital, and Ancillary provider list.	VI. Review and Approval of Consent Calendar Items. a. The Credentials Committee members reviewed the list of Consent Calendar Items. A motion for approval was made by Bradley Sandler, MD and seconded by Michele Herman, MD. The Credentialing Committee unanimously approved.		12/10/2025
VII. Meeting Adjourned.	VII. Meeting adjourned.			

Credentials Meeting Summary for 12/10/2025 respectfully prepared and submitted by J'aime Seale, Credentialing Lead.

Chairman Signature of Approval _____ ***Date*** ***12/10/2025***_____

Mark Netherda, M.D., PHC Credentialing Chairman

December 2025
Routine Practitioner List

App. Type	Full Name	NPI Number	Provider Type C	Name/Street	County Nam	Specialty Desc	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Ca
I	Akines, Vanessa C.,FNP-C	1790417434	PCP	West County Health Center	Sonoma	Family Nurse P	American Acad	12/31/2021	Yes		
I	Almirol, Jenna S.,BCBA	1487143822	BHP	California Sprout MC 1 LLC	Napa	BCBA	Behavior Analy	02/28/2018	Yes		
I	Amador Nunez, Miriam BCBA	1043713035	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analy	10/19/2021	Yes		
R	Aronson, Erica R.,MD	1033431549	SPEC	Solano Dermatology Assoc	Napa	Dermatology	ABMS of Derm	07/25/2013	Yes	Providence Qu	Consulti
I	Arostegui, Giulia S.,FNP-BC	1508631912	PCP	One Community Health - In	Yolo	Family Nurse P	American Nurs	08/13/2025	Yes		
I	Arrivillaga, Adrian AMFT	1871231068	W&R	Family Spring Psychology	Solano	Wellness and F	None		No		
I	Astin, Holly MD	1245974302	PCP	Adventist Health Ukiah Vall	Mendocino	Family Medicin	ABMS of Famil	09/15/2025	Yes	Adventist - Uki	Provisio
I	Balmorez, Kimberly FNP-BC	1457167256	PCP	Santa Rosa Community He	Sonoma	Family Nurse P	American Nurs	10/18/2025	Yes		
I	Baugh, Charles M.,MD	1477133445	SPEC	Adventist Health Ukiah Vall	Mendocino	Sports Medicin	ABMS of Famil	07/10/2025	Yes	Adventist - How	Provisio
I	Benn, Jamila M.,MD	1477564946	PCP	Santa Rosa Community He	Sonoma	Family Medicin	ABMS of Famil	07/22/2006	Yes	Admitting Agre	Active
R	Bennett, Patrick M.,MD	1891713418	SPEC	Marin Community Clinic: La	Marin	Urology	ABMS of Urolo	02/28/1998	Yes	Marin Health M	Active
R	Borchert, Sherry D.,PharmD	1194886481	SPEC	Anderson RX, Inc	Shasta	Pharmacy	None		No		
I	Brahen, Joshua PA-C	1740604495	BOTH	Tahoe Forest MultiSpecialty	Nevada	Physician Assis	National Comm	08/22/2013	Yes		
I	Buchloh, Grace CNM	1104502863	SPEC	Enloe Women's Services (S	Butte	Obstetrics and	None		No		
I	Byrne, Lisa BCBA	1952655987	BHP	Positive Behavior Supports	Yolo	BCABA	Behavior Analy	09/30/2012	Yes		
I	Cabral, Erik S.,MD	1023252350	SPEC	Yuba City Dermatology & S	Sutter	Dermatology	ABMS of Derm	07/25/2013	Yes	Admitting Agre	None
I	Camp, Patricia CADC CAS	1467955617	W&R	Archway Recovery Services	Solano	Wellness and F	California Cons	06/27/2016	Yes		
R	Carter-Runyon, Lori K.,SUDCC III	1194969113	Allied	Hilltop Recovery Services -	Lake	Wellness and F	California Subs	07/06/2025	Yes		
I	Castillo, Nicole BCBA	1396281721	BHP	Montera Health California, L	Yolo	BCBA	Behavior Analy	02/10/2023	Yes		
R	Chan, Theron H.,MD	1952385833	PCP	Adventist Health Ukiah Vall	Mendocino	Family Medicin	ABMS of Famil	08/27/1978	Yes	Adventist - Uki	Active
R	Chinnock, Andrew K.,FNP-C	1174844674	PCP	Adventist Health Clearlake	Lake	Family Nurse P	American Nurs	10/28/2009	Yes		
I	Christian, Amanda M.,CNM	1972891273	SPEC	NBHG: Center for Women's	Solano	Certified Nurse	American Midw	02/01/2011	Yes		
I	Clements, Jan AGNP-C	1124449285	PCP	ReSolution Care, PC	Solano	Adult-Gerontol	American Acad	12/27/2013	Yes		
I	Cordova, Martina S.,FNP-C	1114793643	PCP	Providence Medical Group,	Sonoma	Family Nurse P	American Acad	09/29/2023	Yes		
R	Crabtree, Karen E.,MD	1629276472	SPEC	Mendocino Community Hea	Mendocino	Obstetrics and	ABMS of Obste	11/13/1993	Yes	Ukiah Valley M	Active
I	Crowell, Travis W.,FNP-C	1467349977	PCP	Lassen Medical Clinic - Cot	Shasta	Family Nurse P	American Acad	06/05/2025	Yes		
R	Dandekar, Jessica BCBA	1275051468	BHP	Kyo Autism Therapy, LLC	Solano	Behavioral Hea	Behavior Analy	08/31/2019	Yes		
R	Davis, Rikki I.,SUDRC	1336863158	W&R	Hilltop Recovery Services -	Lake	Wellness and F	California Subs	05/05/2025	Yes		
I	DeFreitas, Sarah E.,PA-C	1801288972	SPEC	Jiva Health, Inc- Redding	Shasta	Physician Assis	National Comm	12/26/2014	Yes		
I	Dhaliwal, Jaspreet BCBA	1497343115	BHP	Maxim Healthcare Services	Solano	BCBA	Behavior Analy	08/05/2025	Yes		
I	Dunston, Aphrael G.,FNP-C	1477346575	PCP	Adventist Health Ukiah Vall	Mendocino	Family Nurse P	American Acad	06/19/2025	Yes		
I	Duro, Teodor MD	1780180315	SPEC	NorthBay Health Endocrinol	Solano	Endocrinology,	ABMS of Intern	10/24/2023	Yes	Admitting Agre	None
I	Edegbe, Nicole FNP-BC	1336030691	PCP	Harmony Health Medical Cl	Yuba	Family Nurse P	American Nurs	10/20/2024	Yes		
I	Edwards, Shaun R.,AGNP-C	1679957609	PCP	Open Door Community Hea	Del Norte	Adult-Gerontol	American Acad	06/24/2015	Yes		
R	Equi, Robert A.,MD	1497864664	SPEC	Retinal Consultants Medica	Yolo	Ophthalmology	ABMS of Ophth	05/16/2004	Yes	Mercy General	Active
I	Ervin, Victoria FNP-C	1316495666	PCP	Santa Rosa Community He	Sonoma	Family Nurse P	American Acad	06/27/2016	Yes		
I	Fernwood, Elizabeth V.,FNP-BC	1023883527	PCP	Santa Rosa Community He	Sonoma	Family Nurse P	American Nurs	08/13/2025	Yes		
I	Figaniak, Amanda SUDRC	1174406433	W&R	MedMark Treatment Center	Solano	Substance Use	California Subs	06/20/2025	Yes		
I	Fischbein, Pamela J.,BCBA	1538555453	BHP	California Sprout MC 1 LLC	Napa	BCBA	Behavior Analy	02/28/2015	Yes		
I	Flores, Yesenia BCBA	1740504828	BHP	California Sprout MC 1 LLC	Napa	BCBA	Behavior Analy	01/31/2011	Yes		
I	Fowler, Vickie L.,ANP-C	1952625881	PCP	Open Door Community Hea	Humboldt	Adult Nurse Pr	American Acad	10/24/2012	Yes		
I	Galligan, Megan BCBA	1336655778	BHP	California Sprout MC 1 LLC	Napa	BCBA	Behavior Analy	02/28/2018	Yes		
R	Garcia, Mario M.,PA-C	1184274615	PCP	Petaluma Health Center	Sonoma	Physician Assis	National Comm	09/05/2019	Yes		
I	Gill, Parmpreet PA-C	1750932844	SPEC	Pacific Skin Institute	Yolo	Physician Assis	National Comm	09/04/2020			
R	Gladney, Elizabeth M.,AGACNP-B	1376109033	SPEC	NBHG: Neurology	Solano	Adult-Gerontol	American Nurs	03/05/2019	Yes		
I	Goodman, Angel Doula	1164210324	SPEC	No'os Doula Services	Humboldt	Doula	None		No		
I	Grapel, Cynthia Doula	1245112796	SPEC	Loula Perinatal Health Serv	Solano	Doula	None		No		
I	Green, Akiba E.,DO	1144422056	SPEC	Adventist Health Physicians	Sutter	Obstetrics and	AOB of Obstetr	10/17/2009	Yes	Admitting Agre	None
I	Green, Teresa Doula	1285472605	SPEC	Loula Perinatal Health Serv	Solano	Doula					

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Routine Practitioner List

App. Type	Full Name	NPI Number	Provider Type C	Name/Street	County Nam	Specialty Desc	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Ca
I	Guenther, Timothy M.,MD	1003261892	SPEC	NBHG: Heart and Vascular	Solano	Thoracic Surge	None		No	NorthBay Medi	Provisio
I	Gupta, Arika MD	1831171735	SPEC	Sierra Nevada Specialty Ca	Nevada	Nephrology	ABMS of Intern	11/05/2003	Yes	Admitting Agre	None
I	Hankins, Ashleigh BCBA	1811486822	BHP	Kyo Autism Therapy LLC, fk	Marin	BCBA	Behavior Analy	01/31/2021	Yes		
I	Hansen, Mette V.,MD	1063445682	SPEC	North Coast Physical Medic	Sonoma	Physical Medic	ABMS of Physi	07/01/2022	Yes	Admitting Agre	Active
I	Harleman, Anna RD	1053435610	Allied	Sonoma Valley Community	Sonoma	Registered Die	Commission of	12/21/2003	Yes		
I	Harris, Peter J.,MD	1134563109	SPEC	Western Sierra Medical Clir	Nevada	Pediatrics	ABMS of Pedia	10/20/2016	Yes	Admitting Agre	None
I	Heath, Hobart B.,DO	1104352210	SPEC	Vohra Wound Physicians of	Solano	Family Medicin	AOB of Family	07/01/2020	Yes	Admitting Agre	Active
R	Heichman, Sharon L.,MD	1316443757	SPEC	Fairchild Medical Clinic Spe	Siskiyou	Obstetrics and	ABMS of Obste	10/27/2023	Yes	Fairchild Medic	Active
R	Herbert, Heather A.,SUDRC	1386360782	Allied	Hilltop Recovery Services -	Lake	Wellness and F	California Subs	09/30/2025	Yes		
I	Herbert, Sheldon A.,MD	1700407871	PCP	UIHS - Potawot Health Villa	Humboldt	Family Medicin	ABMS of Famil	09/28/2023	Yes	Admitting Agre	None
I	Hilton, Kelley F.,PA-C	1780014175	SPEC	Providence Medical Group,	Sonoma	Physician Assis	National Comm	05/27/2021	Yes		
I	Hirschfield, Kristine M.,MD	1780670091	SPEC	Yuba City Dermatology & S	Sutter	Dermatology	None		No	Admitting Agre	None
I	Hooper, Joanna J.,MD	1275780140	PCP	UIHS - Potawot Health Villa	Humboldt	Family Medicin	ABMS of Famil	11/17/2011	Yes	Admitting Agre	None
I	Iqbal, Wurda BCBA	1356862312	BHP	Roman Empire ABA Service	Solano	BCBA	Behavior Analy	08/12/2020	Yes		
I	Jansen, Corinne N.,MD	1679065817	SPEC	Bay Area Surgical Specialis	Solano	Obstetrics and	ABMS of Obste	10/27/2023	Yes	Admitting Agre	None
I	Jensen, Brianna BCBA	1700488590	BHP	Autism Learning Partners	Humboldt	BCBA	Behavior Analy	08/08/2025	Yes		
I	Johnson, Trisha CADC II	1568279198	W&R	Shasta County Alcohol and	Shasta	CADC II	California Cons	06/16/2025	Yes		
I	Jolly, Nichole K.,FNP-C	1467340570	PCP	Adventist Health	Butte	Family Nurse P	American Acad	06/12/2025	Yes		
I	Jones-Valenti, Merissa A.,AGPCN	1649978412	PCP	Telehealth Specialty Medica	Yolo	Adult-Gerontol	American Nurs	11/13/2015	Yes		
R	Kamras, Samantha A.,MD	1982861746	PCP	Marin Community Clinic: Sa	Marin	Pediatrics	ABMS of Pedia	10/12/2009	Yes	Marin Health M	Active
R	Kohli, Amitpal MD	1215151071	SPEC	Telehealth Specialty Medica	Yolo	Endocrinology,	ABMS of Intern	11/18/2010	Yes	Admitting Agre	None
R	Kulkarni, Vedant A.,MD	1023273604	SPEC	Shriners Hospitals for Child	Yolo	Orthopaedic Su	ABMS of Ortho	07/24/2014	Yes	Shriners Hospit	Active
R	La Rocca, Ann C.,NP	1306149240	PCP	Adventist Health Clearlake -	Lake	Nurse Practitio	None		No		
I	Lakshman, Sneha MD	1811472400	SPEC	Nagarathna G. Manjappa M	Napa	Nephrology	None		No	Providence Qu	Provisio
I	Lanouette, Gregory W.,MD	1710974365	SPEC	Tahoe Forest MultiSpecialty	Nevada	Urology	ABMS of Urolo	02/19/1989	Yes	Tahoe Forest H	Provisio
I	Laubach, Tyler A.,DO	1285201186	PCP	Adventist Health Ukiah Vall	Mendocino	Family Medicin	ABMS of Famil	07/01/2024	Yes	Adventist - Uki	Provisio
I	Lawton, Susan MD	1659390110	PCP	Mendocino Community Hea	Mendocino	Family Medicin	ABMS of Famil	07/12/1991	Yes	Admitting Agre	None
R	Leach, Joshua P.,DC	1104265131	SPEC	Shingletown Medical Cente	Shasta	Chiropractic	None		No		
I	Leschke, Tykeshia Doula	1063800092	SPEC	Mama Humboldt Birth Servi	Humboldt	Doula	None		No		
R	Levy, Gregory P.,PharmD	1467940643	SPEC	Lark Drugs Pharmacy	Sonoma	Pharmacy	None		No		
I	Loudon, Alexis A.,FNP-C	1700666138	PCP	Adventist Health Mendocino	Mendocino	Family Nurse P	American Acad	08/10/2023	Yes		
I	Love, Shayanna Doula	1093553661	SPEC	Shayanna Love	Alameda	Doula	None		Not Applicable		
R	Lucas, Jennifer B.,MD	1619078979	SPEC	Marin Cancer Care Inc.	Marin	Medical Oncolo	ABMS of Intern	11/08/2000	Yes	Marin General	Active
I	Magyar, Allison M.,FNP-BC	1073405213	PCP	Santa Rosa Community He	Sonoma	Family Nurse P	American Nurs	02/04/2025	Yes		
R	Majeski, Michael M.,PharmD	1912431461	SPEC	Sebastopol Family Pharma	Sonoma	Pharmacy	None		No		
I	Massatt, Sarah E., MD	1164878351	PCP	SCHC: Shasta Community	Shasta	Family Medicin	ABMS of Famil	07/01/2019	Yes	Admitting Agre	None
I	Medina, Celia BCBA	1639672538	BHP	Autism Learning Partners	Yolo	BCBA	Behavior Analy	06/13/2020	Yes		
I	Miller, Clifton CADC II	1710868971	W&R	Recover Medical Group	Solano	Wellness and F	California Cons	06/25/2021	Yes		
R	Mockus, Mary B.,MD	1134203128	SPEC	Marin Community Clinic	Marin	General Surger	Previously Boa	09/21/1994	No	Admitting Agre	None
I	Montes, Monica BCBA	1568017044	BHP	Positive Behavior Supports	Yolo	BCBA	Behavior Analy	10/16/2025	Yes		
I	Munguia, Danny E.,LCSW	1598831042	BHP	Enloe Health and Wellness	Butte	Licensed Clinic	None		No		
I	Narayanan, Meena R.,MD	1508170697	PCP	Heart and Vascular Centers	Sacramento	Internal Medici	Meets MPCR#	08/12/2011	Yes	Admitting Agre	None
I	Naval, Roni-Jo P.,FNP-C	1134987688	SPEC	NBHG: NorthBay Healthcar	Solano	Family Nurse P	American Acad	02/20/2024	Yes		
I	Newman, Phillip AGPCNP-BC	1427579895	SPEC	Tahoe Forest MultiSpecialty	Nevada	Adult-Gerontol	American Nurs	07/26/2017	Yes		
I	Oakley, Samantha RD	1437730298	Allied	My Diabetes Tutor	Kings	Registered Die	Commission of	01/19/2021	Yes		
I	Oates, Carmen M., Doula	1083390074	SPEC	Malama Medical Group (CA	Solano	Doula	None		No		
I	Ofili, Rosemary N.,FNP-C	1790157709	PCP	Lassen Indian Health Cente	Lassen	Family Nurse P	American Acad	07/08/2015	Yes		
I	Okere, Emilia FNP-C	1760983886	PCP	Adventist Health Clearlake	Lake	Family Nurse P	American Acad	11/27/2017	Yes		
I	Patel, Maulik Mafatla MD	1295940278	SPEC	Providence Medical Group,	Humboldt	Interventional C	ABMS of Intern	11/05/2012	Yes	Admitting Agre	Active

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Routine Practitioner List

App. Type	Full Name	NPI Number	Provider Type C	Name/Street	County Nam	Specialty Desc	Board Name	Initial Cert Date	Board Certi	Hospital Name	Staff Ca
I	Patel, Dharuviben BCBA	1144987652	BHP	Burnett Therapeutic Service	Napa	BCBA	Behavior Analy	10/08/2025	Yes		
I	Pena, Elizabeth DO	1477809846	SPEC	Telehealth Specialty Medica	Yolo	Physical Medic	ABMS of Physi	07/01/2019	Yes	Admitting Agre	None
I	Peyton, Melissa L.,FNP-C	1679315295	PCP	NBHG: Center for Primary (	Solano	Family Nurse P	American Acad	09/23/2024	Yes		
I	Pierson, Allison E.,FNP-BC	1922806157	PCP	West County Health Center	Sonoma	Family Nurse P	American Nurs	02/26/2025	Yes		
I	Powell, Ermal G.,LAc	1962226274	Allied	Petaluma Health Center, In	Marin	Acupuncture					
R	Powelson, Ian A.,MD	1053739185	SPEC	Shriners Hospitals for Childı	Yolo	Plastic Surgery	ABMS of Plasti	11/16/2024	Yes	Shriners Hospit	Consulti
I	Price, Stacy A.,CATC II	1831841774	W&R	Drug Abuse Alternative Cen	Sonoma	Wellness and F	Addiction Coun	10/04/2023	Yes		
I	Rah, Jasmine Y.,MD	1902485089	SPEC	Enloe Women's Services (E	Butte	Obstetrics and	Meets MPCR #		No	Admitting Agre	None
I	Ramirez, Crystal N.,SUDRC	1205717451	W&R	Ujima Family Recovery Ser	Solano	Wellness and F	California Subs	05/28/2025	Yes		
I	Ramos-Pamplona, Gabriela FNP-(	1164070371	PCP	NBHG: Center for Primary (	Napa	Family Nurse P	American Acad	08/13/2019	Yes		
R	Ransom, Kyle E.,DO	1013404318	PCP	Santa Rosa Community He	Sonoma	Family Medicin	ABMS of Intern	11/13/2021	Yes	Admitting Agre	None
I	Ray, Katie L.,MD	1578875886	PCP	Open Door Community Hea	Humboldt	Family Medicin	ABMS of Famil	07/01/2013	Yes	Admitting Agre	None
I	Reed Temes, Melissa BCBA	1730638149	BHP	Autism Advocacy and Interv	Lake	BCBA	Behavior Analy	08/31/2016	Yes		
I	Rezapour, Alireza MD	1043370224	PCP	NBHG: Center for Primary (	Solano	Internal Medicir	Meets MPCR #		No	Admitting Agre	None
R	Ribordy, Jeffrey T.,MD	1467458380	PCP	UIHS - Potawot Health Villa	Humboldt	Pediatrics	ABMS of Pedia	10/28/1998	Yes	Admitting Agre	None
I	Roberts, Bryan BCBA	1144837337	BHP	California Sprout MC 1 LLC	Napa	BCBA	Behavior Analy	12/05/2022	Yes		
R	Roberts, Daylen C.,LCSW	1699102004	SPEC	Hilltop Recovery Services -	Lake	Licensed Clinic	None		Yes		
R	Robinson, Michael F.,MD	1174634513	SPEC	Consolidated Tribal Health I	Mendocino	Endocrinology	None		No	Admitting Agre	None
I	Robles, Natalie M.,PA-C	1902261522	SPEC	NorthBay Health Urgent Ca	Solano	Physician Assis	National Comm	12/03/2015	Yes		
I	Rubio, Lea K., FNP	1780478024	SPEC	Jiva Health Inc - Concord	Concord	Family Nurse P	American Acad	02/24/2025	Yes	None	
I	Sackfield, Bradley C.,MD	1851920409	SPEC	Interventional Radiation On	Solano	Medical Oncolc	Meets MPCR #			Mercy Medical	Active
I	Samuelson, Eric E.,FNP-C	1003608498	PCP	Sacramento Community Cli	Placer	Family Nurse P	American Acad	07/30/2025	Yes		
R	Santos, Andrea G.,NP	1265830871	SPEC	Shriners Hospitals for Childı	Yolo	Nurse Practitio	None		No		
R	Sekeres, Jade L.,NP	1487208252	PCP	McCloud Healthcare Clinic	Siskiyou	Nurse Practitio	None		No		
I	Sharma, Julia D.,MD	1528579810	SPEC	Shriners Hospitals for Childı	Yolo	Neurological Su	Meets MPCR#'		No	Shriners Hospit	Consulti
R	Smith, Elizabeth P.,CNM	1497016711	SPEC	Santa Rosa Midwifery Cent	Sonoma	Certified Nurse	American Midw	01/01/1999	Yes		
I	Sorenson, Kristen BCBA	1487149951	BHP	Kyo Autism Therapy, LLC	Solano	BCBA	Behavior Analy	05/31/2018	Yes		
I	Stephenson, Joanna M.,FNP-C	1558245936	PCP	Solano County Family Healt	Solano	Family Nurse P	American Acad	07/03/2025	Yes		
I	Stone, Jennifer L.,MD	1003010307	PCP	West County Health Center	Sonoma	Family Medicin	ABMS of Famil	07/19/2007	Yes	Admitting Agre	None
I	Svidler, Frances DPM	1124761705	SPEC	Bay Area Foot Care Inc	Marin	Podiatry	Confirmed per /		No	Admitting Agre	None
I	Swenson, Rodney M.,DO	1407863913	PCP	Providence Family Practice	Humboldt	Family Medicin	Meets MPCR #	05/15/1995	Yes	Redwood Mem	Active
I	Tapia-Nuss, Rocio J.,FNP-BC	1144977893	PCP	Santa Rosa Community He	Sonoma	Family Nurse P	American Nurs	08/01/2025	Yes		
I	Taylor, Marley BCBA	1174209613	BHP	ACES 2020, LLC	Placer	Board Certified	Behavior Analy	04/17/2025	Yes		
I	Thaiyananthan, Gowriharan MD	1518164110	SPEC	NBHG: Neurosurgery and P	Solano	Neurological Su	ABMS of Neurc	11/14/2013	Yes	Admitting Agre	None
I	Thomas, Jyssica BCBA	1912583279	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analy	07/03/2025	Yes		
I	Thompson, Darren R.,DO	1942513734	PCP	Ampla Health North Chico M	Butte	Family Medicin	Meets MPCR #		No	Admitting Agre	None
R	Treadaway, Jolene M.,LCSW	1710343785	Allied	H.O.M.E Tule House	Lake	Licensed Clinic	None		No		
I	Turner, Kiana R.,Doula	1528831898	SPEC	Embodied Doula Support	Solano	Doula	None		No		
R	Vadlamudi, Gautam K.,MD	1184729212	BOTH	Vacaville Urgent Care Medi	Solano	Family Practice	Meets MPCR#'	07/10/1992	No	NorthBay Medi	Active N
R	Vinogradova, Helen L.,MD	1972695252	PCP	Elica Health Centers - North	Placer	Family Medicin	ABMS of Famil	07/10/2004	Yes	Admitting Agre	Active
I	Wehner, JesseLa Doula	1548091150	SPEC	Crowned SeLah Wellness	Solano	Doula	None		Not Applicable		
R	Whitaker, Amanda T.,MD	1700111887	SPEC	Shriners Hospitals for Childı	Yolo	Pediatric Ortho	None		No	Shriners Hospit	Consulti
R	White, Neal W.,Jr., MD	1659301216	SPEC	John Muir Cardiovascular M	Solano	Cardiovascular	ABMS of Intern	11/08/1989	Yes	John Muir Medi	Active
I	Whitman, Megan H.,MD	1134363393	PCP	Santa Rosa Community He	Sonoma	Internal Medicir	ABMS of Intern	08/06/2013	Yes	Admitting Agre	None
I	Wilson, Kisha BCBA	1073068573	BHP	Center for Social Dynamics	Solano	BCBA	Behavior Analy	06/26/2020	Yes		
I	Woldesilasse, Zeyerusalem T.,FNI	1174292767	SPEC	NorthBay Health Urgent Ca	Solano	Family Nurse P	American Acad	10/23/2020	Yes		
I	Wright, Vanessa Doula	1609684604	SPEC	Grace Doulas	Shasta	Doula	None		No		

MEETING MINUTES

Meeting Name: Pediatric Quality Committee (PQC)
Date: November 5, 2025 **Time:** 1:00 – 3:00 p.m.
Location: Partnership HealthPlan of California

Attendees:

Advising Members	
Carol Miller, MD - Marin	Rebekah Kim, DO - Yolo
James Huang, MD - UCSF	Victoria Morgese, MD - Napa
Lauren Burchfield, RN - Humboldt	

Other Members	
Alyssa Soto - Lassen	Jessica Hamon - Placer
Bré Whitley - Sierra	Jessica Johnson - Butte
Caryl Greenwood - Shasta	Katie Magliocca - Nevada
Celia Su - Colusa	Katrina Whitaker - Sutter
Charlene Weiss-Wenzl - Nevada	Linda Hunt - Modoc
Chelsea Linthicum - Sutter	Linda Singler - Shasta
DeLellis York - Butte	Lorri McKey - Colusa
Jennifer Hathaway - Siskiyou	

Partnership Members	
Armando Romo - Care Coordination	Nicole Hartigan, RN - Care Coordination
Brigid Gast, RN - Sr. Director of Care Management	Samantha Ogston, RN - Care Coordination
Doreen Crume, RN - Care Coordination	Sitara Cavanagh - Care Coordination
Jeff Ribordy, MD - Medical Director | Committee Chair	Stan Leung, Pharm.D - Pharmacy
Kelly YoungStone, RN - Care Coordination	Suzanne Trepoy Papadopoulos, RN - Care Coordination
Mohamed Jalloh, PharmD - Health Equity	Teresa Frankovich, MD - Medical Director

Agenda Topic	Minutes	Action Items
Introductions and Objective of Meeting *Speaker: Jeff Ribordy, MD*	The PQC Committee Chair commenced the meeting at 1:02 p.m. Attendance was recorded.	
Review and Approve Minutes from Last Meeting *Speaker: Jeff Ribordy, MD*	Motion to approve minutes from PQC held on August 6, 2025. Approved, no objections.	
Policy Review *Speaker: Jeff Ribordy, MD*	Partnership Policy *MCQG 1015 – Pediatric Preventive Health Guidelines* reviewed and approved with no further edits.	
Updates From the Last FAC Meeting *Speaker: Armando Romo*	The Family Advisory Committee (FAC) meeting was held on August 26, 2025. Key outcomes and updates included: • <u>Family Engagement</u> FAC Family Members shared milestones and experiences. FAC Family Members also shared challenges around specialty care access and were referred to Partnership Care Coordination (CC) for support. • <u>Whole Child Model (WCM) Transition</u> Partnership continues to provide support to transitioning members and outreaching members through health risk assessments and annual medical redetermination processes to foster member engagement. • <u>Transportation Services Benefit</u>	

	FAC Family Members were given updates on transportation benefits. Families offered feedback on their experiences, including successes and challenges using the pilot program and the mobile application. • <u>Enhanced Care Management (ECM) and Community Supports (CS)</u> Partnership presented information on ECM and CS resources. FAC Family Members noted the needs of community members who face several challenges, including behavioral health and housing issues.	
Transition Planning *Speaker: Kelly YoungStone*	Partnership Director of Care Coordination provided an update on transition planning for Whole Child Model (WCM) Members who are aging out of the program into adult care. In alignment with the Department of Health Care Services (DHCS), transition planning is a prioritized area of focus and Partnership is committed to collaborating with individual counties, as well as the Medical Therapy Units (MTU), to ensure members are prepared well in advance of the member's age-out date. Dr. Miller (Marin County) shared her experiences and challenges related to accessing adult care providers who have experience with complex pediatric conditions. Dr. Huang (UCSF) proposed a collaboration between primary and specialty care centers to ensure members' care needs are met once they transition to adult care. Rural counties have additional challenges surrounding access to primary care, particularly for WCM members who have multiple chronic and/or complex diagnoses.	
WCM Memorandum of Understanding (MOU) Update *Speaker: Brigid Gast*	Partnership Senior Director of Care Management shared an update on MOUs. Executed MOUs covering pediatric and youth programs and benefits are being received, including Local Health Department, Regional Center, and WCM MOUs. Collaboration is sought for pediatric members in local health department MOUs, including but not limited to blood lead screenings, immunizations, maternal/child/adolescent health programs, as well as programmatic and organizational referrals across MOUs. MOUs are discussed and collaborated upon in various forums including the WCM CCS Joint Operations Committee meetings, executed MOU meetings, and individual county meetings.	

	Partnership recognizes that DHCS has communicated a potential update to the MOU template. CCS Programs have communicated awaiting updates from DHCS on high-risk infant follow-up (HRIF) and neonatal intensive care unit (NICU) to incorporate into MOU drafts.	
Ad Hoc Agenda Item *Speaker: Stan Leung, PharmD*	Partnership Director of Pharmacy Services provided an update pursuant to the DHCS 6-day notice related to over-the-counter (OTC) products, e.g. multivitamins, single ingredient vitamins, first and second-generation antihistamines. Per regulatory guidance, these products will not be impacted if the prescription is submitted by a CCS-paneled network provider. Fluoride coverage is restricted for gels and tablets, while the chewable and drop forms are still covered.	

Decisions Made		
Notes	**Follow-Up Items**	**Assigned To**
	N/A	

Next Meeting	
Date	**Suggestions for Agenda**
February 3, 2026	N/A

AGENDA ITEM: II.C.
DATE: 02/11/2026

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TO: Physician Advisory Committee

FROM: Robert Moore, MD, MPH, MBA, Chief Medical Officer

DATE: 02/11/2026

SUBJECT: Partnership Committee Memberships

Appointment

Physician Advisory Committee

Dr. Betza Kunkel, Psychiatrist and Family Physician for CommuniCare+OLE, volunteers to serve as a PAC voting member.

Her appointment as a voting member is recommended.

AGENDA ITEM: II.C.
DATE: 02/11/2026

PARTNERSHIP HEALTHPLAN OF CALIFORNIA

TO: Physician Advisory Committee

FROM: Robert Moore, MD, MPH, MBA, Chief Medical Officer

DATE: 02/11/2026

SUBJECT: Partnership Committee Memberships

Resignation

Physician Advisory Committee

Dr. Mustafa Ammar, Chief Medical Officer at Ampla Health, resigns his position as PAC voting member.

The Physician Advisory Committee thanks Dr. Ammar for his support of PAC.

Datalink Pilot Update

February 11, 2026

Kristine Gual, Director of Quality Measurement

Drivers of High Performance on Quality Measures

Completion of Services

- ✓ Increasing Access
- ✓ Building capacity for quality work
- ✓ Pay for performance
- ✓ Reducing inequities
- ✓ Member engagement
- ✓ Response to community needs
- ✓ Population health tools

Data Completeness

- ✓ Data sharing through Health Information Exchange
- ✓ Claims/encounters coding
- ✓ Data feeds from DHCS, CAIR, Quest, Labcorp
- ✓ New data sources *(Datalink)*
- ✓ Validation of data

Overcoming Measure Limitations

- ✓ HEDIS Year-Round Medical Record Review (W30)
- ✓ Addressing health system data gaps

Background: Why Datalink?

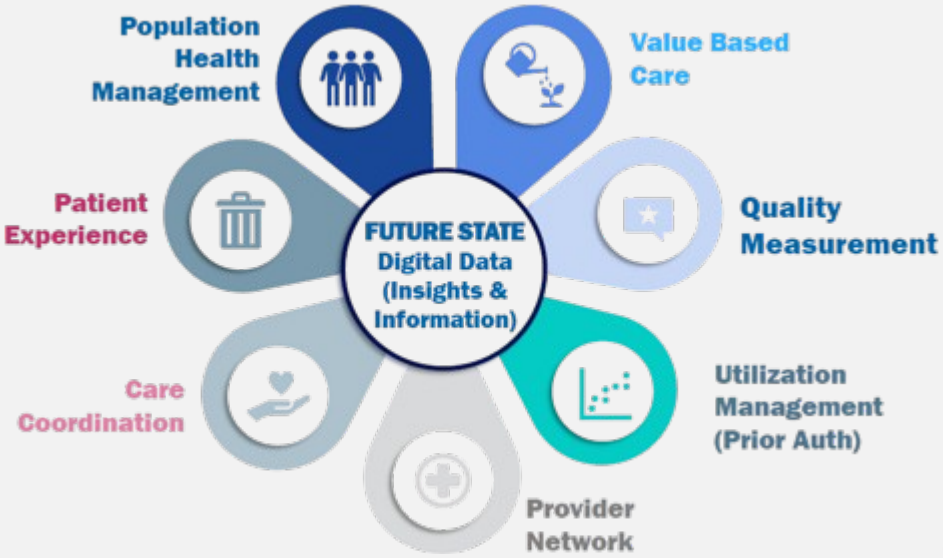
- NCQA plans to transition all hybrid HEDIS measures to ECDS measures by MY2029
- Multiple **new MCAS Accountable ECDS measures** can only be reported through clinical data, not claims and encounters:
  - DSF-E (2) – Depression Screening and Follow Up for Adolescents and Adults - **362,000** members
  - PND-E - Prenatal Depression Screening and Follow Up - MCAS Accountable – approx. 10,000 members
  - PDS-E - Postpartum Depression Screening and Follow Up - MCAS Accountable – approx. 10,000 members
- Additional MCAS/Withhold measures are underreported through claims or encounters:
  - Controlling Blood Pressure – **Withhold**/MCAS Accountable
  - Glycemic Status Assessment for Patients With Diabetes – **Withhold**/MCAS Accountable
- Continuing data completeness issues with incoming Partnership practices

Datalink Initiative

Datalink helps Partnership report complete data for key HEDIS measures

- Datalink is an NCQA Validated Data Aggregator
- Captures structured clinical data, diagnoses and coding that isn't captured by Partnership claims
- Anticipate savings for provider network time and resources
  - **Partnership is covering the cost of implementing Datalink for our provider network**
  - HEDIS hybrid chart chase replaced by use of claims/encounters, HIE's, and Data Aggregator
  - Goal of replacing QIP measure uploads and manual attestations with Datalink extracts
- Vision is increased use of **Digital Data** throughout Partnership

Digital data is an organizational asset



Datalink – Pilot Year 1 (July 2024-June 2025)

- Datalink piloted as a supplemental data source for MY2024 HEDIS Annual Project
- MY2024 HEDIS Annual project received 103,000 clinical files from 6 practices
- Focus on 4 Depression screening measures – data can not be reported through claims or encounters:
  - DSF-E (2) – Depression Screening and Follow Up for Adolescents and Adults
  - PND-E - Prenatal Depression Screening and Follow Up
  - PDS-E - Postpartum Depression Screening and Follow Up
- Pilot Evaluation Questions:
  - *What was the ROI from MY2024 Datalink pilot for **Depression Screening measures**?*
  - *What was the ROI from MY2024 Datalink pilot for **additional measures** in Partnership's HEDIS Projects? (MCAS Accountable/Reporting)*

Datalink Impact – MY2024 MCAS Measures

ABBR	MEASURE	DENOMINATOR	NUMERATOR	DATALINK IMPACT	MY2024 PLAN WIDE RATE	MY2024 PERCENTILE	DATALINK IMPACT
DSF	Depression Screening All Ages	381,163	**9091**	2.39%	2.39%	**66th**	100.00%
DSF	Follow-Up to Pos Screen All Ages	72	**48**	66.67%	79.17%	**75th**	84.21%
PDS-E	Postpartum Depression Screening	8,670	**78**	0.90%	0.90%	33rd	100.00%
PND-E	Prenatal Depression screening	8,714	**89**	1.02%	1.02%	25th	100.00%

Preliminary MY2024 Plan Wide rates as of 4/8/2025

- For 3 of 4 Depression Screening measures, Datalink was sole source of data for the MY2024 rates
  - DSF-E, PND-E, and PDS-E are MCAS Accountable measures in MY2026 onward
- As a result of the Datalink pilot using 6 practices, **2 of 4 Depression Screening measures exceeded the 50th percentile**

Datalink Impact – MY2024 MCAS Measures *(continued)*

ABBR	MEASURE	ADMIN DENOMINATOR	NUMERATOR	MY2024 PLAN WIDE ADMIN RATE	DATALINK IMPACT ON ADMIN RATE
CCS-E	Cervical Cancer Screening EDS	152,163	**948**	41.49%	1.49%
CBP	Controlling Blood Pressure**	26,358	**1,462**	35.45%	15.66%
GSD	Glycemic Status Assessment for Patients with Diabetes <=9**	32,526	**608**	48.00%	3.90%
GSD	Glycemic Status Assessment for Patients with Diabetes (<9%)**	32,526	**80**	52.00%	0.46%

Preliminary MY2024 Admin rates as of 4/8/2025
*** = Hybrid measures, numerator columns shows administrative numerator completions*

- MCAS Accountable measures also showed impact on administrative rates from Datalink data
- Improvements in **hybrid measures** via administrative data **reduces the time, resources, and risk** of hybrid measure medical record reviews and **creates foundation for ECDS transitions**
- Datalink was the **largest supplemental source of MY2024 Blood Pressure Measurement administrative data**

Datalink – Pilot Year 2 (July 2025-June 2026)

Year 1 Pilot (2024-25)	Year 2 Pilot (2025-26)
6 practices (Nextgen and ECW)	Spread to additional EMR's and focus on regional spread
Requested all member charts from a practice	Requested only member charts in high-priority measure EP's
Minimal iterative data element mapping to improve numerator hits	Focus on iterative analysis and data mapping improvement at EMR level
Minimal validation with practices	Rate validation with practices for each EMR

MOST VALUED MEMBER FILES - HEDIS MY2025
MEASURE COHORT
(ADDITIONAL MEASURES)

CCS-E (PPC, PDS-E, PND-E, DSF-E)	CHL (PPC, PDS-E, PND-E, DSF-E, WCV)	CIS-E (LSC, W30, DEV, TFL-CH)	IMA-E (DSF-E, DRR-E, WCV, TFL-CH)	CBP (DSF-E)	GSD (DSF-E)	DSNP (DSNP Part C & Display measures)

- MY2025 Datalink project will prioritize MCAS Accountable measures transitioning to ECDS and expand to include additional EMR's and practices
- Strategic planning around identifying members whose charts will provide ROI to HEDIS project
- ROI on charts requires sustained engagement with vendor and practices around prioritized measures
  - File configuration and mapping has high impact on numerator hits

Datalink
Pilot Year 2 (July 2025-June 2026)

1 Contracting

- Practice contracting with Datalink
- Gateway measure for Perinatal QIP by 6/30/2026

2 Data Extraction & Handoff

- Practice level configuration, varies by EHR

3 Partnership Data Ingestion

- Partnership Data Warehouse
- Partnership HEDIS Engine
- Iterative data

4 Analysis & Validation

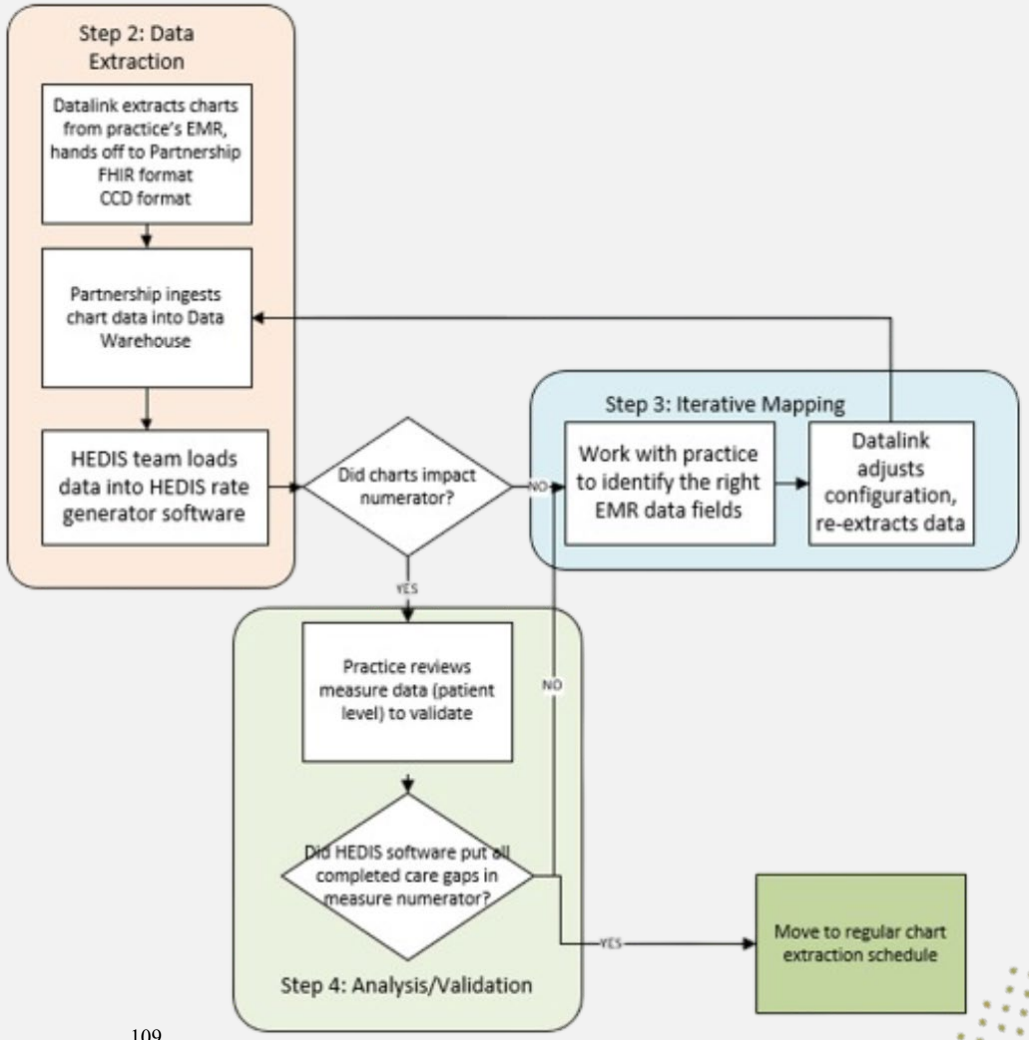
- Practice-level validation
- Auditor validation for Annual Projects
- field mapping

5 Application to Partnership Programs

- Primary Source Verification
- Applied to MY2025 HEDIS Annual rates

More Details on Pilot Steps

- Datalink has an “out of the box” template for how to find measure data points in structured data fields
- If practices are not using those specific fields, Datalink is capable of “remapping” their chart extraction to pull different fields
- Validation step allows practices to ensure that completed care gaps show in measure numerator



Pilot Year 2 Progress (July – December 2025)

EMR System	Charts extracted via Datalink (12/2025)	1. Contracting with Datalink	2. Data Extraction & Handoff	3. Partnership Data Ingestion Iterative Mapping In Process	4. Analysis & Validation
OCHIN Epic	10,000	8	3	3	--
Athena	15,000	--	--	11	--
eCW	27,000	--	1	--	**6**
NextGen Enterprise	650	--	3	2	--
Other EMR's AllScripts, PracticeFusion, Greenway, Cerner	250	1	5	2	--
Total Practice Count	**Approx. 53,000 charts**	**9**	**12**	**18**	**6**

45 Partnership practices are engaged with Datalink

Pilot Year 2 Progress (July – December 2025)

ABBR	MEASURE	DENOMINATOR	NUMERATOR FROM DATALINK	TOTAL NUMERATOR	ADMIN RATE, ALL DATA SOURCES	MY2025 PERCENTILE	DATALINK IMPACT
DSF-E	Depression Screening All Ages	78,178	**5,543**	5,603	7.17%	**67th**	**98.9%**
DSF-E	Depression Screening Follow-up	16	**6**	15	93.75%	**90th**	**40%**
PDS-E	Postpartum Depression Screening	2,313	**130**	130	5.62%	50th	**100%**
PND-E	Prenatal Depression screening	1,952	**306**	306	15.68%	50th	**100%**
CBP	Controlling Blood Pressure (Hybrid in MY2025)	8,914	**915**	4,939	55.41%	Hybrid Rate Pending	**19%**
CCS-E	Cervical Cancer Screening ECDS	31,932	**463**	12,381	38.77%	5th	**4%**
GSD	Glycemic Status for Patients with Diabetes >9	8,904	**105**	4,504	50.58%	Hybrid Rate Pending	**2%**

Highlights!

1. All 5 counties > 50th for DSF-E – **large potential MY2026 sanctions avoided**
2. Datalink the **sole source of data for 3 of 4 depression screening measures**
3. CBP: **19% of numerator hits from Datalink** for Withhold measure that will transition to ECDS by 2029

Example of Datalink impact on Chico Region measures:

- Approximately 20,000 charts extracted from eClinical Works EMR (6 high-priority measure EP's)
- Total of 7,468 numerator hits for 7 high-priority MCAS/Withhold measures
- Service area in Butte, Colusa, Glenn, Sutter, Yuba counties
- Practice is on Step 4, ready for validation of measure rates

Preliminary impact of Datalink charts on selected HEDIS Measures, Chico Region, Dec. 2025

Goals for Remainder of Pilot Year 2

Step 1:Contracting

Perinatal QIP practices contracted with Datalink

by 6/30/2026

Step 2: Data Extraction

Complete data extraction for all OCHIN Epic, Athena, Nextgen, eCW practices contracted by 12/2025

by 02/27/2026

Step 3: Data Ingestion / Iterative Mapping

Complete iterative mapping for top 4 EMR's for high priority measures: Depression and Chronic Condition measures

✓ **by 01/31/2026**

Step 4: Analysis / Validation

Practice validation by at least 1 practice per EMR (1000 records minimum) on high priority measures

by 06/30/2026

Support the Spread of Datalink

Contract with Datalink

Reach out to QIP@partnershiphp.org to start the contracting process with Datalink (Compliance) *

Chart Extraction

Support the Datalink chart extraction process – differs by EMR (IT)

Partner with Datalink/Partnership

Partner to validate your data around key measures once *Iterative Mapping* is complete (QI) **

* If you are in the Perinatal QIP, you MUST contract by 6/30/2026

** Standard EMR template fields for POC tests, BP's, depression screens

Questions?

Please reach out to QIP@partnershiphp.org
to start the contracting process with Datalink