PARTNERSHIP HEALTHPLAN OF CALIFORNIA
PHYSICIAN ADVISORY COMMITTEE ~ MEETING NOTICE

Members: (21)

Angela Brennan, D.O. (Chair)
Betzabel Kunkel, M.D.
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.
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	Vacant
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
Vacant, 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

cc: Partnership Commission Chair
Dean Germano, Partnership Board Chair

FROM: PAC@partnershipHP.org
DATE: May 8, 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, May 13, 2026 **TIME: 7:30 a.m. – 9:00 a.m.**

HOSTING LOCATIONS

Partnership HealthPlan of California
4605 Business Center Drive
Fairfield, CA

Partnership – Santa Rosa
495 Tesconi Circle
Santa Rosa, CA

Partnership – Redding
2525 Airpark Drive
Redding, CA

Partnership – Eureka
1036 5th Street
Eureka, CA

Partnership - Auburn
281 Nevada St.
Auburn, CA 95603

Partnership - Chico
1000 Fortress St.
Chico, CA 95973

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 (800) 863-4155, or e-mail pac@partnershiphp.org.

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

Date: May 13, 2026 Time: 7:30 – 9:00 a.m. Location: Partnership

Partnership HealthPlan of California
4605 Business Center Drive
Fairfield, CA

Partnership – Santa Rosa Office
495 Tesconi Circle
Santa Rosa, CA

Partnership – Redding Office
2525 Airpark Drive
Redding, CA

Partnership – Eureka Office
1036 5th Street
Eureka, CA

Partnership - Auburn Office
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Marin Community Clinic
3260 Kerner Blvd.
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. Bjork**		**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 April 8, 2026, PAC Minutes**	**Dr. Brennan**	**5**	**7:55**
B.	A	**Consent Review: Agenda Items II. B.1, B.2, B.3, B.4, and B.5** **Consent review allows multiple agenda items to be approved with one motion.*	**Dr. Brennan**	**15 - 143**	**7:58**

1	C	**Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – April 15, 2026**
		Acceptance of Meeting Materials
		• Internal Quality Improvement Meetings
		  • March 10, 2026 – Minutes (Final)
		  • April 7, 2026 – Agenda
		  • April 7, 2026 – Minutes
		• Quality / Utilization Advisory Committee
		  • March 18, 2026
		  ▪ Minutes (Draft)
		  • April 15, 2026
		  ▪ Agenda
		  ▪ Minutes
		  ▪ Quality Improvement Update
		Special Presentations (not included in the packet, for reference only)
		• *Annual 2025 Utilization Management (UM) Program Evaluation – NCQA UM Standard 1 Element G2025 C&L/QIHETP Work Plan Final Update*
		• *Supplemental TAR Report to the 2025 UM Program Evaluation*
		• *Population Needs Assessment Presentation*
			Dr. Brennan	**15**
				27
				29
				47
				60
				62
				80
					7:58

<table>
<tr><th>II.B</th><th>C</th><th>Consent Review: Agenda Items II. B.2, B.3, B.4, and B.5 Continued</th><th>LEAD</th><th>PG</th><th>TIME</th></tr>
<tr><td>2</td><td>C</td><td>
<table>
<tr><th colspan="2"><u>Policies/Procedures/Guidelines for Action</u></th></tr>
<tr><th colspan="2">Behavioral Health</th></tr>
<tr><td>MPBP8003</td><td>Mental Health Services</td></tr>
<tr><td>MPBP8011</td><td>Scope of Primary Care – Behavioral Health Indications for Referral Guidelines</td></tr>
<tr><th colspan="2">Care Coordination</th></tr>
<tr><td>MCCP2036</td><td>Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities</td></tr>
<tr><th colspan="2">Pharmacy Operations</th></tr>
<tr><td>MCRP4068</td><td>Medical Benefit Medication TAR Policy</td></tr>
<tr><td>MPRP4034</td><td>Pharmaceutical Patient Safety</td></tr>
<tr><td>MPRP4065</td><td>Drug Utilization Review (DUR) Program</td></tr>
<tr><th colspan="2">Quality Improvement</th></tr>
<tr><td>MPQP1006</td><td>Clinical Practice Guidelines</td></tr>
<tr><td>MPXG5001</td><td>Clinical Practice Guidelines for the Diagnosis & Management of Asthma</td></tr>
<tr><td>MPXG5002</td><td>Clinical Practice Guidelines for Diabetes Cellulitis</td></tr>
<tr><td>MPQP1022</td><td>Site Review Requirements and Guidelines – Site Review Requirements and Guidelines</td></tr>
<tr><th colspan="2">Utilization Management</th></tr>
<tr><td>MPUD3001</td><td>Utilization Management Program Description</td></tr>
<tr><td>MCUP3133</td><td>Wheelchair Mobility, Seating and Positional Components</td></tr>
<tr><td>MCUP3037</td><td>Appeals of Utilization Management/ Pharmacy Decisions</td></tr>
<tr><td>MPUP3026</td><td>Inter-Rater Reliability Policy</td></tr>
</table>
<u>All policies linked in Policy Summary (see page 93)</u>
• Policy Summary
• Detailed Synopsis of Changes
</td><td>Dr. Brennan</td><td>93
94</td><td>7:58</td></tr>
<tr><td>3</td><td>C</td><td>Pharmacy & Therapeutics Committee
• Summary, April 9, 2026
• Approved Criteria</td><td>Dr. Stan Leung</td><td>97
111</td><td>7:58</td></tr>
<tr><td>4</td><td>C</td><td>Provider Education & Networking (PEN) Meeting
• Summary, April 2, 2026</td><td>Mr. Brincko</td><td>132</td><td>7:58</td></tr>
<tr><td>5</td><td>C</td><td>Credentials Committee Meeting
• Summary, March 11, 2026
• Credentialed List, March 11, 2026</td><td>Dr. Netherda</td><td>135
140</td><td>7:58</td></tr>
<tr><td>6</td><td>C</td><td>Pediatric Quality Committee</td><td>Dr. Ribordy</td><td></td><td></td></tr>
<tr><td>7</td><td>C</td><td>Quality Improvement Health Equity Committee</td><td>Dr. Jalloh</td><td></td><td></td></tr>
<tr><td>C.</td><td>A</td><td>Physician Advisory Committee Membership</td><td>Dr. Brennan</td><td></td><td></td></tr>
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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. Matthews		8:17
F.	I	Plumas, Sierra, Nevada & Placer	Dr. Morris		8:21
IV.	*I*	*Committee Introduction*	*LEAD*	*PG*	*TIME*
V.	*I*	*Old Business*	*LEAD*	*PG*	*TIME*
VI.	I	SPECIAL PRESENTATIONS	LEAD	PG	TIME
A	A	Proposed 2026 Hospital QIP 6-month Bridge Measure Set	Troy Foster	143	8:25
B	A	Proposed 2027 Palliative Care QIP Measure Set	Eva Lopez	147	8:30
C	I	Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Member Experience Survey	Dr. Moore	*N/A*	8:35
VII.	I	ADJOURNMENT	LEAD		9:00
		Next PAC on June 10, 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 (800) 863-4155 or by email at pac@partnershiphp.org. Notification in advance of the meeting will enable Partnership to make reasonable arrangements to ensure accessibility to this meeting and to materials related to it.

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

PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PARTNERSHIP)
MEETING MINUTES

Committee: **Physician Advisory Committee**
Date / Time: **April 8, 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)*	Candy Stockton, MD *(E)*		
	Betzabel Kunkel, MD *(FF)*	Christina Lasich, MD		
	Brian Montenegro, MD *(FF)*	Malia Honda, MD *(E)*		
	Steven Gwiazdowski, MD *(FF)*	Chester Austin, MD *(C)*		
	Karen Sprague, MSN, CFNP *(FF)*	Karina Gookin, MD *(A)*		
	Zoe Cappe, MD *(FF)*	Derice Seid, MD *(MCC)*		
Members Excused:	Michelle Herman, MD	Chris Myers, MD	Darrick Nelson, MD	John McDermott, FNP *(C)*
	Matthew Zavod, MD	Mills Matheson, MD	Teresa Shinder, MD	
Members Absent:	Vanessa Walker, DO			
	Danielle Oryn, DO			

FF Fairfield *MCC Marin Community Clinics*
SR Santa Rosa *OMM Office of Dr. Matheson*
E Eureka *SH Sutter Health Roseville*
R Redding *SL Sutter Health Lakeside*
C Chico *A Aliados Health*
AU Auburn

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

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	DATE RESOLVED
Public Comments	PAC Chairperson asked for any public comments. None presented.	N/A	N/A
Quorum	12/21 – PAC	Committee quorum requirements met (12).	04/08/26

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

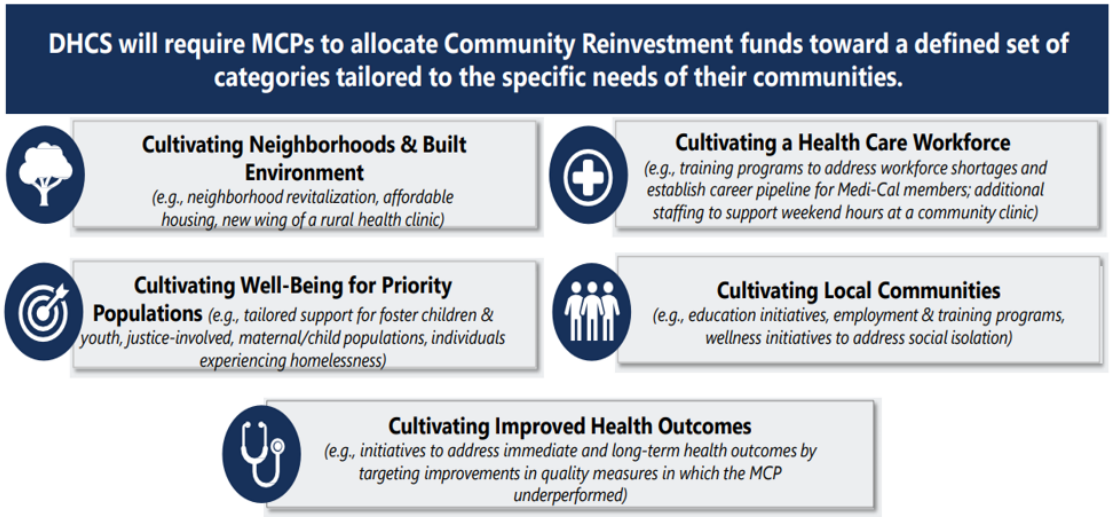
I.A. Chief Executive Officer (CEO) Report	**Partnership's Chief Operations Officer provided the following report for Partnership activities on behalf of the Chief Executive Officer.**
	
	• **Partnership Transportation App is Operational**
	  • Partnership is urging members who use transportation services to adopt the Kinetic App.
	  • Members can sign up by calling Partnership and receiving a link. It is not available from an app store. Contacting Partnership is required.
	  • The app allows members to request a ride, receive confirmation and updates, and message.
	  • Outreach efforts are ongoing to increase use of the app and reduce call volume.
	  • Partnership's Transportation Department scheduled 1.3 million rides in 2025 and received nearly 4,000 calls per day.
	• **Partnership Operations**
	  • Partnership's permanent Chico office held its grand opening and is able to host meetings.
	  • Mobile vision buses have been operating two days per week for three weeks in Garberville to improve vision access. More are planned for the future in other areas lacking access.
	  • Mobile dental buses are being considered as well.
	  • Physician contracting efforts are ongoing in area where access is strained and they have been reluctant to join the network due to reimbursement rates.
	  • Partnership's new claim system, Health Rules Payer (HRP) through Health Edge Corporation, is in the testing phase with each operational department. A go-live date has not been announced, but hopes are for late summer.
	  • HRP will enable a way to ingest taxonomy codes, edit EDIs to avoid rejecting claims, and address missing or inaccurate National Drug Code (NDC).
	  • Outreach efforts are ongoing with providers and billing teams in preparation.
	  • Partnership's COO discussed a California Health Care Foundation (CHCF) regional market 2025 report for Shasta and Lassen Counties and participated in a panel with Mr. Todd Smith of Dignity Mercy Medical Center, Mr. Brandon Thornock of Shasta Community Health Center, and Ms. Shannon Garret of Mountain Valley to discuss the findings.
	  • Political divisiveness is impacting initiatives. Provider recruiting and retention are also concerns in addition to the impacts of H.R.1 implementation on Medi-Cal members.
	  • Panel was attended by more than 150 people in addition to Senator Megan Dahle.

I.B. Chief Medical Officer (CMO) Health Services Report	**Partnership's Regional Medical Director for Solano, Napa, and Yolo counties presented a brief update for Health Services on behalf of the Chief Medical Officer**
	
	• **CMO Activities**
	  • Regional Medical Director forums are ongoing throughout the regions in California. Events have been well attended.
	  • Topics include Medi-Cal policy changes, county-level data for the region, and pharmacy updates
	  • Public Health Officer (PHO) meeting to discuss trends, challenges, and successes. Funding shortfalls are a challenge affecting county departments.
	• **Regulatory Changes**
	  • DHCS made changes to GLP-1 prior authorization criteria to remove the Treatment Authorization Request (TAR) requirement for Metabolic dysfunction-associated steatohepatitis (MASH), however, the correct diagnosis code is needed on the prescription to ensure it can be filled.
	  • All other diagnoses still require a TAR for GLP-1 prescriptions.
	• **Rural Health Transformation Grants**
	  • California Department of Health Care Access and Information (HCAI) has received federal funding for grants to provide funding to the regions and highlight collaborative efforts to identify locations for improving access.
	  • Grants will be competitive, but regions have been speaking with Public Health Officers ahead of the application process.
	  • Partnership will support application efforts with webinars. Application information has not been released.
	  • HCAI will likely be looking for projects in specialty access, workforce development and pipeline, recruitment and retention of staff, and IT system enhancement, and building up Obstetrics (OB) access is areas where hospital services have been diminished or canceled.

AGENDA ITEM	MOTIONS FOR APPROVAL	RECOMMENDATIONS / ACTION	DATE RESOLVED
II.A.	**March 11, 2026, PAC minutes were presented for approval.**	**MOTION:** Dr. Gwiazdowski moved to approve Agenda II.A as presented, seconded by, seconded by Ms. Sprague. **ACTION SUMMARY:** [12] yes, [0] no, [0] abstentions.	04/08/26 Motion carried.
II.B. II.B.1 II.B.2 II.B.5 II.B.6 II.B.7	**Consent Calendar Review** • Quality / Utilization Advisory Committee (QUAC) Activities Report with Attachments – April 15, 2026 • Policies, Procedures, and Guidelines for Action Policy Summary April 2026 • Credentials Committee Meeting, February 11, 2026 Minutes Credentialed List • Pediatric Quality Committee Summary, February 3, 2026 • Quality Improvement Health Equity Committee Summary, March 17, 2026 • Credentials Committee Meeting, February 11, 2026 Minutes Credentialed List	**MOTION:** Dr. Austin moved to approve Agenda II.B.1, II.B.2, II.B.5, II.B.6, and II.B.7 as modified, seconded by Dr. Montenegro. **ACTION SUMMARY:** [12] yes, [0] no, [0] abstentions. MPQG1005-A Adult Preventative Guidelines was amended for clarity of Assessment for Hearing Impairment and now reads, "For individuals likely to take action based on abnormal testing results, consider a three-question screening:"	04/08/26 Motion carried.
VI.A	Proposed 2026 Perinatal QIP 6-month Bridge Measure Set Summary, February	**MOTION:** Dr. Montenegro moved to approve Agenda item VI.A as presented, seconded by Dr. Kunkel. **ACTION SUMMARY:** [12] yes, [0] no, [0] abstentions.	04/08/26 Motion carried

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
III.A Status Update, Regional Medical	**Partnership's Regional Medical Director presented a brief update on activities for Napa, Solano, and Yolo Counties.** • Napa/Solano Regional Quality meeting held in Fairfield. Operation Access was in attendance to discuss colorectal screening for uninsured populations. Partnership recognizes many current members may become uninsured in the future and is proactively discussing options. • Leadership meeting will be held with CEOs and CMOs throughout Napa County to discuss health topics such as H.R.1 impacts and Community Health Assessment/Community Health Improvement Projects (CHA/CHIP). • CHA/CHIP work focused on well-child care is ongoing in Solano County. • Partnership Perinatal Symposium will be held on Monday, April 13, 2026. Topics include comprehensive perinatal care, medical services, nutrition, behavioral health, and case management during pregnancy.
III.B. Status Update, Regional Medical	**Partnership's Regional Medical Director for Marin and Sonoma Counties presented a brief update on activities.** • Working on pilot to increase cervical cancer screenings with self-swab Linux kits. • Efforts to improve claims issues are ongoing between Partnership Provider Relations, Claims, and area providers. • Planning convening to discuss unhoused services and free care in Marin County with county staff and community-based organizations (CBO). • Sonoma Valley Hospital has been expanding physical therapy and asked Partnership to survey demand for evening and weekend hours. • Participated in California Academy of Family Physicians (CAFP) Legislative Advocacy Day focused on advocating for bills aiming to reduce administrative burden for Medi-Cal enrollment and reinstate some benefits impacted by budget cuts. • Presented effects of H.R.1 and state budgets cuts at Sonoma, Lake, Mendocino County Medical Association.

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
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.** • Sutter-Lakeside has appointed Laura Horn as interim CEO. Recruitment efforts for a permanent CEO are underway. • Lake County Health Services is recruiting an Executive Director and hired a new Public Health Officer, Dr. Daniel Goold. • Lake County Tribal Health now offers ophthalmology services. • Providence St. Joseph is in discussion with the Office of California Attorney General to settle case regarding violations of laws for emergency abortion care. • United Indian Health Service has a new Physician Assistant offering nephrology consultations. • Regional Medical Director forum in Ukiah was well attended and discussions centered on members losing care due to H.R.1 implementation. • Fresenius Kidney Care will be closing the McKinleyville site leaving only the one in Eureka. • Redwood Women's Health Center is looking into adding primary care.
III.D. Status Update, Regional Medical	**Partnership's Regional Director for Plumas, Sierra, Nevada & Placer Counties presented a brief update on activities on behalf of Regional Director for Glenn, Butte, Sutter, and Colusa Counties.** • Healthy Rural California residency program announced they have matched four new psychiatrists and six new family medicine residents. • The Mind Behavioral Health Continuum Infrastructure program announced their recent grants awarded through Department of Health Care Services (DHCS) to help transform California's mental health and substance use disorder (SUD) treatment systems; Chico received $27 million to add 100 new beds for SUD and social rehab in Sutter and Yuba Counties.
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.** • Staffing remains stable in the area. • Regional Medical Director Forum in Redding was well attended. • Nourish and Flourish event will be taking place at the Redding Farmer's Market on May 30, 2026 where hemoglobin A1C checks, blood pressure checks, and mobile mammograms will be offered for preventative health. • Shasta Regional Medical Center is recruiting for more specialty care providers.
III.F Status Update, Regional Medical	**Partnership's Regional Director for Plumas, Sierra, Nevada & Placer presented a brief update on activities.** • Area health care organizations and providers are seeking ways to assist members keep their Medi-Cal coverage. Partnership provides a Keep Your Medi-Cal toolkit, but Nevada County Health and Social Services has also been able to provide education to healthcare providers. • Nevada County is piloting a mobile health unit called the Common Resource Center to set up a free, monthly clinic providing immunizations, HIV screening, hepatitis C screening, and dental services in addition to food distribution and bike repairs. Two events have taken place with more planned. • Sierra County has also begun mobile services and will be collaborating with Nevada County for sharing of best practices. • Sierra Nevade Family Medicine Residency program filled positions with two new residents. • Nevada County Public Health Director and Nursing Director have announced retirement. • Regional Medical Director Forum will be hosted in Truckee on May 8, 2026.
IV. Introductions	*None*
V. Old Business	*None*

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
VI.A Community Reinvestment Review of Requirements and Funding Options	**Community Reinvestment Review of Requirements and Funding Options** The Department of Health Care Services is requiring that all health plans reinvest a portion of their net income into their local communities to address unmet health-related social needs and support community wellbeing per their calculations **What Are The Minimum Funding Calculations?** <u>Base Community Reinvestment Requirement</u> MCPs **and** Qualifying Subcontractors with positive net income must contribute: • 5% of annual income if **net revenue is less than or equal to 7.5%** • 7.5% of annual income if **net revenue is greater than 7.5%** **Annual net revenue for initial cycle must come from their Medi-Cal contract revenues for 2024.* **<u>Quality Achievement Requirement</u>** MCPs with positive net income must contribute: An additional 7.5% of their annual net income for counties with an Enforcement Tier 2 or 3 assignment Tier 2: assigned to any county where MCP has 2 or more measures below MPL in any 1 MCAS domain Tier 3: assigned to any county where MCP has 3 or more measures below MPL in 2 or more MCAS domains *Funding will be 100% allocated to improving quality measures below target for counties within Enforcement Teir 2 or 3 **Which Counties Will Receive Funding?** 2024, 2025, and 2026 Funding Calculations per APL - 14 Original Counties 2025, 2026, and 2027 Funding Calculations per APL*** - 10 Expansion Counties **What are we allowed to fund?** 

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

VI.A Community Reinvestment Review of Requirements and Funding Option, Continued	**How Much Will My County Get?**
	
	• DHCS will calculate Partnership's annual net income as a statewide aggregate based on various factors and notify plans in Q2 2026 and stratify per county (Per APL and FAQ sheet).
	  o Contingent on Positive Net Income
	  o Adjusted for Quality Achievement
	  o Adjusted for Medi-Cal membership size
	
	DHCS Examples - High Level Social Determinants of Health (SDOH)
	
	"Yays"
	• Funding for scholarships for allied health professions
	• Funding for Park development in a community
	• Funding for Hospital development in a community
	
	"Nays"
	• Funding for clinical services at a clinic or hospital
	• Funding for Expanding Provider Networks for the delivery of services covered under the MCP Contract
	• Funding street medicine services for persons experiencing unsheltered homelessness.
	
	Who was "Required" to Be Involved in Community Reinvestment Planning and Decision-Making Process?
	
	• County Public Health Directors
	• Community Advisory Committee (CAC)
	• County Behavioral Health Directors
	• Executive and CR Project Leadership
	
	2025 Methodology Review
	• Partnership team reviewed APL and developed preliminary list of ideas
	• Partnership surveyed internal leaders (Regional Directors, Department Directors, etc.) for additional feedback and ideas after reviewing CHA/CHIP data and other sources.
	• Partnership team reviewed APL and developed preliminary list of ideas
	• Partnership hosted a special December meeting for additional external community members and leaders, including external members of Partnership committees.
	
	Q1 2026 Methodology
	• Partnership Collated Information and Presented to Internal Leaders in first week of January
	• Internal Leaders voted and recommended top 1-2 funding options per category
	• Integrated feedback of combining funding options

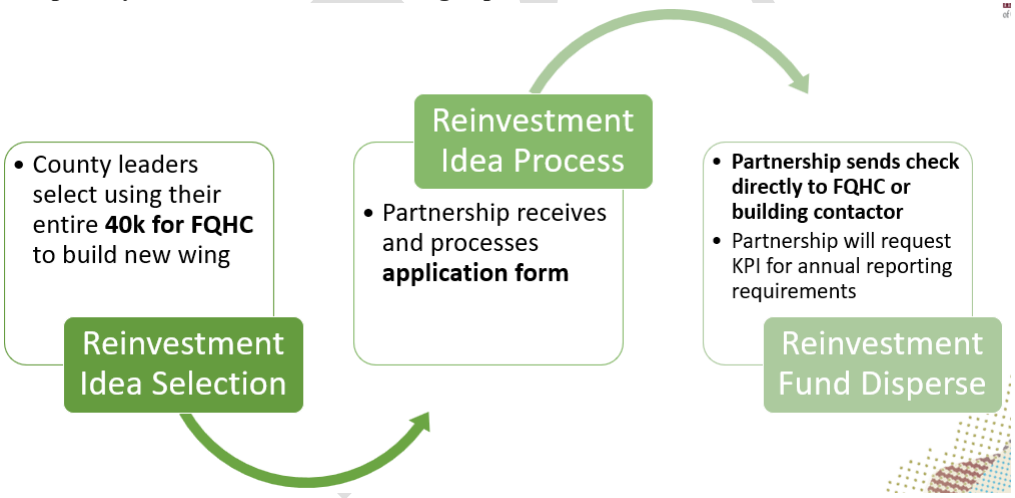
AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.

VI.A Community Reinvestment Review of Requirements and Funding Option, Continued	**Key Factors Considered for Determining Reinvestment Options**
	• DHCS APL requirements
	• Annual Health Disparities Assessment
	• CHA Analysis
	• CHIP Analysis
	• Access Improvement Assessment
	• Community Support
	  ○ CAC Support via Survey
	  ○ BHT Director Support via Survey
	  ○ LHJ Director Support Via Survey

List of Reinvestment Options

Cultivating Neighborhood	Cultivating Healthcare Workforce	Cultivating Wellbeing	Cultivating Local Communities
Option #1: Funding To Support Expansion of RHC or FQHC facility to meet community needs	**Option #1:** Funding to Support Specialty Provider Recruitment	**Option #1:** Funding to Support Community Wellness and Resource Centers	**Option #1:** Funding to Support the development and funding of CHW programs in each county
Option #2: Funding to Support Expansion of Mobile Health Services to meet community needs	**Option #2:** Funding to Support Expansion of Residency Slots, Programs, and Development	**Option #2:** Funding To Support Accountable Communities for Health (ACH) initiatives and programming	**Option #2:** Funding to Support the development and funding of doula programs in each county
	Option #3: Funding to Support Expansion of Student Slots, Programs, and Development	**Option #3:** Funding to Support Community Fitness Programs	

Example Payment Workflow for funding expansion of local FQHC who is awarded $40,000



<table>
<tr><th>AGENDA ITEM</th><th>DISCUSSION / CONCLUSIONS
For information only, no formal action required.</th></tr>
<tr><td>VI.A
Community Reinvestment Review of Requirements and Funding Option, Continued</td><td>
What we still don't know
• How much each county will receive each year
• The exact date of when DHCS will clarify county amounts
• The exact dates of when funds need to be dispersed?
• Will DHCS approve submissions in a timely manner? Can Partnership dispense payment pending approval?

What Counties Can Start Doing Now
To Prepare for the potential community reinvestment application process:
1. Identify ONE Central Point of Contact for reinvestment application per county
2. Review 9 potential reinvestment options with local stakeholders involved with the County's Community Health Improvement Plan.
3. Review the county's current performance on the DHCS bold quality goals to identify intersecting priorities or additional priorities to consider.
4. Narrow done options to one or two areas which stakeholders agree best aligns with the goals and objectives of the County Health Improvement Plan, as well as the DHCS bold quality goals.

Note for 10 Expansion Counties
• The Board of Commissioners has approved a focused reinvestment for the 10 expansion counties to be allocated starting in 2026 only (when the other 14 counties will be receiving their 2024 reinvestment allocations).
• The details of this one-year reinvestment fund are being developed and will be discussed in future communications

Questions can be directed to Communityreinvestment@partnershiphp.org
</td></tr>
<tr><td>VI.B
Proposed 2026 6-Month Perinatal Quality Improvement Program (PQIP) Measurement Set

Measurement Period April 7, 2026, to October 7, 2026: Index period by which women with live births are identified.</td><td>
I. Summary of Current and Proposed Measures and/or Measure Changes
(A) Gateway Measure – Measure 1
DataLink allows for data exchange from Provider Electronic Health Records to PARTNERSHIP to capture depression screening and follow-up care. DataLink implementation is a vital component of furthering PQIP technical advancement through the capture of claims and electronic data directly exported from participating providers Electronic Health Records (EHR) systems

(B) Clinical Measures – Measures 2-6
PHPS practices and select perinatal providers who provide quality and timely prenatal and postpartum care to PARTNERSHIP members have the option to earn additional financial incentives. The PQIP framework offers a simple and meaningful measurement set developed for PCPs and OB/GYNs and includes the following clinical measures: Timely Immunization Status - Tdap and Influenza Vaccine, Timely Prenatal Care, Late Entry to Care with Depression Screening >14 weeks gestation, Timely Postpartum Care and Timely Assessments (monitoring only measure).

Key:
Change to Measure Design

<table>
<tr><th>Current FY2024-25 Measures</th><th>Proposed FY2025-26 Measures</th></tr>
<tr><td colspan="2">ECDS & Clinical Domains</td></tr>
<tr><td>Perinatal Medicine:
1. Electronic Clinical Data Systems (ECDS)
2. Prenatal Immunization
3. Timely Prenatal Care
4. Depression Screening
5. Timely Postpartum Care
6. Timely Comprehensive Assessments Monitoring</td><td>Perinatal Medicine:
1. Electronic Clinical Data Systems (ECDS)
2. Prenatal Immunization
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5. Timely Postpartum Care
6. Timely Comprehensive Assessments Monitoring</td></tr>
</table>
</td></tr>
</table>

AGENDA ITEM	DISCUSSION / CONCLUSIONS For information only, no formal action required.
VI.B Proposed 2026 6-Month Perinatal Quality Improvement Program (PQIP) Measurement Set Measurement Period April 7, 2026, to October 7, 2026: Index period by which women with live births are identified.	**Programmatic Changes** Due to a new federal regulation that went into effect at the end of 2025, the Perinatal Quality Incentive Program must transition to a calendar year program by January 2027. Therefore, the proposed changes below pertain to the proposed abbreviated six-month bridge measurement set covering the period of July 1, 2026, through December 31, 2026. There are no new measures proposed for this set, but some revisions are suggested In general, all the reporting timelines for any measures included in this set have been adjusted to correlate to the six-month period. Those revisions are not presented here. What follows are the proposed measure changes with their rationales. **A. Gateway Measure 1: Electronic Clinical Data Systems (ECDS) – Datalink Implementation** This measure supports the allowance of data exchange from provider Electronic Health Records to Partnership to capture clinical screenings, follow-up care and outcomes. ECDS participation is a vital component of furthering the quality of care for covered Partnership members. Note that NCQA is converting most hybrid measures to ECDS measures in the coming years. DHCS continues to make Partnership accountable for several ECDS measures. Partnership partnered with DataLink (a qualified HEDIS data aggregator) who can pull a much larger scope of measures than what is currently required for the Perinatal QIP. The DataLink process will continue to increase in emphasis and is now a gateway measure to the Perinatal QIP. Proposal: It is proposed to keep the gateway measure the same except for changing the dates to align with the 6-month period of July 1, 2026 – December 31, 2026. This means contracting and connecting would still be a gateway to earning perinatal incentive. **B. Clinical Measures** **Measure 3.** Timely Prenatal Care (<14 Weeks of Gestation) **Measure Summary:** Timely prenatal care services rendered to pregnant Partnership members in the first trimester, as defined as less than 14 weeks of gestation, or within 42 days of enrollment in the organization. **Proposal**: Since DataLink connections and extractions have occurred for many PQIP providers, it is proposed to add monthly DataLink extractions as Option 1 to submit monthly perinatal visits and depression screening data. The current process for manual submissions would become Option 2. Below is the suggested language change for the reporting section of the measure. **Reporting – Applies to Measures 3 & 4** **Option 1: Monthly DataLink Extractions** PQIP providers must have an active connection with DataLink and have successfully completed the extraction process to utilize this option. Counts of qualifying prenatal visits will be gathered through the DataLink extraction process. Partnership reserves the right to periodically request manual submissions to validate extracted data. **Option 2: Monthly Manual submissions** **Measure 4**: Depression Screening at First Prenatal Visit with Late Entry to Care (>14 weeks Gestation) Measure Summary: Prenatal care visits to an OB/GYN or other perinatal care practitioner or PCP in the first trimester (less than 14 weeks of gestation, as documented in the medical record) will be eligible for the incentive payment. **Proposal:** It is proposed to change the title of this measure to add the words "with Late Entry to Care". This helps clarify the intent of the measure for providers. It is also proposed that Measure 4 have the same Option 1 and Option 2 as noted in the Measure 3 proposal. **Measure 5:** Timely Postpartum Care **Measure Summary**: Timely postpartum care is a measure of quality care and can contribute to healthier outcomes for women after delivery. Postpartum visits are an important opportunity to educate new mothers on expectations about motherhood, address concerns, and reinforce the importance of routine preventive health care. **Proposal:** It is proposed to adjust the Index period by which women with live births are identified from an April through April date to April through October date as noted below. This allows for consistency in our data collection and will avoid gaps in the measure.

AGENDA ITEM	ADJOURMENT
PAC adjourned at 8:59 a.m.	**Next Physician Advisory Committee announced for May 13, 2026.**

For Signature Only

The foregoing minutes were APPROVED AS PRESENTED on _____ _____

Date **Angela Brennan, D.O., Committee Chairperson**

The foregoing minutes were APPROVED WITH MODIFICATION on _____ _____

Date **Angela Brennan, D.O., Committee Chairperson**

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Mar. 10, 2026 / 1:32 – 3:09 PM

Members Present:

Barresi, Katherine, RN, BSN, PHN, Chief Health Services Officer
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations
Bjork, Sonja, JD, Chief Executive Officer
Bontrager, Mark, Senior Director of Behavioral Health, Health Services
Brown, Isaac, MHA/MBA, Senior Director, Q & PI
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, MPH, Policy Analyst, Utilization Management
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Srvcs
Klakken, Vicky, Regional Director (NW-Eureka)
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Newman, Rachel, RN, BSN, Mgr, Clinical Comp. – Quality Inspections
O'Connell, Lisa Brundage, MHA, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Sharp, Tim, Regional Director (NE-Redding)
Turnipseed, Amy, Chief Strategy and Government Affairs Officer
Villasenor, Edna, Senior Director, Member Services and Grievance
Ward, Lisa, MD, Regional Medical Director (SW-Santa Rosa)

Members Absent:

Andrews, Leigha, Regional Director (SW)
Ayala, Priscila, Director of Network Services
Boyle, Shannon, RN, Manager of CC Regulatory Performance
Brincko, Aaron, Director of Provider Relations
Davis, Wendi, Chief Operating Officer
DeVido, Jeffrey, MD, Behavioral Health Clinical Director
Esget, Heather, RN, MSN, ACM, Director of Utilization Management
Innes, Latrice, Compliance Manager, Grievance & Appeals
Jalloh, Mohamed, Pharm.D, Dir. of Health Equity (Health Equity Officer)
Matthews, R. Douglas, "Doug," MD, Regional Medical Director (Chico)
Ruffin, DeLorean, DrPH, Director of Population Health
Townsend, Colleen, MD, Regional Medical Director (SE-Fairfield)
Vaisenberg, Liat, Director of Health Analytics
YoungStone, Kelly, RN, Director of Care Coordination

Guests:

Allen, Angier, Sr. Data Scientist I, Finance
Arrazola, Kelcie, Lead Trainer, Provider Relations
Biasotti, Danielle, RPht, Director of Transportation Services
Bikila, Dejene, Manager of Data Science, Finance
Carpio, Von, Ops. & Systems Technician III
Chebolu, Radha, Sr. Data Scientist II, Finance
Clark, Kristen, Manager of Qlty. & Training, Member Services
Cook, Dawn, Program Manager II, QI
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Director of Quality Improvement, QI
Durst, Jennifer, Senior Manager of Performance Improvement, QI
Foster, Troy, Program Manager II, QI
Harris, Vander, Sr. Health Data Analyst I, Finance
Isola, Brandy, Manager of Performance Improvement, QI
Jensen, Annika, RN, Assoc. Dir. of Clinical Integration, Care Coordination
Kim, Amanda, Improvement Advisor, QI
Kubota, Marshall, MD, Associate Medical Director
Kulkarni, Shreya, Policy Analyst, Regulatory Affairs & Compliance
Lee, Donna, Manager of Claims
Moore, Jordan, Education Specialist, Provider Relations
Mootz, Michelle, Associate Director of Transportation Services
Moraghebi, Roudabeh, Manager of Health Analyst, Finance
Nguyen, Tom, Manager of Health Analyt., Finance
Quichocho, Sue, Manager of Quality Measurement, QI
Rathnayake, Rasitha, Sr. Health Data Analyst I, Finance
Roach, Erika, Program Manager II, Network Services
Rodriguez, Cindy, Project Coordinator II, QI
Salehi, Tiphanie, Sr. Health Data Analyst I, Finance
Seale, J'aime, PR Lead, Network Services
Sivasankar, Shivani, Sr. Data Scientist, Finance
Spiller, Bettina, MD, Associate Medical Director
Trosky, Renee, BSRRT, MOL, Manager of Network Services Compliance
Ungaro, Chloe, Sr. Program Manager, Provider Relations
Vance, Brooke, Program Manager, Network Services
Yu, Fei, Sr. 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 Fairfield-West office. 1. Approval of the Feb. 10, 2026 IQI Minutes 2. Acknowledgment and Acceptance of the draft minutes of the Jan. 29, 2026 Over/Under Utilization Workgroup Meeting Minutes	Motion to **approve IQI Minutes**: Stan Leung Second: Isaac Brown

II. Old Business

Compliance department to provide information on the process for routing policies to DHCS.

Dr. Moore confirmed that all proposed changes need to be made in PowerDMS to allow a smoother flow and consistency.

Starting for IQI in August, policies will be pre-reviewed robustly by RAC. Starting in June they will begin reviewing the policies that are on the August agenda. The business owner of that policy should also be reviewing them and be finished a couple weeks before IQI. If both are using PowerDMS then both can make changes within it. This allows for an easier flow into IQI. RAC needs to notify business owner of potential changes in their review and should all be completed by 2 weeks prior to IQI. Sonja said should be added as a topic to Ops.

RAC is putting out a policy on policies that will outline specifics, along with how departments should proceed if they do not have access to PowerDMS. This policy will also include a hierarchy to help determine which committees policies need to go through for review and/or approval.

Dr. Moore asked how do we communicate our policies to DHCS? Kenzie confirmed certain committees, Quality and Health Equity, the DHCS mandate states our minutes are submitted to them quarterly along with adhoc during audits. This should be represented somewhere whether that's a program description or QIHETP program description along with a narrative. An APL or readiness project (a deliverable) also has to be submitted to DHCS as they are finalized. If it doesn't fall into these buckets then they are submitted annually as a group. They are submitted through the DHCS portal but no confirmation number is given, however an artifact number would be available although its not for tracking. Verbiage should be updated to not reference the word "recorded" and instead should state "minutes were taken" to remove confusion. Brown Act Committee does not need to be included in the policy.

17:13

As APLs come out, Shreya (RAC Policy Analyst) is assessing if it effects any of our current policies or if a policy is needed.

III. New Business Consent Calendar (Committee Members as applicable)

G&A Pulse Report / Issue 20 / March 2026 **Health Services Policies** Care Coordination MCCP2014 – Continuity of Care – *The Adult Expansion population and associated attachments have been removed and archived, as references to populations and immigration status are considered protected language and are not appropriate for inclusion in policy content. The policy is bundled here without Attachment C (400 pages of codes).* Pharmacy MPRP4034 – Pharmaceutical Patient Safety MPRP4065 – Drug Utilization Review (DUR) Program Quality Improvement MPQP1002 – Quality/Utilization Advisory Committee - **Pulled**	*Motion to **approve the slate without the four pulled policies**: Mark Netherda, MD* *Second: Kristine Gual* Next Steps: *None*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPQP1003 – Physician Advisory Committee (PAC) Policy - **Pulled** MPQP1004 – Internal Quality Improvement Committee - **Pulled** <u>Utilization Management</u> MCUP3124 – Referral to Specialist (RAF) Policy MCUP3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21 MCUP3121 – Neonatal Circumcision MPUG3031 – Nebulizer Guidelines MPUP3110 – Evaluation and Management of Obstructive Sleep Apnea in Adults MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump **Non-Health Services Policies** <u>Network Services – Credentialing</u> MPCR4B – Identification of HIV/AIDS Specialists MPCR13 – Credentialing of Pain Management Specialist MPCR13A – Credentialing of Hospice and Palliative Care Medicine Specialist MPCR13B – Buprenorphine Prescriber Credentialing MPCR13C – Osteopathic Manipulation Treatment Credentialing MPCR17 – Standards for Contracted Primary Care and Urgent Care Physicians MPCR19 – Skilled Nursing Facility Providers (SNFists) Credentialing Policy MPCR101 – Ensuring Non-discriminatory Credentialing and Re-credentialing processes MPCR500 – Ongoing Monitoring of Sanctions MPCR600 – Range of Actions to Improve Practitioner Performance MPCR601 – Fair Hearing and Appeals Process for Adverse Decisions MPCR700 – Assessment of Organizational Providers MPCR701 – Ancillary Care Services Provider Credentialing and Re-credentialing Requirements ***- Pulled for removal from packet and will bring back at future IQI*** MPCR800 – Delegation of Credentialing and Re-credentialing Activities MPPR203 – Provider Enrollment Status Guidelines MPPR209 – Provider Network/Subcontractor Contract terminations and Facility De-certifications and Suspension <u>Provider Relations</u> MPPRGR210 – Provider Grievance **MPQP1002 – Quality/Utilization Advisory Committee** <u>Section 6.A.1.2 – Minutes</u> New language will be “Minutes are taken at all meetings. Approved minutes ae submitted monthly to the Regulatory Affairs and Compliance (RAC) inboxes. RAC submits these minutes quarterly to Department of Healthcare Services (DHCS) and forwards the tracking documentation to designated QI staff. *Mark Netherda, MD / Lisa O’Connell* **MPQP1004 – Internal Quality Improvement Committee** <u>Section 6.A.2 – Minutes</u>		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
New language will be "Minutes are taken at all meetings. Approved minutes ae submitted monthly to the Regulatory Affairs and Compliance (RAC) inboxes. RAC submits these minutes quarterly to Department of Healthcare Services (DHCS) and forwards the tracking documentation to designated QI staff. *Mark Netherda, MD / Isaac Brown,* MHA/MBA **MPQP1003 – Physician Advisory Committee (PAC) Policy** <u>Section 6.A.2 – Minutes</u> New language will be "Minutes are taken at all meetings. Approved minutes ae submitted monthly to the Regulatory Affairs and Compliance (RAC) inboxes. RAC submits these minutes quarterly to Department of Healthcare Services (DHCS) and forwards the tracking documentation to designated QI staff. *Mark Netherda, MD / Lisa Ward, MD*		
IV. New Business – Discussion Policies		
Policy Owner: Transportation – *Presenter: Danielle Biasotti, RPht, Director of Transportation Services*		

MPTP2503 – Transportation-Related Travel Expenses, Lodging, Meals, Attendants, Parking and Tolls	• Transportation's content contributors will be their leadership but they are currently working on identifying a policy liaison and will reach out to RAC to get them setup with PowerDMS access along with training.
	
	Synopsis of Changed reviewed:
	• Updated related policies revised MCCP2016 to new policy number MPTP2503 and added MPTP2501
	• Updated Partnership Advantage go live to January 1, 2027
	• Changed member to Member throughout the policy
	• Transportation-Related Travel Expenses Benefit
	  o Revising the milage requests for transportation-related travel expenses within 150 miles of the member's residence may be subject to additional review, up to and including Medical Director review for necessity. This is to align with our current processes. Change from 50 to 150 miles.
	• Updated the Lodging section to include:
	  o Receipts must be itemized
	  o The member will not be reimbursed if they choose to lodge outside of the prebooked hotel and do not notify Partnership in advance.
	  o Partnership is not responsible for fees such as early check in, late check out, incidentals, pet fees, protection coverage, and/or cleaning fees.
	• Updated the Meals section with the following:
	  o To require a minimum of five calendar days prior to the date of service to align with processes.
	  o Breastfeeding moms with a child two or younger may qualify for meals but not to exceed fifteen (15) days of meals for each thirty (30) days of the member's hospitalization. Beginning with the day of member's admission. Each new hospitalization shall begin a new thirty (30) day benefit period.
	• Updated Parking and Tolls section with the following:
	  o Express lanes are not covered
	  o Hand-written parking receipts will only be accepted if they are from a bank or credit card company showing proof of payment.
		*Motion to **approve as amended:** Anna Campbell*
		Second: Mark Netherda, MD
		
		<u>*Next Steps*</u>*:*
		Mar. 18 Q/UAC
		Apr. 8 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Parking and tolls will only be approved if there is a coinciding Travel Related Expense or Gas Millage Reimbursement request and the member cannot submit parking and/or toll receipts without a valid request on file to support it. **<u>Discussion:</u>** • Anna noticed one spelling error on page 262 section E.1.G. "Millage" needs to be updated to mileage and right below that in section H.1. the old policy number of MCCP2016 needing to be updated to the current one. • Cases regarding incontinence due to back pain are not covered in the policy and will remain case by case for review.	
Policy Owner: Pharmacy – *Presenter: Andrea Ocampo, PharmD, Clinical Pharmacist*		
PARP4102 – Medicare Part D Formulary Management and P&T Committee Oversight	*Pulled from the packet for this month so they can be further reviewed by RAC and the Medicare team and will come back at a later time.*	*<u>Next Steps:</u>* *This policy will return at to a later IQI meeting after further review.*
Policy Owner: Pharmacy – *Presenter: Andrea Ocampo, PharmD, Clinical Pharmacist*		
PARP4103 – Pharmacy Benefit Management Delegation Oversight	*Pulled from the packet for this month so they can be further reviewed by RAC and the Medicare team and will come back at a later time.*	*<u>Next Steps:</u>* *This policy will return at to a later IQI meeting after further review.*
Policy Owner: Quality Improvement – *Presenter: Mark Netherda, MD, Medical Director for Quality (Vice Chair)*		
MPQG1005 – Adult Preventive Health Guidelines	• This policy was reviewed by both Dr. Netherda and Dr. Ward. Dr. Netherda will be presenting on it today and Dr. Ward will be presenting on it in QUAC. **Synopsis of Changed reviewed:** <u>MPQG1005 – Adult Preventive Health Guidelines</u> In addition to correcting some typos and attempting to standardize capitalizations, etc., the following significant changes were made to the policy. Section V. Purpose Added new professional sources used in creating this document, specifically, the American Society for Colposcopy and Cervical Pathology (ASCCP) and the California Department of Public Health (CDPH). Section VI. Guideline/ Procedure:	***Motion to approve as amended:*** *Kristine Gual* *Second: Richard Matthews, MD* *<u>Next Steps</u>:* *Mar. 18 Q/UAC* *Apr. 8 PAC*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	B. 2. Which addresses immunizations, we replaced "the Advisory Committee on Immunization Practices (ACIP) with the California Department of Public Health as the source for recommended immunizations for all members. B.3. We clarified the language regarding the Cognitive Health Assessment (CHA) requirement for members who are 65 years of age or older and who do not have Medicare coverage. Retaining the recommendation for providers to complete the DHCS Dementia Care Aware training before administering the CHA, adding that this training is no longer required for providers to be able to bill for this service. Note that this is in anticipation of a change to APL 22-025, which is currently being updated to add some clarification, while removing the training requirement. Section VII. References: We added References – the California Department of Public Health and the American Society for Colposcopy and Cervical Pathology (ASCCP). Attachment A – Adult Preventive Health Screening Guidelines In addition to ensuring we have the most current version of each policy, we added a couple of references that were missing and had the following significant changes: • **Vaccination** - Based on age and risk factors. For updated schedule, reference the CDPH guidelines. CDPH Vaccination Guidelines • ***NEW* Cognitive Health Assessments (CHA) for Members 65 years of age and older** – The USPSTF (February 2020 – currently under review) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for cognitive impairment in older adults. DHCS, however, per APL 22 025, REQUIRES an annual cognitive health assessment (CHA) for Medi-Cal Members 65 years of age and older if they are otherwise ineligible for a similar assessment as part of an Annual Wellness Visit through the Medicare Program. The annual CHA is intended to identify whether the patient has signs of Alzheimer's disease or related dementias, consistent with the standards for detecting cognitive impairment under the Medicare Annual Wellness Visit and the recommendations by the American Academy of Neurology (AAN). (The additional requirement that Medi-Cal Providers must complete the DHCS Dementia Care Aware CHA training to be eligible for billing for this service is expected to be eliminated in 2026.) • **Screening for Perinatal Depression** - Risk factors include low socio-economic status. Consequently, all pregnant Partnership members should be referred for at least one counseling session. The Partnership HealthPlan Perinatal Services (PHPS) Program includes provision of counseling services. If a PHPS program is available, all eligible Partnership members should be referred to a PHPS program for counseling and other services. *(CPSP was replaced with PHPS)*	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• **Cervical Cancer Screening** – Additional notes: The American Society for Colposcopy and Cervical Pathology (ASCCP) recommends the use of vaginal swab collection for high-risk HPV testing in cervical cancer (April 2025) o Clinician collected specimens are preferred and self-collected vaginal specimens are acceptable o Vaginal swab collection is recommended for primary HPV screening in asymptomatic, average-risk people with a cervix ages 25-65 years o Repeat testing each 3 years following a negative HPV test using self-collected vaginal specimens o Self-collected vaginal specimens resulting in HPV positive results require a follow-up visit for clinician-collected cervical specimen o Self-collection is not recommended for high-risk individual, including those with immunosuppression o Use only FDA-approved collection devices and HPV assays. **<u>Discussion:</u>** • Anna asked what was changed in Attachment B as she is noticing a discrepancy with the dates with Dr. Netherda confirming that the content itself did not change, it was only the little policy numbers. Dates need to be fixed to align with the other attachments and policy itself.	
Policy Owner: Utilization Management – *Presenter: Anna Campbell, MPH, Policy Analyst, Utilization Management*		
MPUG3019 – Hearing Aid Guidelines	**Synopsis of Changed reviewed:** During the annual review of this policy, updates were made to clarify the conditions under which hearing aids will be authorized. **Section VI.A.2. S**entence deleted which previously stated "Routing authorizations will be for one hearing aid only. Per discussion with Medical Directors, we are dropping the binaural restriction. **Section VI.A.4.a.** The hearing loss level at which a hearing aid may be authorized was changed from 25 dB to 26 dB to align with InterQual criteria® **Section VI.A.4.d.** Added statement to specify that "InterQual® criteria for *Durable Medical Equipment: Hearing Aids* will be used to approve hearing aids. **Section VI.A.6.** This entire section regarding binaural hearing aids was deleted as per discussion with Medical Directors that we are dropping the binaural restriction. **Section VI.A.5.** Reference to "Attachment A" was deleted. **Section VI.B.2.** Clarified that a trial period for hearing aids is 30 days. **Section VI.B.8.** Add criteria for the authorization of Contralateral Routing of Signals (CROS)-type hearing aids.	*Motion to **approve as presented:** Lisa Ward, MD* *Second: Isaac Brown* <u>*Next Steps*</u>*:* *Mar. 18 Q/UAC* *Apr. 8 PAC*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.B.9. Add criteria for the authorization of Bilateral Contralateral Routing of Signals (BiCROS) hearing aids **Section VII.B. – D:** Added further description and hyperlinks for Title 22 references. At Reference D., the Title 22 CCR code was updated from 51340.1(b)(2) to 51340.1(c) as (b)(2) currently refers to Orthodontic services but (c) refers to Hearing Services. **Section VII.E.:** Added further description and hyperlink for WIC reference. **Discussion:** • No questions or discussion regarding this policy.	
Policy Owner: Utilization Management – *Presenter: Anna Campbell, MPH, Policy Analyst, Utilization Management*		
MCUG3024 – Inpatient Utilization Management	**Synopsis of Changed reviewed:** This policy was updated off-cycle to clarify processes for achieving placements for Members at the appropriate level of care and for providers seeking Reconsideration of Inpatient UM Determinations. **Section I.** Policy MPUP3018 - Health Services Review of Observation Code Billing was added as a Related Policy. **Section III.G.3. thru 5.** The Definitions of Long Term Acute Care, Subacute Care and Skilled Nursing Facilities were updated. **Section IV.** Attachment A document title was updated to "Request for Reconsideration of Inpatient UM Determination (RRIU): Post Discharge Review for Inpatient Services." **Section VI.D.1.b.** Language was added in the Elective/Scheduled Admission Authorization Process section to say "*For elective surgeries in which a post-operative admission directly to an acute inpatient rehabilitation facility is recommended instead of an initial inpatient stay, the prior authorization should be submitted prior to surgery to ensure timely placement*." **Section VI.E.5.b.** Concurrent review time frame for continued review was corrected to be *72* hours instead of 24 hours. **Section VI.E.5.i.** Language clarified to reflect that a provider will be notified verbally, "*via telephone*," if an inpatient stay is determined to be not medically necessary and the facility stay is denied. **Section VI.E.5.j. and k.** Language updated to reflect that attending clinicians of inpatient facilities may request a Peer to Peer for a Member currently admitted to the facility "*or within 3 business days of discharge*." At VI.E.5.k., title of dispute from was changed from provider dispute resolution request to "*Request to Reconsider an Inpatient UM Determination*." **Section VI.G.2.** Added additional facility types: "*Long Term Care Facility (LTC), Medical Respite, Acute Inpatient Rehabilitation, Subacute Rehabilitation*" to the list of facilities where an inpatient facility might make outreach for placement of a Member who no longer requires acute inpatient level of care. **Section VI.G.3.b.** Added this specification for the process when acute inpatient facilities seek placement for Members: "*Once begun, a daily assessment of placement status is expected, summarized in progress notes no less frequently than every 3 calendar days*."	*Motion to* ***approve as presented:*** *Sonja Bjork* *Second: Richard Matthews, MD* *Next Steps:* *Mar. 18 Q/UAC* *Apr. 8 PAC*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.G.3.d. Added specification for acute inpatient admin days as follows: "*If a member meets the criteria for acute inpatient administrative days (as defined in this section), but no placement is achieved and the patient ends up being discharged to a non-covered setting (e.g. home, congregate living, homeless shelter), administrative days can still be assigned those days that met criteria while outreach efforts were being made.*" **Section VI.G.4.** Added specification for acute inpatient admin days as follows: "*For Members with a terminal illness, administrative days may be considered while the facility finalizes an appropriate discharge disposition (SNF with hospice, home with hospice) for a patient with a terminal illness who, when admitted, met acute inpatient criteria, and the records show that the goals of care for the Member have transitioned to comfort care measures*." **Section VI.L.1.** Updated policy reference for UM Communications Services to reflect MPUD3001 UM Program Description. **Discussion:** • No questions or discussion regarding this policy.	
V. Presentations		
QI Update – *Isaac Brown, MPH/MBA, Senior Director, Quality Improvement and Performance*		
• Due to the state no longer offering a long-term care quality incentive program (QIP), Partnership will be launching the Extended Care Facility (EXT) QIP this year. Part of this QIP Is asking the SNIFs to participate and to submit their Quality Assurance and Performance Improvement (QAPI) plans. This is a part of their gateway measures that are required to participate in QIP. Emily, Deanna, and others are starting to mark the importance of the QAPI plans so they can participate in QIP. • Moving forward the QI Update will have brief program descriptions for each topic. • March 2nd eReports launched for our providers to see their quality metrics closer to real time. In a couple months we will be launching the Partnership Quality Dashboard (PQD) that will give further insight into their metrics. • Evaluated our diabetic retinal cameras. All 9 providers that received them exceeded the 50th percentile for the first time in 2025. There were observed delays in acquiring cameras from the vendor, so those looking to purchase cameras for MY2026 should consider purchasing early to account for shipping times. • ABCs of Quality training in Redding is coming up on 03/19/2026 for an in-person training and it is encouraged to share with our network for registration. • CAHPS regulated survey has been distributed to our members to find out how their experience has been with our health plan and their provider. • Gap assessment is being conducted with a company called Rex Wallace looking at our member experience to see how we can be better compared to other managed healthcare plans. Thank you to all who provided data and materials to this. • Trilogy season is coming up with notifications coming up for the Work Plan and Evaluation.		
Site Review & PARS Reports – *Rachel Newman, RN, BSN, Manager of Clinical Compliance – Quality Inspections*		
• This report is an overview of the site review process which includes the Facility Site Review (FSR) and Medical Records Review (MRR). All sites need to score over an 80% in order to be passing, otherwise they are issued a corrective action plan (CAP) that they are expected to fix within 30 days, or a critical element (CE) could require a quicker turnaround. Different sites are reviewed during the audit period so a year-to-year comparison can be challenging. The audit cadence for any given site can be every 1 – 3 years depending on how well the provider does during their previous one. • Page 332 shows the FSR scores by region and county. Everyone is over 90% with the commonly missed things including emergency medications, newer training on disability rights and provider obligations, and height adjustable vision charts.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- Page 336 shows scoring for the MMR's with the scores being lower compared to FSR's. There was improvement in pediatric preventative although it's still lower than the expectation.
- There were not many reviews for OB so the numbers are lower because of this.
- Page 340 covers any type of additional activities or work that has been done.
- Page 342 is their Physical Accessibility Review Survey (PARS) report. The table within the report was reviewed on level of access/domains and their definitions.

Discussion

- Dr. Netherda asked for Rachel to expand on what happens when a site fails their FSR. Rachel explained that when a site fails something they notify Provider Relations (PR) who immediately stop their membership until their CAP is fixed. The site can continue to see current members but will not be assigned any new members which is made clear to the site. Once the CAP is fixed then the membership assignments will be reinstated. If a site fails 3 times, they are kicked out of the network, although this has not happened before, but a couple of sites are close.
- Dr. Netherda also noted that a CE is critical that if they don't have can result in more serious actions with a quicker turnaround timeframe. This team works really close with the site to get these completed and typically are done well within the 30 days.

Proposed 2026 Perinatal QIP 6-month Bridge Measure Set – *Troy Foster, Program Manager ll, Quality Improvement*

- All of the QIP programs will be transitioning by January 2027 to a calendar year cycle which causing some of our QIP programs to transition into a temporary 6 month measure set that will run from July 1, 2026 – December 31, 2026.
- All current 6 measures will remain for the 6 month bridge set with slight modifications, mainly modifying the dates to align with the temporary 6 month bridge of July 1, 2026 – December 31, 2026 but the proposed changes include:
    - The gateway measure is only changing the dates to July 1, 2026 – December 31, 2026. ~70% of perinatal programs are signed up with DataLink and are moving towards extraction by June 30, 2026.
    - Measure 3 to add monthly data extractions as Option 1 with manual submissions being moved to Option 2.
    - Measure 4 to add to the name "with late Entry to Care" as there have been some confusion with providers on this one along with changing the options as noted in measure 3.
    - Measure 5 adjust index period to ensure there is no gap in care.

Discussion

- Kristine asked if the gateway is being extended to the December 31, 2026 or if this will be considered a new gateway measure with its own deadline. Troy confirmed it will be the latter, a second gateway measure and not an extension of the previous one.
- James asked if the verbiage regarding women should be updated to "female at birth" to align with NCQA. Dr. Moore said that with QIP we do not have to, although it would be better to do so.
- Katherine and Dr. Moore agreed that the Postpartum measure should have the "timely" language updated to have the first visit target at 7 – 14 days and second visit target would be 13 days - 6 weeks to align with the Transitional Care Services High Risk Population. DHCS has a new pop health policy guide that re-stratified pregnant and/or postpartum individuals into high and medium risk with health plans required to do certain activities for them. Prenatal Policy does not need this specified currently but will be in the future when we have to screen everyone.
- Changes will be implemented with Dr. Townsend and then this will go to PAC next month – no approval needed during this meeting.

Cultural & Linguistic Grand Analysis Presentation – *Hannah O'Leary, Manager of Population Health*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
• MPND9002 2026 C&L Program Description • 2026 C&L Work Plan • 2025 C&L Program Evaluation • 2025 C&L/QIHETP Work Plan Final Update	**Synopsis of Changed reviewed (433):** This program description was updated to reflect changes per the NCQA 2026 HOA Standards and Guidelines, APL 25-016 *Alternative Format Selection for Members with Visual Impairments*, and organizational changes. Includes minor grammar, formatting, and hyperlink updates. **Policy Codes** • Removed APL 22-022 references throughout document and updated to APL 25-016. **Auxiliary Aids (pg. 16)** • Clarified requirements for providing auxiliary aids and services to the Member's Authorized Representative (AR) or other individuals authorized by the Member or as designated by law. **Alternative Formats (pg. 17-18)** • Clarified that Members may request an encrypted (password-protected) electronic format; if not requested, an unencrypted electronic format will be provided. • Removed references to MCP receipt of weekly AFS extracts; MCPs will rely on 834 membership data. • Added language describing Partnership's reasonable efforts to direct Members to BenefitsCal or local county offices for AFS updates. **Team Roles and Responsibilities (pg. 26)** • Updated existing Partnership position descriptions (across PHM, Health Equity, and G&A) to cover staff dedicated to C&L activities. **Updated Attachment A: Criteria for Interpreter Services** • In Telephonic or Video Remote Interpreter Services section, added extra possible context in which a request could be made, "calling Partnership HealthPlan of California." • Removed last paragraph describing referral to Carelon for Face-to-Face Interpreter Services, due to changes in Behavioral Health operations (de-delegation of Carelon). **Updated Attachment B: Providing Auxiliary Aids and Services for Persons with Disabilities** • Edits to update from "language assistance taglines" to the newer "Notice of Availability" name. • Edits clarify that a Partnership representative will help the requester fill out the Auxiliary Aid Request Form **Updated Attachment E: CAC Guiding Principles** • Edits made to align with DHCS APL 25-009 Community Advisory Committee. • Added details around what resources may be shared to help educate CAC members. • Added additional points to the list of CAC's responsibilities. • Clarified the role of both Partnership's Board of Commissioners and Health Equity in the CAC member selection process.	*Motion to **approve as presented:** Isaac Brown, MHA/MBA* *Second: Lisa Ward, MD*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Clarified that interpretation and translation services are available to all CAC members upon request, and that the CAC organizing team will ensure all locations where meetings are held are accessible to all members. **Discussion:** • Sonja and Dr. Moore both commended Hannah for efficiently reviewing the material and appreciated the hard work that her team put into the goals. • Isaac asked if the C&L Program Evaluation findings were a pretty big difference due to better data or material change? Hannah said it was that for the alternative formats they were provided better data. • Anna asked about the almost 2,000% increase on the alternative format request. What staff were processing that difference? Hannah confirmed it wasn't that it was different, it just wasn't really tracked the year previously. This year there was a standard implemented to make it easier to track.	
VI. Adjournment		
Dr. Moore adjourned the meeting at 3:14 p.m. IQI will meet next Tuesday, Apr. 7, 2026.		
Respectfully Submitted by Chandler Ackerman, Project Manager I, Quality Improvement *Approval Signature:* *Date:* *Robert Moore, MD, MHA, MBA* *Chief Medical Officer and Committee Chair*		

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

Date: Tuesday, Apr. 7, 2026 **Time: 1:30 - 3:30 p.m.**

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

To Join by Webex:
https://partnershiphp.webex.com/meet/iqi
Meeting # 2631 319 6924

To Join by Telephone:
Toll Free: 844-621-3956
Access Code: 2631 319 6924

	Item	Lead	Time	Page #
I.	**Call to Order//New Staff Introduction(s)/Announcements/Approval of Minutes**			
1	Approval of Internal Quality Improvement (IQI) Committee Meeting Minutes of Mar. 10	Robert Moore, MD, MPH, MBA	1:30	6
2	*Acknowledgement and acceptance of* • Feb. 26, 2026 Member Grievance Review Committee minutes • March 12, 2026 Population Needs Assessment (PNA) Committee minutes (Committee has been disbanded- These are the final Minutes of this Committee)			19 27
II.	**Old Business**			
	MPCR700- edits made after March IQI to MPCR700 regarding Accreditation, approved by Dr. Moore			32
III.	**New Business – Consent Calendar Policies**			
	Consent Calendar		1:37	42
Health Services Departments	**Care Coordination**			
	MCCP2036 – Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities			44
	Health Equity			
	MCEO6003 – Race/Ethnicity, Language, Gender Identity, and Sexual Orientation Individual Member Data Collection/Storage /Retrieval			77
	MCEO6003-A – Attachment A			84
	Quality Improvement			
	MPQP1006 – Clinical Practice Guidelines			104
	MPXG5001 – Clinical Practice Guidelines for the Diagnosis & Management of Asthma			109
	MPXG5002 – Clinical Practice Guidelines for Diabetes Cellulitis			113
	Utilization Management			
	MPUP3026 – Inter-Rater Reliability Policy			117
	MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions			121
Non – HS Departments	**Network Services – Credentialing**			
	MPCR13D – Registered Pharmacist for AB1114 Credentialing			131
	MPCR602 – Reporting Actions to Authorities			134
	MPPR200 – Partnership Network Providers and Contracts			139
	MPPR210 – Long Term Support Services Liaison			144

	Item	Lead	Time	Page #
	MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements			148
IV.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	156
Non-HS	**Behavioral Health**			
	MPBP8003 – Mental Health Services	Jeffrey DeVido, MD	1:44	164
	MPBP8011 – Scope of Primary Care – Behavioral Health Indications for Referral Guidelines	Jeffrey DeVido, MD	1:49	182
	Network Services			
	MPCR17 – Standards for Contracted Primary Care and Urgent Care Physicians	Mark Netherda, MD	1:54	190
HS Policy	**Care Coordination**			
	MPCP2034 – Transitional Care Services (TCS)	Aryana Cunnigham	1:59	195
	Pharmacy			
	MCRP4068 – Medical Benefit Medication TAR Policy	Andrea Ocampo, Pharm.D.	2:04	209
	Quality Improvement			
	MPQP1022 – Site Review Requirements and Guidelines	Rachel Newman, RN	2:09	218
	Utilization Management			
	MCUP3133 – Wheelchair Mobility, Seating and Positional Components	Tony Hightower	2:14	419
	MPUD3001 Utilization Management Program Description is included in the Presentation section as part of our Annual UM Program Evaluation (see below)	--	2:19	--
V.	**Presentations**			
1	QI Update	Isaac Brown		432
2	MPUD3001 – Utilization Management Program Description – *synopsis of changes begins on p.446*	Tony Hightower	2:24	449
3	Annual 2025 Utilization Management (UM) Program Evaluation – NCQA UM Standard 1 Element G • Supplemental TAR Report to the 2025 UM Program Evaluation	Tony Hightower / Andrea Ocampo, Pharm.D.	2:39	479
4	Population Needs Assessment Presentation	Hannah O'Leary	2:54	535
5	Proposed 2027 Palliative Care QIP Measure Set	Eva Lopez	3:09	650
6	Proposed 2026 Hospital QIP 6-month Bridge Measure Set	Troy Foster	3:19	652
FYI	*Pharmacy Operations Update 2a – direct any questions to Stan Leung*			657
	Adjournment by 3:30 p.m. Tuesday, May 12, 2026			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
INTERNAL QUALITY IMPROVEMENT (IQI) COMMITTEE MEETING MINUTES
Tuesday, Apr.. 7, 2026 / 1:30 – 3:24 PM

Members Present:

Andrews, Leigha, Regional Director (SW)
Barresi, Katherine, RN, BSN, PHN, Chief Health Services Officer
Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations
Bontrager, Mark, Senior Director of Behavioral Health, Health Services
Brincko, Aaron, Director of Provider Relations
Brown, Isaac, MHA/MBA, Senior Director, Q & PI
Brunkal, Monika, RPh, Associate Director of Population Health
Campbell, Anna, MPH, Policy Analyst, Utilization Management
DeVido, Jeffrey, MD, Behavioral Health Clinical Director
Esget, Heather, RN, MSN, ACM, Director of Utilization Management
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
Gual, Kristine, PMP, CPHQ, Director of Quality Measurement, QI
Hightower, Tony, CPhT, Associate Director, UM Regulations
Innes, Latrice, Compliance Manager, Grievance & Appeals
Jalloh, Mohamed, Pharm.D, Dir. of Health Equity (Health Equity Officer)
Jones, Kermit, MD, JD, Deputy CMO/Medical Director for Medicare Srvcs
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer (Chair)
Netherda, Mark, MD, Medical Director for Quality (Vice Chair)
Newman, Rachel, RN, BSN, Mgr, Clinical Comp. – Quality Inspections
O'Connell, Lisa Brundage, MHA, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ruffin, DeLorean, DrPH, Director of Population Health
Townsend, Colleen, MD, Regional Medical Director (SE-Fairfield)
Villasenor, Edna, Senior Director, Member Services and Grievance
Ward, Lisa, MD, Regional Medical Director (SW-Santa Rosa)

Members Absent:

Ayala, Priscila, Director of Network Services
Bjork, Sonja, JD, Chief Executive Officer
Boyle, Shannon, RN, Manager of CC Regulatory Performance
Davis, Wendi, Chief Operating Officer
Klakken, Vicky, Regional Director (NW-Eureka)
Matthews, R. Douglas, "Doug," MD, Regional Medical Director (Chico)
Sharp, Tim, Regional Director (NE-Redding)
Turnipseed, Amy, Chief Strategy and Government Affairs Officer
Vaisenberg, Liat, Director of Health Analytics
YoungStone, Kelly, RN, Director of Care Coordination

Guests:

Akintan, Folo, Epidemiologist, Pop Health
Allen, Angier, Sr. Data Scientist I, Finance
Arguello, Amanda, Lead Trainer, Network Services
Banuelos, Anna, Nurse Case Manager II, Care Coordination
Beard, Alyssa, RN, Manager of CC Regulatory Performance
Bikila, Dejene, Manager of Data Science, Finance
Brown, Evangeline, RN, Manager of Utilization Management
Chebolu, Radha, Sr. Data Scientist II, Finance
Clark, Kristen, Manager of Qlty. & Training, Member Services
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Director of Quality Improvement, QI
Diaz, Alondra, Project Coordinator I, Care Coordination
Durst, Jennifer, Senior Manager of Performance Improvement, QI
Foster, Troy, Program Manager II, QI
Hanusiak, Kenzie, Associate Director of Reg. Affairs/Compliance
Harris, Vander, Sr. Health Data Analyst I, Finance
Hazel, Jerry, RN, Supervisor of UM
Ling, Samuel, Sr. Health Data Analyst I, Finance
Lopez, Eva, CPhT, Program Manager I, QI
Lopez, Rosalee, Manager of UM Operations
Moore, Jordan, Education Specialist, Provider Relations
Morris, Matthew, MD, Regional Medical Director
Muncy, Kellie, Manager of Change Management & Configuration
Nguyen, Tom, Manager of Health Analyt., Finance
Ogren, Danielle, Sr. Director of Reg. Affairs & Compliance
Quichocho, Sue, Manager of Quality Measurement, QI
Rathnayake, Rasitha, Sr. Health Data Analyst I, Finance
Robertello, Kimberly, Manager of Medicare Quality, QI
Rodriguez, Cindy, Project Coordinator II, QI
Rushing, Eric, Manager of Mental Health Programs
Salehi, Tiphanie, Sr. Health Data Analyst I, Finance
Seale, J'aime, PR Lead, Network Services
Sivasankar, Shivani, Sr. Data Scientist, Finance
Smith, Christine, Community Health Needs Liaison, Pop Health

Hostesttler, Rebekah, RN, Supervisor of UM	Spiller, Bettina, MD, Associate Medical Director
Isola, Brandy, Manager of Performance Improvement, QI	Thomas, Penny, Sr. Health Data Analyst I, Finance
Jensen, Annika, RN, Assoc. Dir. of Clinical Integration, Care Coordination	Ungaro, Chloe, Sr. Program Manager, Provider Relations
Kubota, Marshall, MD, Associate Medical Director	Vance, Brooke, Program Manager, Network Services
Kulkarni, Shreya, Policy Analyst, Regulatory Affairs & Compliance	Williams, Joanie, RN, Manager of UM
Lee, Donna, Manager of Claims	

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 1:30 p.m. from the Fairfield-West office. 1. Approval of the Mar. 10, 2026 IQI Minutes 2. Acknowledgment and Acceptance of the draft minutes of: • Jan. 29, 2026 Over/Under Utilization Workgroup Meeting Minutes • March 12, 2026 Population Needs Assessment (PNA) Committee minutes	*Motion to **approve IQI Minutes**: Kristine Brown, PMP, CPHQ* *Second: Isaac Brown, MHA/MBA* *Motion to **approve Over/Under Utilization Workgroup Minutes and PNA Minutes**: Kristine Gual, PMP, CPHQ* *Second: Lisa Ward, MD*

II. Old Business

MPCR700- Assessment of Organizational Providers (page 32)

- Edits were made after the March IQI meeting regarding accreditation and were approved by Dr. Moore. This topic is being brought back to notify the IQI committee before it goes to the final approving body the credentials committee. Brooke confirmed removed accreditation piece and left the site review.
- Informational only topic with no further questions.

Policy Workflow

- Dr. Moore gave the reminder that starting in June in preparation for the August IQI meeting we will be doing reviews of the policies earlier than normal through PowerDMS. The goal is to have both individual business owners, assigned medical directors, and RAC to review the policies a little more than 2 months prior than they are due. The timeline is that for August IQI reviews would start in June. 2 weeks before submissions are due to IQI (3 weeks before August IQI) they should be reconciling their edits with RAC so by the time it gets to the August IQI the experts have already weighed in.
- Kenzie from RAC added that she and Shreya will be presenting **CMP44** Policy on Policies which will entail the workflow on how these should be handled to Ops next week. Once that has been approved it will be uploaded into PowerDMS. This policy will also outline the roles and responsibilities for the policy workflow. They will also share a list soon of who currently has access to PowerDMS and can begin using it now versus who will need access. If you have any questions or in the future, please reach out to Kenzie and/or Shreya for support.

III. New Business Consent Calendar (Committee Members as applicable)

Health Services Policies Care Coordination MCCP2036 – Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities Health Equity MCEO6003 – Race/Ethnicity, Language, Gender Identity, and Sexual Orientation Individual Member Data Collection/Storage	*Motion to **approve the slate without the one pulled policy**: Isaac Brown, MHA/MBA* *Second: Lisa Ward, MD* Next Steps:

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
/Retrieval MCEO6003-A – Attachment A <u>Quality Improvement</u> MPQP1006 – Clinical Practice Guidelines MPXG5001 – Clinical Practice Guidelines for the Diagnosis & Management of Asthma MPXG5002 – Clinical Practice Guidelines for Diabetes Cellulitis <u>Utilization Management</u> MPUP3026 – Inter-Rater Reliability Policy MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions **Non-Health Services Policies** <u>Network Services – Credentialing</u> MPCR13D – Registered Pharmacist for AB1114 Credentialing MPCR602 – Reporting Actions to Authorities MPPR200 – Partnership Network Providers and Contracts MPPR210 – Long Term Support Services Liaison ***– Pulled – held from this meeting and will be added to May's IQI meeting.*** MPCR301 – Non-Physician Clinician Credentialing and Re-credentialing Requirements		*Apr. 15 Q/UAC* *May 13 PAC*
IV. New Business – Discussion Policies		
Policy Owner: Behavioral Health – *Presenter: Jeffrey DeVido, Behavioral Health Clinical Director*		
MPBP8003 – Mental Health Services	**<u>Synopsis of Changed reviewed (page 156):</u>** • Added, "and dyadic Behavioral Health Services" to section I. 1. Changes were made to align with APL 26-002 wording. • Changed wording "medications" to "drugs" in section I. 5. Changes were made to align with APL 26-002 wording. • Updated DHCS BHIN 21-073 reference to updated BHIN 26-002. DHCS updated BHIN. • Added wording "Partnership covers NSMHS without prior authorization requirements.". This aligns with Partnerships NCQA requirements for no authorization required for MH services. • Added section K. Youth Trauma Screening Tools. Section added to align with new Youth Trauma Screening Tool requirements in DHCS APL 26-002 • Updated and Added wording related to EPSDT benefit to section H 1. Changes were made to align with APL 26-002 guidance. • Added wording "Partnership covers clinically relevant laboratory and radiologic studies…" to align with wording in APL 26-002. • Removed "up to 20" limitation on individual and/or group counseling sessions for pregnant and postpartum Members. Changes were made to align with APL 26-002 guidance. • Added sections N and O in Partnership is responsible for: SABIRT services and Preventive screenings for tobacco, alcohol and drugs. Changes were made to align with APL 26-002 guidance. • Updated wording in section R. 1. "and Partnership will notify members of such applicable policies." to align with wording in APL 26-002 • Removed superseded references and added reference to APL 26-002.	*Motion to **approve as amended:** Mark Bontrager Second: Isaac Brown, MHA/MBA* <u>Next Steps</u>: *Apr. 15 Q/UAC* *May 13 PAC*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Changed "sound" to "current evidence based" and changed "principles and processes" to "practice guidelines". Changes made to align with wording in APL 26-002 **Discussion:** • Anna noticed that there were edits to the medical disclaimer on page 188 and recalled that due to an audit in the past they had to include the medical disclaimer as it was. She asked if DHCS had requested this change and if so if the changes need to be run by compliance and then updated on all other policies that use the medical disclaimer. o Eric said that the new wording is the exact wording from APL 26-002. Anna asked if it should be updated everywhere? o Dr. DeVido shared the policy on the screen and it was determined that the language was referencing a different policy. Dr. Moore recommended the medical disclaimer language be reverted to its original state with no changes.	
MPBP8011 – Scope of Primary Care – Behavioral Health Indications for Referral Guidelines	**Synopsis of Changes reviewed:** • Added, "and dyadic Behavioral Health Services" to section A. 1. Changes were made to align with APL 26-002 wording. • Changed wording "medications" to "drugs" in section A. 5. Changes were made to align with wording in APL 26-002. • Updated BHIN 21-073 reference to updated BHIN 26-002. DHCS updated BHIN. • Added wording "If a PCP cannot perform the mental health assessment, they must refer the Member to the appropriate Provider and delivery system for mental health services…". Changes made to align with APL 26-002. • Added section e. Reference to Youth Mental Health Screening Tools in Policy MPBP8003. Changes made to align with APL 26-002. • Added sections a, b, c and d. PCPs should screen and refer members with SUD as follows: SABIRT services, Preventive screenings for tobacco, MAT services, and Emergency and Post-Stabilization service. Changes were made to align with APL 26-002. • Removed superseded references and added reference to APL 26-002. • Changed "sound" to "current evidence based" and changed "principles and processes" to "practice guidelines". Changes made to align with wording in APL 26-002 **Discussion:** • *The discussion regarding medical disclaimer language for policy **MPBP8003** – Mental Health Services also reflected this policy with one conversation happening for both policies. Please refer to the minutes for policy **MPBP8003**, with no further discussion happening for policy **MPBP8011**.*	*Motion to **approve as amended:** Anna Campbell, MPH* *Second: Kristine Gual, PMP, CPHQ* Next Steps: *Apr. 15 Q/UAC* *May 13 PAC*
Policy Owner: Network Services – *Presenter: Mark Netherda, MD, Medical Director for Quality*		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
MPCR17 – Standards for Contracted Primary Care and Urgent Care Physicians	**Synopsis of Changes reviewed:** Added language – VI. A. 3. h. - Resident physicians, in the process of completing residency training within a primary care specialty (Pediatrics, Internal Medicine, or Family Medicine) may apply to start the credentialing process upon documented, successful completion of two (2) years of post-graduate training, within a primary care specialty residency. This will facilitate credentialing of physicians wishing to begin working in Partnership contracted practices or groups immediately upon completion of residency requirements. **Discussion:** • Dr. Netherda added that there will be one additional change that has not been implemented yet but would like approval on it. Under section IV. Attachments, A - *Primary Care and Urgent Care Provider Criteria Form*, this is actually a misnomer due to it being a list of procedures or practices that the provider is asking to be credentialed for. Due to it not being an actual criteria they will be replacing the word Criteria to Procedures, *Primary Care and Urgent Care Provider Procedures Form*. o The current link is not attached to the most up to date form. The updated form now has a box where the provider can write in and describe anything else they would like to be approved for if it falls out of the current options since this happens quite often. Attachment A is not included in the packet and is linked within the policy. Brooke is working on getting this updated within PowerDMS so it goes to the newest version.	*Motion to **approve as amended:** Isaac Brown, MHA.MBA* *Second: Aaron Brincko* Next Steps: *May 13 Credentials Committee*
Policy Owner: Care Coordination – *Presenter: Aryana Cunnigham, Policy Analyst – Care Coordination*		
MPCP2034 – Transitional Care Services (TCS)	*Pulled from the packet for this month and will come back at a later time.*	*Next Steps:* *This policy will return at to a later IQI meeting after further review.*
Policy Owner: Pharmacy – *Presenter: Andrea Ocamp, Pharm.D., Clinical Pharmacist – Pharmacy*		
MCRP4068 – Medical Benefit Medication TAR Policy	• This policy is coming back ahead of its annual review to meet NCQA requirements. **Synopsis of Changes reviewed:** Section VI.C-Members or their authorized representative may request a PAD that is not on the list of covered drugs or exceptions to the UM requirements based on medical necessity Section VI.C.1.-Effective June 1, 2026, prescribers submitting TARs for PADs must be enrolled in Medi-Cal FFS using a Type 1 NPI through PAVE. TARs associated with non-enrolled prescribers may be administratively denied. Section VI.D.1.-Providers are expected to include ICD-10 CM codes when applicable to support medical necessity determination	*Motion to **approve as presented:** Kristine Gual, PMP, CPHQ* *Second: Isaac Brown, MHA/MBA* Next Steps: *Apr. 15 Q/UAC* *May 13 PAC*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.I.1.f-Drug exclusions, restrictions, or PA requirements implemented under Medi-Cal Rx effective January 1, 2026 remain outside the scope of Partnership medical benefit review unless DHCS guidance explicitly assigns responsibility to the MCP **Discussion:** • Mark asked if managed care plans will be fielding grievances regarding the June 1, 2026 deadline? o Dr. Moore said that typically grievances are handed over to Magellan to be handled but Partnership does serve as the backup if they do not resolve it well. Since this is regarding provider enrollment the idea is that there will be collaboration to enforce it. A list was provided with 2/5ths of the gigantic list having only filled 1 prescription. The two top prescribers were pharmacists, not outside prescribers. Pharmacists have the ability to prescribe certain things. This last was sent to RAC for investigation. Pharmacy can prescribe nicotine replacement therapy, birth control, and travel health meds directly. o Dr. Jalloh added that pharmacists have to go through various trainings to be able to provide prescriptions directly to patients. For example the state has their own naloxone training that they require for it to be provided.	
Policy Owner: Quality Improvement– *Presenter: Rachel Newman, RN, Manager of Clinical Compliance*		
MPQP1022 – Site Review Requirements and Guidelines	**Synopsis of Changes reviewed:** This policy is coming back ahead of its annual review in large part to accommodate UM's MCUP2033 – Urgent Care Services policy. 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. Policy title changed from MCQP1022 to MPQP1022 due reflect applicability to Partnership Advantage, effective January 1, 2027." **Section III Definitions added:** "Supplemental Facility, Free Standing Urgent Care Provider, Free-Standing Urgent Care Center, Shared Medical Record Practice" to add clarification throughout the policy. **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.** **Attachments are being reordered and thus re-lettered Attachments J-N below are new additions:** J. Free Standing Urgent Care Clinic Facility Site Review Tool K. Urgent Care Medical Record Tool L. PCP Providing Urgent Care Facility Site Review Tool M. Palliative Care Facility Site Review Tool N. Palliative Care Medical Record Review Tool	*Motion to **approve as presented:** Mark Netherda, MD* *Second: Lisa O'Connell, MHA* *Next Steps:* *Apr. 15 Q/UAC* *May 13 PAC*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	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.5) • 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. 5) • 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. 7) • Medical Record Review (MRR) Scoring language is updated (p. 8): "If the minimum number of records is not available, Partnership will document the rationale and complete the MRR with the available records." • Obstetric Specialists and Non-Accredited Sites have been bundled and FSR and MRR language augmented under section "Specialized Site Reviews" (pp. 12) These are followed by additional MMR language pertaining to Free Standing Urgent Care Clinics (p. 12), and "PCP providing Urgent Care Services" (p. 12) "A Palliative Care report is run monthly by the Inspections Site Review Team." (p. 13) • 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. **Discussion:** *No questions or discussion regarding this policy.*	
Policy Owner: Utilization Management – *Presenter: Tony Hightower, Associate Director of UM Regulation*		
MCUP3133 – Wheelchair Mobility, Seating and Positional Components	**Synopsis of Changes reviewed:** **Section VI.A.3.a. and b.:** This policy was updated to include language for Charpentier billing as follows: • Partnership will process a TAR for a dually eligible Member in the same manner as it would process a TAR for a Medi-Cal-only Member, regardless of whether Medicare (or any other health coverage) has authorized the equipment or been billed. • A TAR for such requests must include all medical justification and documentation that would normally accompany a Medi-Cal-only TAR and include the message "Medi/Medi: Charpentier/Rates", "Medi/Medi: Charpentier/Benefit Limitation", or "Medi/Medi: Charpentier/Both Rates and Benefit Limitation" in the Medical Justification section. **Discussion:** • Dr. Spiller expressed concern that if we are saying we are processing the Medi/Medi claims the same as MediCare's decision because often when they are processing the claim MediCare has not made	*Motion to **approve as presented:** Katherine Barresi, RN, BSN, PHN* *Second: Lisa O'Connell, MHA* *Next Steps:* *Apr. 15 Q/UAC* *May 13 PAC*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	their decision yet. She suggested removing this language from the policy and instead having it be on an internal workflow. o Dr. Moore asked if MediCare typically approve the various wheelchair items? Dr. Spiller said they will approve the wheelchair but then deny some of the components, the same as Partnership. Depending on the member, if appropriate, it could go to a QHP eval. o Dr. Moore confirmed that we do not have to define this workflow within the policy and instead will develop a desktop. • Rosalee expressed a concern that if they receive a TAR and the patient is Medi/Medi. If we cannot determine if it was approved and/or paid by MediCare. Would they request the periscope review or would we approve and hope that our Claims stops it? Dr. Moore said that if we do an independent review, then they would need to do the periscope review, along with confirming this is also a workflow issue and not a policy one. • Kellie asked who will be on point for the workflow development to ensure it gets completed. Rosalee and Dr. Spiller will work on it together. Kellie confirmed to also include claims so they are informed on how to process them.	
V. Presentations		
QI Update – *Isaac Brown, MPH/MBA, Senior Director, Quality Improvement and Performance*		
• The Perinatal Symposium will be held on April 13th out of Fairfield and broadcast to Auburn, Eureka and Redding offices for providers to attend in person. Topics covered will include: o Nutrition education and treatment in the perinatal period o Comprehensive assessments: Integrating effective strategies to understand and meet your patient's needs during and after pregnancy o Maternal mood disorders: Screening, diagnosis, and treatment o Substance use disorders during and after pregnancy o Vascular disease: Who is at risk? • Our CAHPS program administers our annual survey with progress on the regulated survey remaining on schedule, with the telephone interviewing phase currently underway. The survey window is expected to close in May, marking the end of the data collection period. • For the upcoming quarter we currently have 40 mobile mammography events scheduled with 19 of those being in Eureka. The calendar is quickly being filled so if there are any providers who are interested please have them reach out to mobilemammography@partnershiphp.org • In the period of 02/26/2026 to 04/01/2026 there were 39 referrals for Potential Quality Issues (PQI) were received with 34 coming from Grievance and Appeals, 3 from Utilization Management, 1 from Care Coordination and 1 from QI Member Safety. There is a training for Grievance and UM coming up so there will likely be an uptick in referrals. If any other department is interested in having this training, please reach out to Robert Bides. • NCQA released the March HPA and HOA Triannual Policy Updates on 3/30/2026. The NCQA Project Management Team has provided updates on impacted standards with respective Business Owners (BOs). BOs are asked to review the updates, assess impact, and/or request clarification to ensure the evidence documentation is aligned with NCQA's scope of review, or must implement/finalize edits within 90 calendar days of the release date for any policy changes or clarifications. **Discussion:** • *No questions or discussion regarding this update.*		
MPUD3001 – Utilization Management Program Description – *Tony Hightower, Associate Director of UM Regulation*		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Pages 449 - 657 **Synopsis of Changes reviewed (page 446):** Annual updates to our UM Program Description for both UM and Pharmacy activities were made in conjunction with our annual UM Program Evaluation. **Page 1:** In the Program Purpose section, "Enhanced Health Services" was added as the eighth Health Services team. **Pages 2 - 19:** Program Staff descriptions were reorganized into sections as follows: OCMO, UM, BH, and Pharmacy. **Page 3:** Added Program Staff description for the new position of Deputy Chief Medical Officer. In the assigned responsibilities for the Medical Director of Quality, added that this position serves as Chair for the Credentials Committee, Directs the two Member Safety Teams for Clinical Compliance and Quality Investigations, and Works with the Grievance and Appeals team to review Member Grievances with possible clinical care elements. **Page 5:** Removed Program Staff description for Director of Health Equity as that position is now described in the QIHETP Program Description, MCED6001. **Page 6:** Updated Program Staff description for the Director of UM to clarify duties and remove responsibility for reporting to Q/UAC on UM activity. **Page 7:** Updated Program Staff description for the Director of EHS. **Page 8:** Updated Program Staff description for the Associate Director of Utilization Management Regulations to state that this position gathers UM program information and incorporates updates into the annual UM evaluation and program description. **Page 9:** Updated Program Staff description for the Associate Director of EHS. **Page 10:** Added new Program Staff description for Manager of Enhanced Health Services Operations. **Page 11:** Updated Program Staff description for the Clinical Supervisor of Enhanced Health Services to include participation in oversight and audit of CalAIM providers. **Pages 12-13:** Updated Program Staff descriptions for Nurse Auditor, Nurse Coordinator II, and Nurse Coordinator I. **Pages 13-14:** Added new Program Staff description for Program Manager II and Program Coordinator II in UM Regulations. Also updated Program Staff description for Program Manager I – (EHS). **Page 15:** Updated Program Staff descriptions for Project Coordinator II - (EHS), Project Coordinator I - (EHS), Health Services Analyst I, and Health Services Administrative Assistant II – UM, EHS. Added a new Program Staff Description for Program Coordinator I - (Training & Education). **Pages 16 - 17:** Updated Program Staff description for Behavioral Health Clinical Director to reflect only MD as that is the credential for the person currently in this position. Other options of DO, PhD, and PsyD were deleted for now. Other updates were made to clarify changes since Carelon was de-delegated. **Pages 17-18:** In the Behavioral Health section, added new Program Staff descriptions for Senior Manager of Behavioral Health, Sr. Manager of Behavioral Health Access, Sr. Manager of Child Welfare Program, Manager of First 5 Commissions, Manager of Mental Health Programs, and County Child Welfare Liaison. **Page 20:** Updated information on attendees for the PAC Committee. **Pages 20-21:** Updated information on attendees for the Q/UAC Committee and specified that the committee activities include annual review of UM rates and identification of actions to address opportunities identified. Also updated information on attendees for the QIHEC committee. **Page 22:** Corrected definition of BHT to reflect Behavioral Health Treatment instead of "therapy" services.	*Motion to **approve as presented:** Lisa O'Connell, MHA* *Second: Kristine Gual, PMP, CPHQ*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Page 24: Updated information on APL 22-012 to reflect APL 25-013 Medi-Cal Rx Pharmacy Benefits and Cell and Gene Therapy Coverage. **Page 25:** Updated policy number MPCP2017 to reflect MPBP8011 because the *Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines* policy has been transferred from Care Coordination to the Behavioral Health department. **Page 27:** In the Utilization Manager Process section, added statement to say that "Appropriately licensed professionals supervise all medical necessity decisions as described in the UM Program Staff section starting on page four (4)." This was a recommendation from our NCQA consultant. Consultant also added clarification to last statement on the page to specify that UM considers the "local" delivery system and the availability of services with "their ability to meet the Member's specific health care needs." **Page 31:** In the UM chart for Non-Behavioral Healthcare Decisions and Behavioral Healthcare Decisions, the time frame for Non-urgent pre-service decisions was changed from 5 business days to 7 calendar days as per DHCS regulations. A new time frame chart was added to describe Pharmacy Decisions that must be made within 24 hours of receipt of request for Urgent Concurrent, Urgent Pre-service, and Non-urgent pre-service decisions. **Page 33:** In the Availability of Criteria section, language was updated to say that the Provider Relations department notifies providers in writing "and electronically" regarding availability of UM criteria. Per our NCQA consultant, this statement was also added to describe our upcoming D-SNP program: "Partnership's UM Program plans include development and implementation of its CMS Final Rule Interoperability plan during CY 2026. This plan will include steps for the implementation of practitioner access to criteria electronically at point of service. Implementation is planned for January 2027." **Page 35:** The section on Appeals was updated per recommendation from our NCQA consultant. The title of the section was changed to specify "Process for ***a Member or a*** Provider ***on Behalf of a Member*** to Appeal an Adverse Benefit Determination," and the following language was added to this section. "The Member or their authorized representative may submit a request for appeal verbally or in writing. The Member or the authorized representative may submit additional information for review and may request copies of all documents considered as part of the review. The time for resolution begins when the request is received, even if the information provided is incomplete. Partnership makes appropriate attempts to obtain any needed information for review within the required timelines, in order to make an informed decision within required timeframes based on clinical urgency and according to our policies and procedures." **Page 39:** The Annual Program Evaluation section was updated to specify that the Behavioral Health department participates in the evaluation, and the following additional positions were added for leadership who contribute: Senior Director of Care Management, Senior Director of Behavioral Health, and the Director of Enhanced Health Services. **Discussion:** • *No questions or discussion regarding this policy.*	
Annual 2025 Utilization Management (UM) Program Evaluation - NCQA UM Standard 1 Element G *–Tony Hightower, Associate Director of UM Regulation and Andrea Ocampo, Pharm.D.*		
UM 1G Annual UM Program Evaluation (Page 493) • Annual review for the UM program of CY 2025 report assesses the following: o Program Structure		*Motion to* ***approve as presented:*** *Mark Netherda, MD*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	○ Program scope, processes, and information sources used to determine benefit coverage and medical necessity. ○ Level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program ○ Member and Practitioner experience with the UM program • **Program Structure: Staffing Oversight (Page 496)** ○ Currently Partnership established a minimum threshold of Medical Directors to Nurses and Medical Directors to Pharmacists at 1:5 at 1:5 (20%). Partnership's Physician to Pharmacist ratios were met for all months in 2025 but Physician to Nurse ratios did not meet the threshold goal from July through December 2025. ○ Partnership received about 12,000 pharmacy Treatment Authorization Requests (TARs) which was a 9% increase from 2024. ○ Also monitored the TAR per pharmacist and TAR per tech ratios month to month to assess for adequate staffing. The TAR per pharmacist did exceed the 20% month to month threshold in July and October due to fluctuations in TAR volume and staff retirement. Hired new staff in Q4 to address the staffing gaps and daily workflow demands. • **Program Structure: Staffing Workload (Page 497)** ○ Annual TAR volume was 327,639 which represented a 4.95% decrease from calendar year 2024. ○ Nurse to medical director ratio also operates on the 20% threshold. For quarter 3 and quarter 4 fell below the 20% threshold due to an influx of nursing hires that was out of proportion to the hiring of medical director staff. **Suggested interventions are as follows:** • Continuing to assess and monitor staffing ratios • Continuing to assess opportunities for increased efficiency in evaluating TAR requirements. • Increase staff ratio threshold from 1:5 (0.20) to 1:6 (0.167) based on 2025 process improvement and operational assessment ○ TAR to nurse ratio was met for all quarters. This was a reflected of interventions that were made in 2024 and indicators of the interventions that were put forward were effective. • **Program Structure: Evaluation of the Partnership Advisory Committee Structure (Page 499)** ○ All advisory committees were within quorum threshold. • **Program Process: UM Rates (Page 501)** ○ *The 2025 results, along with the interventions and ongoing activities by UM and Pharmacy to address identified gaps and opportunities are detailed in the UM 1F Evaluation of Utilization Management Rates Report (Appendix A – Page 512) – see below for minutes.* • **Program Process: Consistency of Applying UM Criteria (Page 502)** ○ For inter-rate reliability (IRR), this is the measure of how we apply our criteria for our nursing and medical director staff. NCQA threshold of concurrence is set at 90%. For the UM team it was identified that for the outpatient, LTSS, and medical directors reviewers they were able to meet the 90% threshold. For Inpatient Nurse Reviewers, the concurrence rate for Q2-Q4 fell below the 90% threshold with an overall rate of 89%. **Suggested interventions are as follows:** • Tracking and trending for repeated deficiencies to be observed and acted upon by UM Leadership on a quarter-by-quarter basis. • Conduct team-wide discussions on consistency in applying medical necessity criteria during internal Inpatient Rounds • Conduct annual training on InterQual for UM Nurses. • UM Nurse Scorecard template updated to include IRR components. The scorecard is used to score IRR and other competencies for each nurse on a monthly basis.	*Second: Kristine Gual, PMP, CPHQ*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Transition quarterly IRR monitoring process to the UM Training & Education team to focus and standardize the application of inter-rater reviews and ensure that secondary reviews are consistent. o NCQA threshold of concurrence is set at 90%. This was exceeded for both pharmacists and pharmacy technician reviewers. • **Program Process: Appropriate Care: Monitoring for Over/Underutilization (Page 502)** o This is a summary of over/underutilization activities for the year that were evaluated by the Over/Under Committee. o Evaluation of Over/Under is performed across various groups and committees across the organization along with conducting over/underutilization reviews on HEDIS reviews, IQI committee, QUAC committee through sire review process and through the access and availability grand analysis that is performed by the quality team. Additional analysis and remediation actions for potential areas of noncompliance for over/underutilization are typically handled by the plan via quality improvement programs as well as the standard UM process and review. • **Program Process: Information Source Used to Determine Benefit Coverage and Medical Necessity (Page 506)** o Partnership uses the most currently available InterQual® Criteria sets as the primary review guidelines for UM medical necessity decisions. For the calendar year 2025, UM used the 2024 InterQual decision criteria until the 2025 version became electronically available. o InterQual® criteria and other approved UM criteria outside of InterQual®, are reviewed, discussed, and evaluated at Partnership's Q/UAC and PAC as described in policy MPUP3139 Criteria and Guidelines for Utilization Management. Criteria utilized include, but are not limited to, Medi-Cal (State of California) guidelines, Medicare criteria, State policy letters, national treatment guidelines, and clinical practice recommendations from UpToDate®. o Partnership's medication decision criteria and pharmacological drug classes are reviewed in collaboration with external and internal providers on an on-going and annual basis. Criteria are selected, reviewed, updated or modified using feedback from the Partnership staff, the P&T Committee, the PAC, the Community Advisory Committee (CAC), external providers, State policy letters, or medical literature among other sources. • **Program Process: Prior Authorization Requirements (Page 506)** o Partnership's Pharmacy & Therapeutics (P&T) Committee determines whether or not a particular drug or pharmaceutical class shall be absent of TAR requirements based on therapeutic advantages in safety and efficacy, standards of care, and generally accepted place in therapy. Cost, utilization, and approval rates are also considered. • **Program Process: Involvement of Senior Level Physicians in the UM Process (Page 506)** o Partnership looks at the involvement of the CMO and medical directors including the Behavioral Health clinical director in the UM process. The CMO and medical directors participate in the review and approval policies via PAC and QUAC and for the pharmacy team the PNT workgroups and committees. They also perform daily UM review, decision making, and participate in internal and external clinical rounds. • **Program Process: Assessing Experience with the UM Process: Improving Practitioner Experience with the UM Process (Page 507)** o *Please see Appendix B: Physician Satisfaction Survey for a breakout of the practitioner experience.* o On an annual basis Provider Relations engages with a third party surveyor, Press Ganey, to survey our network of primary care physicians and specialists to gauge their satisfaction with Partnership's UM and Pharmacy processes. o UM was able to meet the threshold goal of 90% with primary care physicians. o UM was unable to meet the threshold goal of 90% with the specialists. 6 UM questions that were posed to our network specialists did not hit the goal. o Pharmacy was unable to meet the threshold goal with primary care physicians. 1 question did not hit the goal.	

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- Pharmacy was able to meet the threshold goal with specialists.
- Analysis of these results it was identified that there was a potential gap in provider education in both Eastern and Southern regions. These results were driven by the Eastern region with this being their first survey. **Suggested interventions are as follows:**
  - Collaborate with the Provider Relations (PR) team to participate in clinic site visits to share information about the Partnership Pharmacy program and the services available to providers.
  - Collaborate with the PR team to educate PCPs on the differences between the Partnership Pharmacy program and Medi-Cal Rx

- **Program Process: Assessing Experience with the UM Process: Member Experience with the UM and Pharmacy Process (Page 509)**
  - *Please refer to Appendix C for further details of Member satisfaction data for 2025.*
  - This portion of the program evaluation was provided by the Grievance and Appeals (G&A) department through the G&A PULSE Report. The report contains an analysis of Member-reported Grievance concerns about any dissatisfactory experience related to Utilization Management (UM).
  - In 2025 there was an overall increase in grievances received when compared to 2024. Majority of areas that did not meet goals centered around provider related concerns. The primary issue reported concerning the UM process was access-related issues. Notably, 57.3% of these access-related issues were associated with Partnership's Referral Authorization Form (RAF) process, while the remaining 42.7% were linked to the Treatment Authorization Request (TAR) process. Among the reported issues within the referral process, delays by providers (162) was the most reported concern.
    - Members alleged that their primary care providers were delaying submission of RAFs, consequently causing delays in obtaining appointments with specialists.
    - The most prominent driver behind Member dissatisfaction with the TAR process was related to Members alleging that their providers delayed submission of TARs to Partnership (87 reported concerns).
  - **Suggested interventions are as follows:**
    - Collaborate with the G&A team to include additional data points in the PULSE report for "Member Experience with the UM Program" —
    - adding data for Member "County" and "Provider Substantiation" (Yes or No). This additional information will allow UM to further stratify the data and gain insights into trends in Member concerns.
    - Collaborate with the PR team in pursuing educational opportunities with our provider network on Partnership processes and resources to improve Member satisfaction with the authorization process.

Supplemental TAR Report to the 2025 UM Program Evaluation (Page 526)

- Tis includes a TAR breakdown of each departments respective TAR numbers by category and status type.
- Also includes a summary breakdown of the percentage of TARs that were approved, modified and approved, denied, and admin denied.
- Summary of the percentage of appeals that were upheld, overturned, and partially overturned.

Appendix A: Evaluation of Utilization Management Rates – NCQA UM Standard 1 Element F (Page 512)

- UM Rates: The aggregate approval rate was 77.58% and the aggregate denial rate was 22.42%. Within the reporting specs provided by NCQA these rates do include all administrative decisions including duplicate tar or no tar required denials. When looking at just medical necessity denials the denial rate was at 6% which is significantly lower than the combined denial rate.

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- Pharmacy Rates: The aggregate approval rate was 86.34% and the aggregate denial rate was 19.46%. This reporting also included all operational and administrative decisions and exclude retrospective decisions. Quarterly report showed that the approval and denial rates remained stable and consistent throughout the year. When looking at just medical necessity denials the denial rate was at 10.49%. Quarterly reports were reviewed showing a 2% denial rate increase from quarter 3 to quarter 4. This increase was due to introduction of new preferred product requirement but after reviewing the rest of the denials there were no other noticeable trends.
- Appeal rates: These are a combination of UM, pharmacy, and GNA teams. Overall appeals rate was 2.91% with an overturn rate of all appeal rates being 29.41%. When evaluating these rates with the GNA team it was determined that most of the overall appeals overturn volume was due to UM receiving a large influx of appeals related to disagreements on level of care decisions for post discharge and patient stays. These primarily came from 2 large hospital providers within our network. GNA also reported that a large proportion of their appeals were focused on medically tailored meals benefit that is processed by the EHS team.
- Timeliness: Rates are evaluated for both Non-Behavioral and Behavioral decisions, although Partnership does not require any prior authorization for Behavioral healthcare so we report none in that section and therefore do not have any data to present on. For both Non-Behavioral and Pharmacy decisions both met the 90th percentile threshold for the year. Due to the updates that UM has encountered with applications of the CMS final rule and that they have a planned transition from the current legacy TARE processing platforms to JIVA platform. This poses a significant risk to timeliness in the later part of 2026 and into 2027. THE UM team will; be increasing the cadence of monitoring timeliness from weekly cadence to a daily cadence in that 30 – 60 day period post go live of JIVA implementation.

Conclusion

Overall, Partnership's UM Leadership concludes there are no significant changes required for the UM program. Activities addressing the improvement opportunities will continue to be monitored, measured, and reported in future evaluations. We find that Partnership's UM program functions effectively and efficiently through a solid program structure, comprehensive set of policies, and robust support, guidance, and engagement from senior level physicians and advisory committee members.

Summary of Opportunities and Proposed Interventions by UM for Approval

Priority	Opportunities Identified	Barriers	UM Program Evaluation Component	Interventions
1	**IRR concurrence rate for inpatient nurse reviewers**	Lack of consistency in applying inpatient criteria by UM Nurses	UM Program Processes	• Tracking and trending for repeated deficiencies to be observed and acted upon by UM Leadership on a quarter-by-quarter basis. • Conduct team-wide discussions on consistency in applying medical necessity criteria during internal Inpatient Rounds • Conduct annual training on InterQual for UM Nurses. • UM Nurse Scorecard template updated to include IRR components. The scorecard is used to score IRR and other

AGENDA ITEM		DISCUSSION			RECOMMENDATIONS / ACTION
				competencies for each nurse on a monthly basis. • Transition quarterly IRR monitoring process to the UM Training & Education team to focus and standardize the application of inter-rater reviews and ensure that secondary reviews are consistent.	
2	**Physician to Nurse staffing ratios**	Uncertain fiscal climate at State and Federal levels	UM Program Structure	• Continuing to assess and monitor staffing ratios • Continuing to assess opportunities for increased efficiency in evaluating TAR requirements. Increase staff ratio threshold from 1:5 (0.20) to 1:6 (0.167) based on 2025 process improvement and operational assessment	
3	**Provider Experience with the UM Process**	Negative provider perceptions of Medi-Cal Rx may be conflated with Partnership's Pharmacy processes.	UM Program Scope	• Collaborate with the Provider Relations (PR) team to participate in clinic site visits to share information about the Partnership Pharmacy program and the services available to providers. • Collaborate with the PR team to educate PCPs on the differences between the Partnership Pharmacy program and Medi-Cal Rx	
4	**Member Experience with the UM Process**	Absence of year-over-year comparative data for recent Eastern Region expansion counties con-strains analysis of factors contributing to lower Member satisfaction scores.	UM Program Processes	• Collaborate with the G&A team to include additional data points in the PULSE report for "Member Experience with the UM Program" — adding data for Member "County" and "Provider Substantiation" (Yes or No). This additional information will allow UM to further stratify the data and gain insights into trends in Member concerns. • Collaborate with the PR team in pursuing educational opportunities with our provider network on Partnership processes and resources to improve Member satisfaction with the authorization process.	

Discussion

- Dr. Netherda commended the evaluation.

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	• Isaac asked that regarding the physicians to nurse threshold being lowered due to more nursing staff added, does the additional staff cause any other complications like more work for the physicians?
	  o Tony said that there is work currently being done to better evaluate requirements and identify opportunities where TAR requirements could be relaxed especially in areas where they ae not showing value. This work requires collaboration with the CMOs.
	• Isaac wanted to know if there was anything that could be done on the Quality or PR side to help address the dissatisfaction from the East Region through the provider survey.
	  o Tony said it was difficult to say as there s an assumption this is their first time being surveyed and seeing these questions. Being that they went through the expansion they also left a two plan model. It was expressed to Partnership that there were certain levels of dissatisfaction with the 2 plan model but it was something that they were used to. QI continuing to engage with providers and helping them become familiar with our plans benefits and programs would be most beneficial.	

Population Needs Assessment Presentation – *Hannah O'Leary, Manager of Population Health*		

	• Presentation begins on page 521 with the full report beginning on page 531.
	• The Population Needs Assessment takes place every year and looks at the needs of our members from the past calendar year, 2025.
	• Key findings included economic instability, lack of access to quality health care, neighborhood and built environmental challenges, limited access to quality education, and social and community context changes.
	• Other community challenge findings included access to care, differences in health outcomes, transportation, environmental concerns (wildland fires), and chronic conditions.
	• Chico region had the greatest percentage of members accessing mental health services.
	• Continuing to struggle in some areas with breast cancer and cervical cancer screenings.
	• Reported some health disparities in a particular set of ethnic and racial categories in clinical measures.
	• Opportunity areas included organizational structure, social and environmental needs, member health and wellness, access to care, health disparities, and health education.
	• **Organization structure:**
	  o Hired a handful of different positions that will support their health equity department.
	  o Fully staffed health needs liaison team to cover all 24 counties.
	• **Social and environmental needs:**
	  o Has been some opportunities to distribute CalAIM distribute payment program: awarded over $52 million in grants. To local entities to build out our enhanced care management and community supports programs.
	  o Many of the households in our counties reported having insufficient income. Partnership is continuing to work on increasing workforce opportunities.
	  o Partnership continues to support its Asthma Emergency Department Visit Outreach Program
	• **Access to Care:**
	  o Some great work around working with our schools to increase behavioral health access
	  o Continued working with Alinea for mobile mammography
	  o Continued to work on providing education regarding the cervical cancer self-swab program
	  o Continued growing together program that focuses on getting kids into well visits and to get vaccinated
	  o Continued working on the provider recruitment and retention programs to increase access
	• **Health Disparities:**
		*Motion to **approve as presented:** Isaac Brown, MHA/MBA*
		Second: Mark Netherda, MD

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	o Continued our tribal health connections in order to support our tribal members who may not have great access to perinatal care • **Health Education:** o Continued with our basic health population management programs o Community resource pages are still available and are a great resource for those who need support with identifies available resources in their area. o Wonderful member education events where members who were new to Partnership were able to ask questions and receive support. **Discussion:** • *No questions or discussion regarding this policy.*	
Proposed 2027 Palliative Care QIP Measure Set – Eva Lopez, Program Manager I, Quality Improvement		
• No approval needed from IQI as it is going to PAC for approval, this is serving as an FYI. • No changes to the measure set, all 3 measures will remain the same for 2027. • If you have any questions please send them to Eva for consideration before it goes in front of PAC next month. **Discussion:** • *No questions or discussion regarding this policy.*		
Proposed 2026 Hospital QIP 6-month Bridge Measure Set – Troy Foster, Program Manager II, Quality Improvement		
• No approval needed from IQI as it is going to PAC for approval, this is serving as an FYI. • Three measures that are being proposed for extension while staying within their current phase: o **Expanding Delivery Privileges** ▪ Will move into the next phase in 2027. o **Doula Support** ▪ Will move into the next phase in 2027. o **Vaccines for Children Enrollment** ▪ Extended for providers to get enrolled. ▪ If already enrolled this measure will be N/A for them. ▪ This measure will retire in 2027. • Three measures are being proposed for removal from this 6 month set: o **QI Capacity** ▪ Hospital Quality Symposium has already been offered for the 25-26 measurement year. The plan is for this measure to return for the full 2027 calendar year HQIP. o **Cal Hospital Compare** ▪ Scores for the 25-26 measurement year would have just been delivered meaning there would be no new information to score the hospitals. The plan is for this measure to be return for the full 2027 calendar year HQIP. o **Health Equity** ▪ Hospitals would have just submitted their annual report to Partnership in August of 2026 and because CMS removed its requirement for Commitment to Health Equity Attestation, which is what this measure was based upon. The plan is to develop a new Health Equity measure that will be added to the full 2027 calendar year HQIP.		

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
• If you have any questions please send them to Troy for consideration before it goes in front of PAC next month. **Discussion:** • *No questions or discussion regarding this policy.*		
VI. Adjournment		
Dr. Moore adjourned the meeting at 3:24 p.m. IQI will meet next Tuesday, May 12, 2026.		
Respectfully Submitted by Chandler Ackerman, Project Manager I, Quality Improvement *Approval Signature:* *Date:* *Robert Moore, MD, MHA, MBA* *Chief Medical Officer and Committee Chair*		

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, Mar. 18, 2025 / 7:30 a.m. – 9:30 a.m. - Napa/Solano Room, Airpark,
Chico – Story Creek

Voting Members Present:

Hackett, Emma, MD, FACOG
Luu, Phuong, MD
Montenegro, Brian, MD
Mulligan, Meagen, FNP-BC
Murphy, John, MD
Strain, Michael, PHC Consumer Member
Swales, Chris, MD
Thomas, Randolph, MD
Wilson, Jennifer, MD, MPH

Voting Members Absent: Sara Choudhry, MD; Steven Gwiazdowski, MD, FAAP; Brandy Lane, Consumer Member; Robert Quon, MD, FACP

Partnership *Ex-Officio* Members Present:

Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI
Brown, Isaac, MBA/MHA, Interim Senior Director of Q & P Improvement
Cox, Bradley, DO, Regional Medical Director (Northeast)
DeVido, Jeff, MD, Behavioral Health Clinical Director
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
Glickstein, Mark, MD, Associate Medical Director
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Newman, Rachel, RN, BSN, Mgr, Clinical Compliance – Quality Inspections
O'Connell, Lisa, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Spiller, Bettina, MD, Associate Medical Director
Townsend, Colleen, MD, Regional Medical Director (Southeast)
Ward, Lisa, MD, Regional Medical Director (Southwest)
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

Partnership *Ex-Officio* Members Absent:

Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Bontrager, Mark, Senior Director of Behavioral Health
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Katz, Dave, MD, Associate Medical Director
Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Thornton, Aaron, MD, Associate Medical Director

Guests:

Brunkal, Monika, RPh, Associate Director, Population Health
Campbell, Anna, Health Policy Analyst, Utilization Management
Chishty, Shahrukh, Sr. Mgr., Child Welfare Programs, Behavioral Health
Cunningham, Aryana, Policy Analyst, Care Coordination
Durst, Jennifer, Manage of Performance Improvement (Fairfield)
Frankovich, Terry, MD, Associate Medical Director
Gual, Kristine, Director of Quality Measurement
Jarrett-Lee, Kevin, RN, Assoc. Dir., Utilization Management (Auburn)
Kubota, Marshall, MD, Reg. Medical Director
Morris, Matthew, MD, Regional Medical Director (Auburn)
O'Leary, Hannah, Manager of Population Health, Pop Health
YoungStone, Kelly, RN, Director of Care Coordination

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Introductions Approval/ Acceptance of Minutes	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:30 a.m. The Feb. 18 Q/UAC Minutes were approved without any corrections. *Acknowledgment and acceptance of draft meeting minutes of the* • Feb. 10 Internal Quality Improvement (IQI) Committee • Jan. 29 Over/Under Utilization Workgroup	Motion to **approve the Q/UAC minutes:** Brian Montenegro, MD Second: Emma Hackett, MD, FACOG *Approved unanimously* Motion to **accept the other minutes:** John Murphy, MD Second: Emma Hackett, MD, FACOG *Accepted unanimously*
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Isaac Brown, Senior Director of Quality and Performance Improvement, QI*	• Due to the state no longer offering a long-term care quality incentive program (QIP), Partnership will be launching the Extended Care Facility (EXT) QIP this year. Part of this QIP Is asking the SNIFs to participate and to submit their Quality Assurance and Performance Improvement (QAPI) plans. This is a part of their gateway measures that are required to participate in QIP. Emily, Deanna, and others are starting to mark the importance of the QAPI plans so they can participate in QIP. • March 2nd eReports launched for our providers to see their quality metrics closer to real time. In a couple months, possibly May, we will be launching the Partnership Quality Dashboard (PQD) that will give further insight into their metrics. • Evaluated our diabetic retinal cameras. All 9 providers that received them exceeded the 50th percentile for the first time in 2025. There were observed delays in acquiring cameras from the vendor, so those looking to purchase cameras for MY2026 should consider purchasing early to account for shipping times. • A couple of Improvement Academy webinars are coming up with Managing Chronic Disease happening on March 25th as part of the Improving Measure Outcome Series. It will encourage best practices and good reminders for these important measures. • CAHPS regulated survey has been distributed to our members to find out how their experience has been with our health plan and their provider. • A Gap assessment is being conducted with a company called Rex Wallace Consulting who is looking at our member experience to see how we can be better compared to other managed healthcare plans. Thank you to all who provided data and materials to this.	*For information only*.
2. HealthPlan Update *Robert Moore, MD, MPH, MBA*	• Due to the stock market doing well until the end of December 2025, the budget shortfall will not be as large as expected. Given the cuts from the federal government there is not a clear answer on how much of shortfall there will be. Currently the legislature is in the middle of their season with several proposals put forward.	*There were no action items.*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
Chief Medical Officer	• In December 2026, CMS announced that through a series of actions that they would no longer be holding the state Medicaid plans accountable for any vaccine measures and invited the states to continue reporting on them but no longer mandatory. Currently awaiting to see if California updates what it holds itself accountable to. Historically it was CIS-2 prior to CIS-10. Dr. Moore is encouraging various specialty societies to weigh in with DHCS with the Covered California and with CalPERS if they have those in that influence there to come up with a different standard than CIS-10 as they work to be back in sync across the three agencies. The current two options: o CIS-3: Seven vaccine series that eliminates the influenza, rotavirus, and hepatitis A. o CIS-7: None vaccine series which eliminates the influenza. • Regional Medical Directors Meetings have begun for 2026. First one was in Fairfield about two weeks ago. In two days, we will be in Eureka and will continue for a total of seven. The main topics covered will be about health policy, health plan and state updates, public health measures, and then quality. Folks are encouraged to attend as it will be a comprehensive review of everything related to Partnership and anything adjacent to the health plan. • Two topics came up in the Fairfield session for vigorous discussion. o One was developmental screening in young children. It's a standard to do them as part of a well child visits up to age five. DHCS has an incentive for completing a developmental screening before one year of age, between one and two years of age, and within two to three years of age with an extra fee paid on top of the regular free. FQHC's, RHC's, and tribal health are included in the ability to get this incentive. Once a child has an abnormal screen the standard of care then is to refer them for further testing to determine why and what is going on, and potentially receive treatment for it. The rate in California of Medicaid children being referred in through that system of treatment is far lower than for the commercial and insured sectors. The bottleneck is related to the regional center capacity and to do those screenings is a problem resulting in some providers not referring patients out and instead reassessing them later. One best practice is that Chapa-De Tribal Health is working on bringing the ability to do the diagnostic evaluations in house. o Second topic was about member experience and how we work on it. Partnership's adult member experience surveys year over year are continually below the Medicaid health plan average. This is driven by three things: access, communication, and how well the health plan does when a patient contacts us. Currently all three of these are suffering and need to be worked on collectively. Some aspects of access are harder to work on, like are there enough providers in a practice to see the patients that have needs. Other items are within the control of the practice like answering the phone, an efficient workflow in the office to keep patients from sitting too long in the waiting room, and assisting them to make sure patients are seeing their own provider as much as possible. A best practice for communication is that we are	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	hiring a company that has national expertise on Medicaid member experience to consult with. They will look at what we are doing and offer additional suggestions. Discussion Dr. Thomas asked if there are outside nonprofits that could help with the screening with a potential to contract with them? Dr. Moore believes more screenings are happening than we are seeing due to providers not using the correct code for it. Due to this concern, we will be doing a deep chart dive to see if providers are completing them without using the proper code, or if they are truly not doing them as claims shows. This may be a solution but will know more in a few months. If there is a need for this, there are several agencies who do this as a side business. Dr. Thomas corrected his original question to be about the follow up for after the screening. Dr. Moore agreed that an alternative needs to be found for the regional center system since the capacity isn't there.	
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
G&A Pulse Report/ Issue 20/ March 2026 **Proposed 2026 Perinatal QIP 6-month Bridge Measure Set** **Health Services Policies** Care Coordination MCCP2014 – Continuity of Care – *The Adult Expansion population and associated attachments have been removed and archived, as references to populations and immigration status are considered protected language and are not appropriate for inclusion in policy content. The policy is bundled here without Attachment C (400 pages of codes).* Quality Improvement MPQP1002 – Quality/Utilization Advisory Committee MPQP1003 – Physician Advisory Committee (PAC) Policy MPQP1004 – Internal Quality Improvement Committee Utilization Management MCUP3124 – Referral to Specialist (RAF) Policy **– *Pulled*** MCUP3126 – Behavioral Health Treatment (BHT) for Members Under the Age of 21 MCUP3121 – Neonatal Circumcision MPUG3031 – Nebulizer Guidelines MPUP3110 – Evaluation and Management of Obstructive Sleep Apnea in Adults MPUP3059 – Negative Pressure Wound Therapy (NPWT) Device/Pump **Non-Health Services Policies** Provider Relations MPPRGR210 – Provider Grievance	*No questions were asked.* Motion to **approve the slate without the one pulled policy:** Brian Montenegro, MD Second: Jennifer Wilson, MD, MPH *Approved unanimously* Next Steps: All policies go to the Mar. 11, 2026 PAC	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	MCUP3124 – Referral to Specialist (RAF) Policy Discussion Dr. Murphy asked when a PCP refers a patient to an in-network specialist and that specialist realizes they should be seeing a different type of specialty office, is the PCP then required to approve the subsequent referral in this workflow? Dr. Moore stated that our current system is hard coded to require that. Along with that this workflow allows for PCP's to intercept patients when they feel as though they can provide the adequate care to reduce over utilization of specialty offices. Dr. Townsend added that it's not the PCP approving a referral from the specialty office, and instead it's a request for the PCP to submit a referral since it can only come from there. Dr. Murphy asked if this workflow should be included in the policy with Dr. Townsend adding that the policy is very specific that referrals can only come from PCP's so a workflow is not needed. Hannah asked at B.1.A. that it's saying it has to be a specialist in the same specialty field? Dr. Moore said that 1 should read as any one of the following circumstances, and not all of them to ensure emergence or urgent conditions are not held up. With corrections the policy will be updated to read under VI.B.1. to specify "under one of the following circumstances." Additionally, we reordered B.1.a. – c. in a hierarchy of most frequent occurrence – a. moved to position c. and c. moved to position a. Motion to **approve as with the changes:** *John Murphy, MD* and Second: *Randolph Thomas, MD* *Approved unanimously*	
V. New Business – Discussion Policies		
Policy Owner: Transportation – *Presenter: Danielle Biasotti, RPht., Director of Transportation Services*		
MPTP2503 – Transportation-Related Travel Expenses, Lodging, Meals, Attendants, Parking and Tolls	**Synopsis of Changed reviewed:** • Updated related policies revised MCCP2016 to new policy number MPTP2503 and added MPTP2501 • Updated Partnership Advantage go live to January 1, 2027 • Changed member to Member throughout the policy • Transportation-Related Travel Expenses Benefit o Revising the milage requests for transportation-related travel expenses within 150 miles of the member's residence may be subject to additional review, up to and including Medical Director review for necessity. This is to align with our current processes. Change from 50 to 150 miles. • Updated the Lodging section to include: o Receipts must be itemized o The member will not be reimbursed if they choose to lodge outside of the prebooked hotel and do not notify Partnership in advance.	No questions for Danielle Biasortti, RPht. Motion to **approve as presented:** Chris Swales, MD Brian Montenegro, MD *Approved unanimously* Next Steps: Apr. 8 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	○ Partnership is not responsible for fees such as early check in, late check out, incidentals, pet fees, protection coverage, and/or cleaning fees. • Updated the Meals section with the following: ○ To require a minimum of five calendar days prior to the date of service to align with processes. ○ Breastfeeding moms with a child two or younger may qualify for meals but not to exceed fifteen (15) days of meals for each thirty (30) days of the member's hospitalization. Beginning with the day of member's admission. Each new hospitalization shall begin a new thirty (30) day benefit period. • Updated Parking and Tolls section with the following: ○ Express lanes are not covered ○ Hand-written parking receipts will only be accepted if they are from a bank or credit card company showing proof of payment. • Parking and tolls will only be approved if there is a coinciding Travel Related Expense or Gas Millage Reimbursement request and the member cannot submit parking and/or toll receipts without a valid request on file to support it.	
Policy Owner: Quality Improvement – *Presenter: Lisa Ward, MD, Regional Medical Director*		
MPQG1005 – Adult Preventive Health Guidelines	• This policy was reviewed by both Dr. Netherda and Dr. Ward. Dr. Netherda presented on it during the March IQI committee meeting and Dr. Ward will be presenting on it today. **Synopsis of Changed reviewed:** <u>MPQG1005 – Adult Preventive Health Guidelines</u> In addition to correcting some typos and attempting to standardize capitalizations, etc., the following significant changes were made to the policy. Section V. Purpose Added new professional sources used in creating this document, specifically, the American Society for Colposcopy and Cervical Pathology (ASCCP) and the California Department of Public Health (CDPH). Section VI. Guideline/ Procedure: B. 2. Which addresses immunizations, we replaced "the Advisory Committee on Immunization Practices (ACIP) with the California Department of Public Health as the source for recommended immunizations for all members. B.3. We clarified the language regarding the Cognitive Health Assessment (CHA) requirement for members who are 65 years of age or older and who do not have Medicare coverage. Retaining the recommendation for providers to complete the DHCS Dementia Care Aware training before administering the CHA, adding that this training is no longer required for providers to be able to bill for this service. Note that this is in anticipation of a change to APL 22-025, which is currently being updated to add some clarification, while removing the training requirement. Section VII. References: We added References – the California Department of Public Health and the American Society for Colposcopy and Cervical Pathology (ASCCP).	Motion to **approve as presented with four ammendments:** Brian Montenegro, MD Second: Meagan Mulligan, FNP-BC *Approved unanimously* <u>Next Steps</u>: Apr. 8 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Attachment A – Adult Preventive Health Screening Guidelines In addition to ensuring we have the most current version of each policy, we added a couple of references that were missing and had the following significant changes: • **Vaccination** - Based on age and risk factors. For updated schedule, reference the CDPH guidelines. CDPH Vaccination Guidelines • ***NEW* Cognitive Health Assessments (CHA) for Members 65 years of age and older** – The USPSTF (February 2020 – currently under review) concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening for cognitive impairment in older adults. DHCS, however, per APL 22 025, REQUIRES an annual cognitive health assessment (CHA) for Medi-Cal Members 65 years of age and older if they are otherwise ineligible for a similar assessment as part of an Annual Wellness Visit through the Medicare Program. The annual CHA is intended to identify whether the patient has signs of Alzheimer's disease or related dementias, consistent with the standards for detecting cognitive impairment under the Medicare Annual Wellness Visit and the recommendations by the American Academy of Neurology (AAN). (The additional requirement that Medi-Cal Providers must complete the DHCS Dementia Care Aware CHA training to be eligible for billing for this service is expected to be eliminated in 2026.) • **Screening for Perinatal Depression** - Risk factors include low socio-economic status. Consequently, all pregnant Partnership members should be referred for at least one counseling session. The Partnership HealthPlan Perinatal Services (PHPS) Program includes provision of counseling services. If a PHPS program is available, all eligible Partnership members should be referred to a PHPS program for counseling and other services. (CPSP was replaced with PHPS) • **Cervical Cancer Screening** – Additional notes: The American Society for Colposcopy and Cervical Pathology (ASCCP) recommends the use of vaginal swab collection for high-risk HPV testing in cervical cancer (April 2025) o Clinician collected specimens are preferred and self-collected vaginal specimens are acceptable o Vaginal swab collection is recommended for primary HPV screening in asymptomatic, average-risk people with a cervix ages 25-65 years o Repeat testing each 3 years following a negative HPV test using self-collected vaginal specimens o Self-collected vaginal specimens resulting in HPV positive results require a follow-up visit for clinician-collected cervical specimen o Self-collection is not recommended for high-risk individual, including those with immunosuppression o Use only FDA-approved collection devices and HPV assays.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Discussion • Dr. Townsend provided an edit on page 181 under the Cervical Cancer Screening guidelines the recommended age for a vaginal swab collection should be 30 to 65 years old as that is currently what is allowed by the FDA, and the next bullet the frequency should be every five years as recommended by the USPSTF which makes it the same as clinician collected high risk HPVT testing. • Dr. Thomas asked that on page 8-0 at the top for abdominal aortic aneurism screening it says the USPSTF recommends one time screening or abdominal aortic aneurism by ultrasound in persons 65 to 75 that have ever smoking and were assigned male at birth if there were a definition of smoking to include since this is open to interpretation. Dr. Ward stated they had used the language offered by the task force and will see if they have a definition of smoking since it's not very clear. Dr. Morris confirmed after reviewing USPSTF information they do have "ever smoked" classified as anyone who has ever smoked a hundred cigarettes or more. This will be added. • Dr. Luu pointed out that on page 184 in the bottom right hand corner it says to "report to county health department" and then following that "consideration of treatment of latent tuberculosis" it gives a false impression that county health departments are going to offer latent tuberculosis treatment. This is not usually offered and we want to encourage primary care providers to offer that treatment just like they would for diabetes treatment. We still own in a suspect or confirm active TB cases so the rest of the section can be left but just moving that box to remove the impression that once reported the PCP's responsibility is done and that public health would own the treatment. Dr. Ward agreed they will move the boxes around and highlight PCP in a way to make it clear they need to continue with treatment.	
Policy Owner: Utilization Management – *Presenter: Anna Campbell, Health Policy Analyst*		
MPUG3019 – Hearing Aid Guidelines	**Synopsis of Changed reviewed:** During the annual review of this policy, updates were made to clarify the conditions under which hearing aids will be authorized. **Section VI.A.2. S**entence deleted which previously stated "Routing authorizations will be for one hearing aid only. Per discussion with Medical Directors, we are dropping the binaural restriction. **Section VI.A.4.a.** The hearing loss level at which a hearing aid may be authorized was changed from 25 dB to 26 dB to align with InterQual criteria® **Section VI.A.4.d.** Added statement to specify that "InterQual® criteria for Durable Medical Equipment: Hearing Aids will be used to approve hearing aids. **Section VI.A.6.** This entire section regarding binaural hearing aids was deleted as per discussion with Medical Directors that we are dropping the binaural restriction. **Section VI.A.5.** Reference to "Attachment A" was deleted. **Section VI.B.2.** Clarified that a trial period for hearing aids is 30 days. **Section VI.B.8.** Add criteria for the authorization of Contralateral Routing of Signals (CROS)-type hearing aids. **Section VI.B.9.** Add criteria for the authorization of Bilateral Contralateral Routing of Signals (BiCROS) hearing aids	No questions for Anna Campbell. Motion to **approve as presented:** Brian Montenegro, MD Second: Meagan Mulligan, FNP-BC *Approved unanimously* Next Steps: Apr. 8 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VII.B. – D: Added further description and hyperlinks for Title 22 references. At Reference D., the Title 22 CCR code was updated from 51340.1(b)(2) to 51340.1(c) as (b)(2) currently refers to Orthodontic services but (c) refers to Hearing Services. **Section VII.E.:** Added further description and hyperlink for WIC reference.	
Policy Owner: Utilization Management – *Presenter: Anna Campbell, Health Policy Analyst*		
MCUG3024 – Inpatient Utilization Management	**Synopsis of Changed reviewed:** This policy was updated off-cycle to clarify processes for achieving placements for Members at the appropriate level of care and for providers seeking Reconsideration of Inpatient UM Determinations. **Section I.** Policy MPUP3018 - Health Services Review of Observation Code Billing was added as a Related Policy. **Section III.G.3. thru 5.** The Definitions of Long Term Acute Care, Subacute Care and Skilled Nursing Facilities were updated. **Section IV.** Attachment A document title was updated to "Request for Reconsideration of Inpatient UM Determination (RRIU): Post Discharge Review for Inpatient Services." **Section VI.D.1.b.** Language was added in the Elective/Scheduled Admission Authorization Process section to say "For elective surgeries in which a post-operative admission directly to an acute inpatient rehabilitation facility is recommended instead of an initial inpatient stay, the prior authorization should be submitted prior to surgery to ensure timely placement." **Section VI.E.5.b.** Concurrent review time frame for continued review was corrected to be 72 hours instead of 24 hours. **Section VI.E.5.i.** Language clarified to reflect that a provider will be notified verbally, "via telephone," if an inpatient stay is determined to be not medically necessary and the facility stay is denied. **Section VI.E.5.j. and k.** Language updated to reflect that attending clinicians of inpatient facilities may request a Peer to Peer for a Member currently admitted to the facility "or within 3 business days of discharge." At VI.E.5.k., title of dispute from was changed from provider dispute resolution request to "Request to Reconsider an Inpatient UM Determination." **Section VI.G.2.** Added additional facility types: "Long Term Care Facility (LTC), Medical Respite, Acute Inpatient Rehabilitation, Subacute Rehabilitation" to the list of facilities where an inpatient facility might make outreach for placement of a Member who no longer requires acute inpatient level of care. **Section VI.G.3.b.** Added this specification for the process when acute inpatient facilities seek placement for Members: "Once begun, a daily assessment of placement status is expected, summarized in progress notes no less frequently than every 3 calendar days." **Section VI.G.3.d.** Added specification for acute inpatient admin days as follows: "If a member meets the criteria for acute inpatient administrative days (as defined in this section), but no placement is achieved and the patient ends up being discharged to a non-covered setting (e.g. home, congregate living, homeless shelter), administrative days can still be assigned those days that met criteria while outreach efforts were being made."	No questions for Anna Campbell. Motion to **approve as presented:** Brian Montenegro, MD Second: Jennifer Wilson, MD, MPH *Approved unanimously* Next Steps: Apr. 8 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Section VI.G.4. Added specification for acute inpatient admin days as follows: "For Members with a terminal illness, administrative days may be considered while the facility finalizes an appropriate discharge disposition (SNF with hospice, home with hospice) for a patient with a terminal illness who, when admitted, met acute inpatient criteria, and the records show that the goals of care for the Member have transitioned to comfort care measures." **Section VI.L.1.** Updated policy reference for UM Communications Services to reflect MPUD3001 UM Program Description.	
VI. Presentations		
Site Review & PARS Reports – *Rachel Newman, RN, Manager of Clinical Compliance*		
• This report, beginning on page 208, is an overview of the site review process which includes the Facility Site Review (FSR) and Medical Records Review (MRR). All sites need to score over 80% to pass, otherwise they are issued a corrective action plan (CAP) that they are expected to fix within 30 days, or a critical element (CE) could require a quicker turnaround. • Page 209 shows the FSR scores by region and county. Everyone is over 90% with the commonly missed things including emergency medications, newer training on disability rights and provider obligations, and height adjustable vision charts. • Page 212 is a comparison but with a reminder that with site reviews they are on average every three years. They can be done every one to two years depending on how the site is scoring. This page is a 2 year look back comparison, but the number of reviews varies along with the sites. Areas found for most improvement with the most missed are having all of the emergency medications, newer training that's required for staff which is visibility rights and provider obligations and then having the proper vision test with the chart needing to be movable up and down to the height of the child. • Page 213 is scoring for the MMR's. Overall, there was improvement in pediatric preventative although it's still lower than the expectation so education will continue. • Page 214 to 215 offers different viewpoints to look at those scoring. • Page 216 is a comparison for the MMR. There were not many reviews for OB due to only four regions with a total of 9 PCP's offering OB care so the numbers are lower because of this. • Page 217 shows the improvements that they are looking for. They have been doing different trainings at their exit interviews, using a new software the last couple years that's been very effective with a staff writer, and continuing to offer virtual medical records reviews. • Page 218 is their Physical Accessibility Review Survey (PARS) report. There are three levels of access they go through alongside their site reviews and it's a review of the parking lot, exterior building, interior building, restrooms, and exam rooms. Providers are not asked to fix anything, this is just for reporting that goes into our directory so people can see what sizes have the best accessibility to meet their needs. For basic you have to meet all 29 elements and for limited you are missing one or more of the elements. For medical equipment it is also mentioned if there is a height adjustable exam table or an accessible weight scale. • Page 219 shows the accessibility by region with the following showing accessibility throughout the network.		
Cultural & Linguistic Grand Analysis Presentation – *Hannah O'Leary, Manager of Population Health*		
• MPND9002 2026 C&L Program Description • 2026 C&L Work Plan • 2025 C&L Program Evaluation	**Synopsis of Changed reviewed (433):** This program description was updated to reflect changes per the NCQA 2026 HOA Standards and Guidelines, APL 25-016 *Alternative Format Selection for Members with Visual Impairments*, and organizational changes. Includes minor grammar, formatting, and hyperlink updates. **Policy Codes** • Removed APL 22-022 references throughout document and updated to APL 25-016.	**Motion to approve as presented:** Brian Montenegro, MD **Second:** Phuong Luu, MD *Approved unanimously*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
• 2025 C&L/QIHETP Work Plan Final Update	**Auxiliary Aids (pg. 16)** • Clarified requirements for providing auxiliary aids and services to the Member's Authorized Representative (AR) or other individuals authorized by the Member or as designated by law. **Alternative Formats (pg. 17-18)** • Clarified that Members may request an encrypted (password-protected) electronic format; if not requested, an unencrypted electronic format will be provided. • Removed references to MCP receipt of weekly AFS extracts; MCPs will rely on 834 membership data. • Added language describing Partnership's reasonable efforts to direct Members to BenefitsCal or local county offices for AFS updates. **Team Roles and Responsibilities (pg. 26)** • Updated existing Partnership position descriptions (across PHM, Health Equity, and G&A) to cover staff dedicated to C&L activities. **Updated Attachment A: Criteria for Interpreter Services** • In Telephonic or Video Remote Interpreter Services section, added extra possible context in which a request could be made, "calling Partnership HealthPlan of California." • Removed last paragraph describing referral to Carelon for Face-to-Face Interpreter Services, due to changes in Behavioral Health operations (de-delegation of Carelon). **Updated Attachment B: Providing Auxiliary Aids and Services for Persons with Disabilities** • Edits to update from "language assistance taglines" to the newer "Notice of Availability" name. • Edits clarify that a Partnership representative will help the requester fill out the Auxiliary Aid Request Form **Updated Attachment E: CAC Guiding Principles** • Edits made to align with DHCS APL 25-009 Community Advisory Committee. • Added details around what resources may be shared to help educate CAC members. • Added additional points to the list of CAC's responsibilities. • Clarified the role of both Partnership's Board of Commissioners and Health Equity in the CAC member selection process. • Clarified that interpretation and translation services are available to all CAC members upon request, and that the CAC organizing team will ensure all locations where meetings are held are accessible to all members. **Discussion:** • Dr. Murphy noted that it would be interesting to see what options, especially for interpretation, might be available in the AI interspace. There is a vendor selection criteria at the bottom of page 258 and they may change a bit with some sort of AI interpretation model. Would be something to consider for the next Trilogy year.	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Dr. Thomas asked if the goal of 75% of bilingual member services representatives was a high bar? Hannah clarified that this goal is referring to Partnership staff here in the office and that there are a series of tests they must complete to meet the criteria of being considered qualified as an interpreter.	

Community Reinvestment- Review of Requirements and Funding Options – *Mohamed Jollah, Pharm.D, Director of Health Equity (Health Equity Officer)*

- Dr. Jalloh provided some background that this presentation will be about how Partnership is considering approaching community reinvestment work per the APL requirements that the state has provided. The state provided this APL requirement that they want us to reinvest part of our net annual net income back in the community. Although this type of work has already been happening, this APL will make it more prescriptive with a required percentage of our profit being used at 5% of annual income if net revenue is less than or equal to 7.5%; if net revenue is greater than 7.5% then 7.5% of annual income will be used. Annual reporting requirements that include how much was reinvested, what activities were done, and what the status is of said activities will also be required.
- More information will come in CY Q2 2026 of what will be expected based off of CY 2024 financial data. Partnership's 10 county expansion region will not be subject to these requirements until 2028 based on CY 2025 financial data.
- The state wants us to work on high level things that are related to social drivers of health meaning activities that cultivate neighborhoods, healthcare workforce, improved health outcomes, and the well being of our local communities. Examples of allowed would include funding for scholarships for allied health professions, funding for park development in a community, and funding for hospital development in a community where as not allowed would be funding for clinical services at a clinic or hospital, funding for expanding provider networks for the delivery of services covered under the MCP contract, and funding street medicine services for persons experiencing unsheltered homelessness.
- County Public Health Directors, Community Advisory Committee (CAC), and County Behavioral Health Directors will need to sign off on this work. These groups were surveyed on potential investment interest with a meeting following in December 2025 with additional external community members and leaders to gain further insight into our community needs.
- A calculation was made based on how many supported each idea that resulted in a list being made of potential activities that a county could pick from with internal workflows already developed detailing what would need to happen to execute it. These 10 options were also developed based off of the DHCS APL requirements, Annual Health Disparities Assessment, CHA Analysis, CHIP analysis, Access Improvement Assessment, and surveying community support with our CAC members, behavioral health directors, and public health directors.
- 10 reinvestment options were reviewed as follows:
    - **Cultivating neighborhoods**: Option #1 – funding to support expansion of RHC or FQHC facility to meet community needs; Option #2 – Funding to support expansion of mobile health services to meet community needs
    - **Cultivating healthcare workforce**: Option #1 – Funding to support specialty provider recruitment; Option #2 – Funding to support expansion of residency slots, programs, and development; Option #3 – Funding to support expansion of student slots, programs, and development
    - **Cultivating wellbeing**: Option #1 – Funding to support community wellness and resource centers; Option #2 – Funding to support accountable communities for health (ACH) initiatives and programming; Option #3 – Funding to support community fitness programs
    - **Cultivating local communities**: Option #1 – Funding to support the development and funding of CHW programs in each county; Option #3 – Funding to support the development and funding of doula programs in each county
    - Cultivating local communities and wellbeing are comparable so the 5th category was not included.
- These 10 options will be recommended but each county will be able to tailor their choice based on their current needs. Each county will fill out an application based on their choice and plan to execute it and submit to Partnership who will review to make sure its accurate and meeting all APL requirements. The state will then review it. Once approval has been received the funding should be provided directly to the county.
- Committee members are asked to start engaging with your county leaders to identify a central point of contact for this work. HHS directors and each counties public health and behavioral health directors will be contacted to collect this information and assess what they will be leaning towards. Next quarter a meeting will be held with county representatives. Along with identifying contacts they should be encouraged to work with their local CBO's, FQHC's, and hospitals to

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

make sure that their recommendation is comprehensive and representative of everyone. The goal is to have an idea of what everyone will be picking by the time we receive the total amount of funding.

- Current unknown is that Partnership does not have the exact amount of what counties will receive and are unsure of when this information will be received. Another unknown is when the state will approve the plans we submit. The last unknown is that it is unclear when the funds would be dispensed. More information to come on these topics.

Discussion

- Dr. Luu noted that it should be made very clear that amount of money being potentially distributed so public health officials can keep the parameters in mind. Currently in a very limited resource environment with abrupt cancellation of grant funding from the federal government currently happening. This will ensure nobody plans larger than realty. Along with this that a lot of counties will be utilizing their community health assessment and behavioral health integrated plans to inform their decision due to the new BHS from prop one.
- Dr. Thomas asked if the funding will go to the health department on a county level? Dr. Jalloh said it would depend on what activity the county chooses. If it makes senses it will be given directly to the county or directly to the entity and will be determined on a case by case scenario.
- Dr. Thomas asked if the deciders at the county would that be the board of supervisors or what level in the county will make these decisions? Dr. Jalloh said it will be county specific because they want a minimum of 2 core signatures per county from the public health director and the behavioral health director. Within this it is recognized that most public health directors cannot sign off on behalf of a county without going through approval from supervisors.

VII. Adjournment

Dr. Moore adjourned the meeting at 9:08 a.m.

Respectfully submitted by: Chandler Ackerman, Program Manager I, QI

Signature of Approval: Date:

Robert Moore, MD, MPH, MBA
Chief Medical Officer

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

Date: Apr. 15, 2026 **Time: 7:30 – 9:00 a.m.**

Locations: Partnership HealthPlan of California
4665 Business Center Drive, Fairfield, CA 94534 | Napa/Solano Room
2525 Airpark Drive, Redding, CA 96002 | Trinity Alps Conference Room
495 Tesconi Circle, Santa Rosa, CA 95401 | Santa Rosa Huddle Room
1000 Fortress Street, Chico, CA 95973 | Stony Creek Conf Room
1036 5th St. Suite E, Eureka, CA 95503 | Grizzly Creek

Other Locations:
Chapa-de Indian Health: 11670 Atwood Road, Auburn
H&HS Dept.,5730 Packard Ave., Suite 100, Marysville
Open Door Community Health Center, 770 10th St., Arcata

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 the Jan. 21, 2026 and Mar. 18, 2026* Quality/Utilization Advisory Committee (Q/UAC) Minutes	Robert Moore, MD, MPH, MBA	7:30	6
2	*Acknowledgment and acceptance of draft minutes of the* • Mar. 10, 2026 Internal Quality Improvement (IQI) Committee • Feb. 26, 2026 Member Grievance Review Committee minutes • March 12, 2026 Population Needs Assessment (PNA) Committee minutes *(Committee has been disbanded- These are the final Minutes for this Committee)*			31 44 52
II.	**Standing Updates**			
1	Quality and Performance Improvement Program Update	Isacc Brown, MHA/MBA	7:35	57
2	HealthPlan Update	Robert Moore, MD	7:42	--
III.	**Old Business – None**			
IV.	**New Business – Consent Calendar**			
	Consent Calendar	All	7:47	71
	Proposed 2027 Palliative Care QIP Measure Set			73
	Proposed 2026 Hospital QIP 6-month Bridge Measure Set			75
Health Services	**Care Coordination**			--
	MCCP2036 – Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities - *Attachments A-L (unchanged from last review) are available on Partnership's external website. Attachment M is the new template added to the policy.*			80
	Quality Improvement			--
	MPQP1006 – Clinical Practice Guidelines			113

	Item	Lead	Time	Page #
	MPXG5001 – Clinical Practice Guidelines for the Diagnosis & Management of Asthma			118
	MPXG5002 – Clinical Practice Guidelines for Diabetes Cellulitis			122
	Utilization Management			--
	MPUP3026 – Inter-Rater Reliability Policy			126
	MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions			130
V.	**New Business – Discussion Policies**			
	Synopsis of Changes		--	140
HS	**Behavioral Health**			
	MPBP8003 – Mental Health Services	Jeffrey DeVido, MD	7:54	144
	MPBP8011 – Scope of Primary Care – Behavioral Health Indications for Referral Guidelines	Jeffrey DeVido, MD	7:59	181
	Quality Improvement			
	MPQP1022 – Site Review Requirements and Guidelines	Rachel Newman, RN	8:04	190
	Utilization Management			
	MCUP3133 – Wheelchair Mobility, Seating and Positional Components	Tony Hightower	8:09	390
	MPUD3001 – Utilization Management Program Description is included in the Presentation section as part of our Annual UM Program Evaluation (see below)	--	--	--
VI.	**Presentations**			
1	MPUD3001 – Utilization Management Program Description – *synopsis of changes begins on p. 403*	Tony Hightower	8:14	406
2	Annual 2025 Utilization Management (UM) Program Evaluation – NCQA UM Standard 1 Element G	Tony Hightower Andrea Ocampo, Pharm.D	8:29	450
3	Supplemental TAR Report to the 2025 UM Program Evaluation		8:44	484
4	Population Needs Assessment Presentation	Hannah O'Leary	8:47	493
VI. FYI & Close	*Pharmacy Operations Update 2a – direct any questions to Stan Leung, PharmD.*			609
	Adjournment scheduled for 9:00 a.m. Q/UAC next meets 7:30 a.m. Wednesday, May. 20, 2026			

PARTNERSHIP HEALTHPLAN OF CALIFORNIA
MEETING MINUTES

Quality and Utilization Advisory Committee (Q/UAC) Meeting
Wednesday, Apr. 15, 2025 / 7:30 a.m. – 9:30 a.m. - Napa/Solano Room, Airpark,
Chico – Story Creek

Voting Members Present:

Gwiazdowski, Steven, MD, FAAP
Hackett, Emma, MD, FACOG
Montenegro, Brian, MD
Mulligan, Meagen, FNP-BC
Murphy, John, MD
Quon, Robert, MD, FACP
Strain, Michael, PHC Consumer Member
Swales, Chris, MD
Wilson, Jennifer, MD, MPH

Voting Members Absent: Luu, Phuong, MD; Thomas, Randolph, MD; Sara Choudhry, MD; Brandy Lane, Consumer Member

Partnership *Ex-Officio* Members Present:

Bides, Robert, RN, BSN, Mgr, Member Safety – Quality Investigations, QI
Bontrager, Mark, Senior Director of Behavioral Health
Brown, Isaac, MBA/MHA, Interim Senior Director of Q & P Improvement
Cox, Bradley, DO, Regional Medical Director (Northeast)
DeVido, Jeff, MD, Behavioral Health Clinical Director
Esget, Heather, RN, BSN, ACM, Director of Utilization Management
Gast, Brigid, MSN, BS, RN, NEA-BC, Senior Director, Care Management
Glickstein, Mark, MD, Associate Medical Director
Hightower, Tony, CPhT, Associate Director, UM Regulations
Jalloh, Mohamed "Moe", Pharm.D, Dir. of Health Equity (Health Equity Officer)
Jensen, Annika, RN, Assoc Dir. of Clinical Integration, Care Coordination
Jones, Kermit, MD, JD, Medical Director for Medicare Services
Leung, Stan, Pharm.D, Director of Pharmacy Services
Moore, Robert, MD, MPH, MBA, Chief Medical Officer – Chair
Netherda, Mark, MD, Medical Director for Quality – Vice Chair
Newman, Rachel, RN, BSN, Mgr, Clinical Compliance – Quality Inspections
O'Connell, Lisa, Director, Enhanced Health Services
Randhawa, Manleen, Senior Health Educator, Population Health
Ribordy, Jeff, MD, Regional Medical Director (Northwest)
Ruffin, DeLorean, DrPH, MPH, Director of Population Health
Townsend, Colleen, MD, Regional Medical Director (Southeast)
Ward, Lisa, MD, Regional Medical Director (Southwest)
Watkins, Kory, MBA-HM, Director, Grievance & Appeals

Partnership *Ex-Officio* Members Absent:

Barresi, Katherine, RN, BSN, PHN, NE-BC, CCM, Chief Health Services Officer
Guillory, Ledra, Senior Manager of Provider Relations Representatives
Katz, Dave, MD, Associate Medical Director
O'Connell, Lisa, Director, Enhanced Health Services
Spiller, Bettina, MD, Associate Medical Director
Thornton, Aaron, MD, Associate Medical Director

Guests:

Beard, Alyssa, RN, Manager of CC Regulatory Performance
Booth, Garnet, Senior Program Manager, Provider Relations
Brunkal, Monika, RPh, Associate Director, Population Health
Campbell, Anna, Health Policy Analyst, Utilization Management
Cunningham, Aryana, Policy Analyst, Care Coordination
Devan, James, Director of Quality Management
Durst, Jennifer, Manage of Performance Improvement (Fairfield)
Frankovich, Terry, MD, Associate Medical Director
Molteni-Casper, Sarah, Program Manager ll, QI
Morris, Matthew, MD, Regional Medical Director (Auburn)
Ocampo, Andrea, Pharm. D, Clinical Pharmacist, Pharmacy
O'Leary, Hannah, Manager of Population Health, Pop Health
Quichocho, Sue, Manager of Quality Measurement, QI
Rushing, Eric, Manager of Mental Health Programs, Behavioral Health
Smith, Christine, Community Health Needs Liaison, Pop Health
Stites, Jaylyn, Program Manager ll, PR

Gual, Kristine, Director of Quality Measurement
Katz, Dave, MD, Associate Medical Director
Kubota, Marshall, MD, Reg. Medical Director
Matthews, Richard, MD, Regional Medical Director (Chico)
Ungaro, Chloe, Sr. Program Manager, PR
Vo, Kathleen, Pharm. D, Clinical Pharmacist, Pharmacy
Williams, Joanie, RN, Manager of UM
YoungStone, Kelly, RN, Director of Care Coordination

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
I. Call to Order Public Comment – *none made* Introductions Approval/ Acceptance of Minutes	Chief Medical Officer and Committee Chair Robert Moore, MD, MPH, MBA, called the meeting to order at 7:30 a.m. The Jan. 21, 2026 and Mar. 18, 2026 Q/UAC Minutes were approved without any corrections. *Acknowledgment and acceptance of draft meeting minutes of the* • Mar. 10, 2026 Internal Quality Improvement (IQI) Committee • Feb. 26, 2026 Member Grievance Committee minutes • Mar. 12, 2026 Population Needs Assessment (PNA) Committee minutes – *(Committee has been disbanded – these are the final minutes for this committee).*	Motion to **approve the Q/UAC minutes:** Steven Gwiazdowski, MD, FAAP Second: Robert Quon, MD, FACP *Approved unanimously* Motion to **accept the other minutes:** Robert Quon, MD, FACP Second: Steven Gwiazdowski, MD, FAAP *Accepted unanimously*
II. Standing Updates		
1. Quality Improvement (QI) Department Update *Isaac Brown, Senior Director of Quality and Performance Improvement, QI*	• Primary Care Provider Quality Incentive Program (PCP QIP) payment for measurement year 2025 is currently underway with the final payment being distributed by the end of May 2026. The PCP QIP Team is working with EDW to process manual adjustments. Providers will be asked to complete validation of their updated scores during the third week of March. Once this validation has been completed, final payment files will be drafted and validated then reviewed with the executive team for final sign off. • The organization, as a whole, has been through kind of an end-to-end assessment of our member experience with a consultant, and they're going to be giving us recommendations and gaps to fill on our own member experience. Final recommendations and prioritized action roadmap will be presented later this year. • Currently have 40 Mobile Mammography event days scheduled with limited availability left. If you know anyone who is interested please have them reach out to mobilemammography@partnershiphp.org.	*For information only*.
2. HealthPlan Update *Robert Moore, MD, MPH, MBA Chief Medical Officer*	• Regional Medical Directors Meetings are currently underway for 2026 with 4 completed and 3 left with Santa Rosa this Friday, Chico in a couple weeks, and then wrapping up in Truckee. The main topics covered will be about health policy, health plan and state updates, public health measures, and then quality. Folks are encouraged to attend as it will be a comprehensive review of everything related to Partnership and anything adjacent to the health plan. • April 1st the State changed the GLP1 prior auth criteria to not require a TAR for metabolic dysfunction-	*There were no action items.*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	associated steatohepatitis (MASH). Just putting the right diagnosis code on the prescription will work, although a TAR is still required for other diagnoses. • Partnership is currently watching closely from a health policy perspective the rural health transformation grants coming through the California Department of Health Care Access and Information (HCAI). $3 million will be distributed this first year with 20% of that being used up by the consultants and HCAI people they hire. Those grants will be sent out most likely in June plus or minus a month. Our regional directors will be working with our providers and organizations that may not have the desire or skills to submit a federal grant. One of the grants will be reviewed by CMS who tend to be meticulous with their budgetary review. Areas of focus will be the workforce pipeline, recruitment and retention of clinical staff, IT system enhancements, and OB access. • Currently looking at doing a periodic review of Partnership's Medical Equipment Distribution Services (PMEDS) program where blood pressure cuffs, scales, nebulizers, and so on are sent directly through partners because they are low cost and it can be hard to get the pharmacies to do it. Please send any frontline stories of how these devices are being used and how they may have benefitted a member to Dr. Moore. **Discussion** *There were no questions for Dr. Moore.*	
III. Old Business – None		
IV. New Business – Consent Calendar (Committee Members as Applicable)		
Proposed 2027 Palliative Care QIP Measure Set **Proposed 2026 Hospital QIP 6-month Bridge Measure Set** **Health Services Policies** Care Coordination MCCP2036 – Memorandum of Understanding (MOU) Requirements For Medi-Cal Managed Care Plans and Third-Party Entities - *Attachments A-L (unchanged from last review) are available on Partnership's external website. Attachment M is the new template added to the policy.* Quality Improvement MPQP1006 – Clinical Practice Guidelines MPXG5001 – Clinical Practice Guidelines for the Diagnosis & Management of Asthma MPXG5002 – Clinical Practice Guidelines for Diabetes Mellitus Utilization Management MPUP3026 – Inter-Rater Reliability Policy MCUP3037 – Appeals of Utilization Management/Pharmacy Decisions		*No questions were asked.* Motion to **approve the slate:** Robert Quon, MD, FACP Second: Steven Gwiazdowski, MD, FAAP *Approved unanimously* Next Steps: All policies go to the May 13, 2026 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
V. New Business – Discussion Policies		
Policy Owner: Behavioral Health – *Presenter: Jeffrey DeVido, MD, Behavioral Health Clinical Director*		
MPBP8003 – Mental Health Services	**Synopsis of changes reviewed:** • Added, "and dyadic Behavioral Health Services" to section I. 1. Changes were made to align with APL 26-002 wording. • Changed wording "medications" to "drugs" in section I. 5. Changes were made to align with APL 26-002 wording. • Updated DHCS BHIN 21-073 reference to updated BHIN 26-002. DHCS updated BHIN. • Added wording "Partnership covers NSMHS without prior authorization requirements.". This aligns with Partnerships NCQA requirements for no authorization required for MH services. • Added section K. Youth Trauma Screening Tools. Section added to align with new Youth Trauma Screening Tool requirements in DHCS APL 26-002 • Updated and Added wording related to EPSDT benefit to section H 1. Changes were made to align with APL 26-002 guidance. • Added wording "Partnership covers clinically relevant laboratory and radiologic studies…" to align with wording in APL 26-002. • Removed "up to 20" limitation on individual and/or group counseling sessions for pregnant and postpartum Members. Changes were made to align with APL 26-002 guidance. • Added sections N and O in Partnership is responsible for: SABIRT services and Preventive screenings for tobacco, alcohol and drugs. Changes were made to align with APL 26-002 guidance. • Updated wording in section R. 1. "and Partnership will notify members of such applicable policies." to align with wording in APL 26-002 • Removed superseded references and added reference to APL 26-002.	*There were no questions for Dr. DeVido.* Motion to **approve as presented:** Robert Quon, MD, FACP Second: John Murphy, MD *Approved unanimously* Next Steps: May. 13 PAC
MPBP8011 – Scope of Primary Care – Behavioral Health Indications for Referral Guidelines	**Synopsis of changes reviewed:** • Added, "and dyadic Behavioral Health Services" to section A. 1. Changes were made to align with APL 26-002 wording. • Changed wording "medications" to "drugs" in section A. 5. Changes were made to align with wording in APL 26-002. • Updated BHIN 21-073 reference to updated BHIN 26-002. DHCS updated BHIN. • Added wording "If a PCP cannot perform the mental health assessment, they must refer the Member to the appropriate Provider and delivery system for mental health services…". Changes made to align with APL 26-002. • Added section e. Reference to Youth Mental Health Screening Tools in Policy MPBP8003. Changes made to align with APL 26-002.	Motion to **approve as presented:** Robert Quon, MD, FACP Second: Steven Gwiazdowski, MD, FAAP *Approved unanimously* Next Steps: May. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Added sections a, b, c and d. PCPs should screen and refer members with SUD as follows: SABIRT services, Preventive screenings for tobacco, MAT services, and Emergency and Post-Stabilization service. Changes were made to align with APL 26-002. • Removed superseded references and added reference to APL 26-002. **Discussion:** • Dr. Katz asked who is responsible for administering these screenings? Are they county mental health or primary care providers or behavioral health providers? Who is qualified to do the screenings to get this pathway started? o Dr. DeVido said that the intent here is that the PCP in the primary care setting would do the screening.	
Policy Owner: Quality Improvement – *Presenter: Rachel Newman, RN, BSN, Manager of Clinical Compliance – Quality Inspections*		
MPQP1022 – Site Review Requirements and Guidelines	**Synopsis of changes reviewed:** This policy is coming back ahead of its annual review in large part to align with Partnership's Urgent Care Services updates as recently described in UM policy MCUP3044. 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. Policy number changed from MCQP1022 to MPQP1022 to reflect its applicability to the future Partnership Advantage D-SNP program. **Section III Definitions added:** "Supplemental Facility, Free Standing Urgent Care Provider, Free-Standing Urgent Care Center, Shared Medical Record Practice" to add clarification throughout the policy. **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.** **Attachments are being reordered and thus re-lettered Attachments J-N below are new additions:** J. Free Standing Urgent Care Clinic Facility Site Review Tool K. Urgent Care Medical Record Tool L. PCP Providing Urgent Care Facility Site Review Tool M. Palliative Care Facility Site Review Tool N. Palliative Care Medical Record Review Tool **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.5) • 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. 5)	*There were no questions for Rachel.* Motion to **approve as presented:** Jennifer Wilson, MD, MPH Second: Steven Gwiazdowski, MD, FAAP *Approved unanimously* Next Steps: May. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• 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. 7) • Medical Record Review (MRR) Scoring language is updated (p. 8): "If the minimum number of records is not available, Partnership will document the rationale and complete the MRR with the available records." • Obstetric Specialists and Non-Accredited Sites have been bundled and FSR and MRR language augmented under section "Specialized Site Reviews" (pp. 12) These are followed by additional MMR language pertaining to Free Standing Urgent Care Clinics (p. 12), and "PCP providing Urgent Care Services" (p. 12) "A Palliative Care report is run monthly by the Inspections Site Review Team." (p. 13) • 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 of UM Regulations*		
MCUP3133 – Wheelchair Mobility, Seating and Positional Components	**Synopsis of changes reviewed:** **Section VI.A.3.a. and b.:** This policy was updated to include language for Charpentier billing as follows: • Partnership will process a TAR for a dually eligible Member in the same manner as it would process a TAR for a Medi-Cal-only Member, regardless of whether Medicare (or any other health coverage) has authorized the equipment or been billed. • A TAR for such requests must include all medical justification and documentation that would normally accompany a Medi-Cal-only TAR and include the message "Medi/Medi: Charpentier/Rates", "Medi/Medi: Charpentier/Benefit Limitation", or "Medi/Medi: Charpentier/Both Rates and Benefit Limitation" in the Medical Justification section. **Discussion:** • Dr. Gwiazdowski asked why did they take out the provision for the denial? o Tony stated that Medicare won't necessarily issue an explanation of benefits (EOB) or evidence of denial for services that they do not cover, and Partnership needs to make sure that, in the case of wheelchair requests, if the Medicare rate is lower than what Medi-Cal will reimburse, that it doesn't get stuck on a provider with that lower reimbursement rate, and that Partnership would consider the service and pay if the Medi-Cal rate was high than the Medicare reimbursement rate.	Motion to **approve as presented:** Steven Gwiazdowski, MD, FAAP Second: Robert Quon, MD, FACP *Approved unanimously* Next Steps: May. 13 PAC
MPUD3001 – Utilization Management Program Description	*Utilization Management Program Description is included in the Presentation section as part of our Annual UM Program Evaluation (see below).*	*See below*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
VI. Presentations		
MPUD3001 – Utilization Management Program Description – *Tony Hightower, Associate Director of UM Regulation*		
Pages 406 - 448 **Synopsis of Changes reviewed (page 403):** Annual updates to our UM Program Description for both UM and Pharmacy activities were made in conjunction with our annual UM Program Evaluation. **Page 1:** In the Program Purpose section, "Enhanced Health Services" was added as the eighth Health Services team. **Pages 2 - 19:** Program Staff descriptions were reorganized into sections as follows: OCMO, UM, BH, and Pharmacy. **Page 3:** Added Program Staff description for the new position of Deputy Chief Medical Officer. In the assigned responsibilities for the Medical Director of Quality, added that this position serves as Chair for the Credentials Committee, Directs the two Member Safety Teams for Clinical Compliance and Quality Investigations, and Works with the Grievance and Appeals team to review Member Grievances with possible clinical care elements. **Page 5:** Removed Program Staff description for Director of Health Equity as that position is now described in the QIHETP Program Description, MCED6001. **Page 6:** Updated Program Staff description for the Director of UM to clarify duties and remove responsibility for reporting to Q/UAC on UM activity. **Page 7:** Updated Program Staff description for the Director of EHS. **Page 8:** Updated Program Staff description for the Associate Director of Utilization Management Regulations to state that this position gathers UM program information and incorporates updates into the annual UM evaluation and program description. **Page 9:** Updated Program Staff description for the Associate Director of EHS. **Page 10:** Added new Program Staff description for Manager of Enhanced Health Services Operations. **Page 11:** Updated Program Staff description for the Clinical Supervisor of Enhanced Health Services to include participation in oversight and audit of CalAIM providers. **Pages 12-13:** Updated Program Staff descriptions for Nurse Auditor, Nurse Coordinator II, and Nurse Coordinator I. **Pages 13-14:** Added new Program Staff description for Program Manager II and Program Coordinator II in UM Regulations. Also updated Program Staff description for Program Manager I – (EHS). **Page 15:** Updated Program Staff descriptions for Project Coordinator II - (EHS), Project Coordinator I - (EHS), Health Services Analyst I, and Health Services Administrative Assistant II – UM, EHS. Added a new Program Staff Description for Program Coordinator I - (Training & Education). **Pages 16 - 17:** Updated Program Staff description for Behavioral Health Clinical Director to reflect only MD as that is the credential for the person currently in this position. Other options of DO, PhD, and PsyD were deleted for now. Other updates were made to clarify changes since Carelon was de-delegated. **Pages 17-18:** In the Behavioral Health section, added new Program Staff descriptions for Senior Manager of Behavioral Health, Sr. Manager of Behavioral Health Access, Sr. Manager of Child Welfare Program, Manager of First 5 Commissions, Manager of Mental Health Programs, and County Child Welfare Liaison. **Page 20:** Updated information on attendees for the PAC Committee.		*Voting was combined for UM Program Description and UM Program Evaluation. Please see below.*

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	Pages 20-21: Updated information on attendees for the Q/UAC Committee and specified that the committee activities include annual review of UM rates and identification of actions to address opportunities identified. Also updated information on attendees for the QIHEC committee. **Page 22:** Corrected definition of BHT to reflect Behavioral Health Treatment instead of "therapy" services. **Page 24:** Updated information on APL 22-012 to reflect APL 25-013 Medi-Cal Rx Pharmacy Benefits and Cell and Gene Therapy Coverage. **Page 25:** Updated policy number MPCP2017 to reflect MPBP8011 because the *Scope of Primary Care - Behavioral Health and Indications for Referral Guidelines* policy has been transferred from Care Coordination to the Behavioral Health department. **Page 27:** In the Utilization Manager Process section, added statement to say that "Appropriately licensed professionals supervise all medical necessity decisions as described in the UM Program Staff section starting on page four (4)." This was a recommendation from our NCQA consultant. Consultant also added clarification to last statement on the page to specify that UM considers the "local" delivery system and the availability of services with "their ability to meet the Member's specific health care needs." **Page 31:** In the UM chart for Non-Behavioral Healthcare Decisions and Behavioral Healthcare Decisions, the time frame for Non-urgent pre-service decisions was changed from 5 business days to 7 calendar days as per DHCS regulations. A new time frame chart was added to describe Pharmacy Decisions that must be made within 24 hours of receipt of request for Urgent Concurrent, Urgent Pre-service, and Non-urgent pre-service decisions. **Post-Meeting Note:** *We also reduced the time frame for a non-urgent preservice extension from 28 to 14 calendar days which will be updated in the PAC meeting packet.* **Page 33:** In the Availability of Criteria section, language was updated to say that the Provider Relations department notifies providers in writing "and electronically" regarding availability of UM criteria. Per our NCQA consultant, this statement was also added to describe our upcoming D-SNP program: "Partnership's UM Program plans include development and implementation of its CMS Final Rule Interoperability plan during CY 2026. This plan will include steps for the implementation of practitioner access to criteria electronically at point of service. Implementation is planned for January 2027." **Page 35:** The section on Appeals was updated per recommendation from our NCQA consultant. The title of the section was changed to specify "Process for ***a Member or a*** Provider ***on Behalf of a Member*** to Appeal an Adverse Benefit Determination," and the following language was added to this section. "The Member or their authorized representative may submit a request for appeal verbally or in writing. The Member or the authorized representative may submit additional information for review and may request copies of all documents considered as part of the review. The time for resolution begins when the request is received, even if the information provided is incomplete. Partnership makes appropriate attempts to obtain any needed information for review within the required timelines, in order to make an informed decision within required timeframes based on clinical urgency and according to our policies and procedures." **Page 39:** The Annual Program Evaluation section was updated to specify that the Behavioral Health department participates in the evaluation, and the following additional positions were added for leadership who contribute: Senior Director of Care Management, Senior Director of Behavioral Health, and the Director of Enhanced Health Services. **<u>Discussion:</u>**	

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• Dr. Gwiazdowski asked why the DO, PhD, and PsyD credentials would be removed from the Program Staff description title for the Behavioral Health Clinical Director (leaving only MD), but then all of the credentials are included in the next sentence in the policy? o Tony answered that when this policy was being reviewed by the NCQA consultant, they requested that we align that credential with the actual medical director that we have in place for that position now. The intent was not necessarily to exclude other credentials from that particular position. Dr. Moore added that the Program Staff descriptions provide a list of individuals that are currently in our department and it's a requirement that the policy states this. o Dr. Gwiazdowski said that this breaks from how we format everything else and may cause confusion.. o Dr. Moore agreed and noted that listing only the current staff credentials for each position in the policy would also cause more work in the future, because if someone leaves, then we would have to update the Program Description each time. He wondered if we should list current staff with their credentials in an addendum or an appendix. o Anna pointed out that we are consistent where we describe all other types of medical directors in the CMO section. We list both MD and DO for each Medical Director position because they could hold either credential, but Dr DeVido's position appears at the start of the Behavioral Health Staff section and the NCQA consultant was very insistent that the description for Behavioral Health Clinical Director had to specify only MD as the qualifying credential because the current person in that role is an MD. o Dr. Moore said that doesn't make sense because this is a program description intended to describe the necessary qualifications for the staff position and not necessarily the specific person who holds the position now. Dr. Quon agreed and said a more typical place to list specific people and their positions is in an addendum. o Dr. Moore suggested removing "MD" in the title of "Behavioral Health Clinical Director ~~MD~~" and then including an addendum to list the people who are actually hold each role. This would be consistent with how staff are listed in the QI Program Description. An entire policy should not have to be changed when a new person switches in. o Anna asked if the addendum would list staff for the entire UM program including Pharmacy, UM, BH, EHS, and CMO? Dr. Moore confirmed yes, it will be a very long list. o Anna expressed concern about including full names, titles, and credentials in a public-facing policy. Dr. Netherda said that we are supposed to be transparent so it shouldn't matter. Dr. Quon said that at Kaiser, it is available in their public policy. o Anna asked if we would need to list all MD's and nurses? Dr. Moore said it should only be the leadership, with Dr. Quon agreeing. o **Dr. Moore proposed that documentation of more specific clinical staff information should be presented at a future meeting (i.e. an org chart, list of clinical staff leadership, both, or neither) for the committee to review.**	
Annual 2025 Utilization Management (UM) Program Evaluation - NCQA UM Standard 1 Element G –*Tony Hightower, Associate Director of UM Regulation and Andrea Ocampo, Pharm.D.*		
UM 1G Annual UM Program Evaluation (Page 450) Tony Hightower led the presentation by stating that the Q/UAC packet was distributed to committee members in advance and it included the following documents: policy MPUD3001 UM Program Description (summarized above), the 2025 Annual UM Program Evaluation Report (UM 1G) and the UM rates Evaluation Report (UM 1F) which analyzes data using a new NCQA workbook.		Motion to **approve MPUD3001 UM Program Description and the UM 1G Annual UM Program Evaluation as presented:** Robert

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	• The annual review for the UM program of CY 2025 report assesses the following: o Program Structure o Program scope, processes, and information sources used to determine benefit coverage and medical necessity. o UM criteria, prior authorization requirements, and level of involvement of the senior-level physician and designated behavioral healthcare practitioner in the UM program o Member and Practitioner experience with the UM program • **Program Structure: Staffing Oversight (Page 453)** o Currently Partnership established a minimum threshold of Medical Directors to Nurses and Medical Directors to Pharmacists at 1:5 at 1:5 (20%). Partnership's Physician to Pharmacist ratios were met for all months in 2025 but Physician to Nurse ratios did not meet the threshold goal from July through December 2025. o Partnership received about 12,000 Pharmacy Treatment Authorization Requests (TARs) which was a 9.43% increase from 2024. o Also monitored the TAR per pharmacist and TAR per tech ratios month to month to assess for adequate staffing. The TAR per pharmacist did exceed the 20% month to month threshold in July and October due to fluctuations in TAR volume and staff retirement. Hired new staff in Q4 to address the staffing gaps and daily workflow demands. • **Program Structure: Staffing Workload (Page 454)** o Annual TAR volume was 327,639 which represented a 4.95% decrease from calendar year 2024. o Nurse to medical director ratio also operates on the 1:5 20% threshold. Q3 and Q4 exceeded the threshold due to an influx of nursing hires that was out of proportion to the hiring of medical director staff. **Suggested interventions are as follows:** • Continuing to assess and monitor staffing ratios • Continuing to assess opportunities for increased efficiency in evaluating TAR requirements. • Increase staff ratio threshold from 1:5 (0.20) to 1:6 (0.167) based on 2025 process improvement and operational assessment o TAR to nurse ratio was met for all quarters. This was a reflection of interventions that were made in 2024 and indicates that interventions were effective. • **Program Structure: Evaluation of the Partnership Advisory Committee Structure (Pages 456-458)** o All advisory committees were within quorum threshold. • **UM Rates** o *The 2025 results, along with the interventions and ongoing activities by UM and Pharmacy to address identified gaps and opportunities are detailed in the UM 1F Evaluation of Utilization Management Rates Report* ***(Appendix A – Page 469)***. o UM Non-behavioral Health Rates: The aggregate approval rate for UM TARs in 2025 was 77.58% and the aggregate denial rate was 22.42%. Within the reporting specs provided by NCQA these rates do include all administrative decisions. When looking at just medical necessity denials, the denial rate was at 6% which is significantly lower than the combined (Administrative and Medical Necessity) denial rate. Partnership does not require any prior authorization for Behavioral healthcare.	Quon, MD, FACP *Second:* Jennifer Wilson, MD, MPH Next Steps for both MPUD3001 UM Program Description and UM 1G Annual Program Evaluation: May. 13 PAC

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- Pharmacy Rates: The aggregate approval rate for Pharmacy TARs in 2025 was 86.34% and the aggregate denial rate was 19.46%. This reporting also included all operational and administrative decisions and excluded retrospective decisions. Quarterly reports showed that the approval and denial rates remained stable and consistent throughout the year. When considering only medical necessity denials, the denial rate was 10.49%. Quarterly reports were reviewed showing a 2% denial rate increase from Q3 to Q4. This increase was due to introduction of new preferred product requirement. After reviewing the rest of the denials, there were no other noticeable trends.
- Appeal rates: These are a combination of UM, Pharmacy, and G&A teams. Overall appeals rate was 2.91% with an overturn rate of all appeals being 29.41%. When evaluating these rates with the G&A team, it was determined that most of the overall appeals overturn volume was due to UM receiving a large influx of appeals related to disagreements on level of care decisions for post discharge and patient stays. These primarily came from 2 large hospital providers within our network. G&A also reported that a large portion of their appeals were focused on the medically-tailored meals benefit that is processed by the EHS team.
- Timeliness: Rates are evaluated for both Non-Behavioral and Behavioral decisions, although Partnership does not require any prior authorization for Behavioral healthcare, so we report none in that section. Both Non-Behavioral and Pharmacy decisions met the 90th percentile timeliness threshold for the year.
- Thresholds for all review categories were met based on the evaluation of the 2025 UM rates. As a result, no opportunities and interventions were identified. TAR timeliness will be an area of focus for 2026 – 2027 due to the updates that UM has encountered with application of the CMS final rule and the planned transition from the current legacy TAR processing platform to a JIVA platform. These changes pose a risk to timeliness, and the UM team plans to increase the cadence of monitoring timeliness from a weekly cadence to a daily cadence for the first 30 – 60 days of the go-live of JIVA implementation.

- **Program Process: Consistency of Applying UM Criteria (Page 459)**
  - Inter-rater reliability (IRR) is the measure of how we apply our criteria for our nursing, pharmacy, and medical director staff. Our threshold for concurrence is set at 90%. For the UM team, it was identified that outpatient nurses, LTSS nurses, and medical director reviewers met the 90% threshold. For Inpatient Nurse Reviewers, the concurrence rate for Q2-Q4 fell slightly below the 90% threshold with an overall rate of 89%. **Suggested interventions are as follows:**
    - Tracking and trending for repeated deficiencies to be observed and acted upon by UM Leadership on a quarter-by-quarter basis.
    - Conduct team-wide discussions on consistency in applying medical necessity criteria during internal Inpatient Rounds
    - Conduct annual training on InterQual® for UM Nurses.
    - UM Nurse Scorecard template updated to include IRR components. The scorecard is used to score IRR and other competencies for each nurse on a monthly basis.
    - Transition quarterly IRR monitoring process from nurse staff at large to the UM Training & Education team to focus and standardize the application of inter-rater reviews and ensure that secondary reviews are consistent.
  - Threshold of concurrence for Pharmacy staff is set at 90%. This was exceeded for both pharmacists and pharmacy technician reviewers.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- **Program Process: Appropriate Care: Monitoring for Over/Underutilization (Page 459)**
  - This is a summary of over/underutilization activities for the year that were evaluated by the Over/Under Committee.
  - Evaluation of Over/Under utilization is performed across various groups and committees in the organization including HEDIS reviews, IQI committee, QUAC committee, through our Site Review process, and through the Access and Availability Grand Analysis that is performed by the Quality team. Additional analyses and remediation actions for potential areas of noncompliance for over/underutilization are typically handled by the Plan via quality improvement programs as well as the standard UM process and review.

- **Prior Authorization Requirements, UM Criteria, and Information Sources Used to Determine Benefit Coverage and Medical Necessity (Page 463)**
  - Partnership uses the most currently available InterQual® Criteria sets as the primary review guidelines for UM medical necessity decisions. For the calendar year 2025, UM used the 2024 InterQual decision criteria until the 2025 version became electronically available.
  - InterQual criteria and other approved UM criteria outside of InterQual, are reviewed, discussed, and evaluated at Partnership's Q/UAC and PAC as described in policy MPUP3139 Criteria and Guidelines for Utilization Management. Criteria utilized include, but are not limited to, Medi-Cal (State of California) guidelines, Medicare criteria, State policy letters, national treatment guidelines, and clinical practice recommendations from UpToDate®.
  - Partnership's medication decision criteria and pharmacological drug classes are reviewed in collaboration with external and internal providers on an on-going and annual basis. Criteria are selected, reviewed, updated or modified using feedback from the Partnership staff, the P&T Committee, the PAC, the Community Advisory Committee (CAC), external providers, State policy letters, or medical literature among other sources.
  - Partnership's Pharmacy & Therapeutics (P&T) Committee determines whether or not a particular drug or pharmaceutical class shall be absent of TAR requirements based on therapeutic advantages in safety and efficacy, standards of care, and generally accepted place in therapy. Cost, utilization, and approval rates are also considered.

- **Involvement of Senior Level Physicians in the UM Process (Page 463)**
  - Partnership looks at the involvement of the CMO and medical directors including the Behavioral Health clinical director in the UM process. The CMO and medical directors participate in the review and approval policies via QUAC and PAC and, for the pharmacy team, via the P&T workgroups and committees. They also perform daily UM review and decision making and participate in internal and external clinical rounds.

- **Assessing Experience with the UM Process: Improving Practitioner Experience with the UM Process (Page 464)**
  - *Please see Appendix B: Physician Satisfaction Survey for a breakout of the practitioner experience.*
  - On an annual basis, Provider Relations engages with a third-party surveyor, Press Ganey, to survey our network of primary care physicians and specialists to gauge their satisfaction with Partnership's UM and Pharmacy processes.
  - UM was able to meet the threshold goal of 90% satisfaction for primary care physicians.
  - UM was unable to meet the threshold goal of 90% satisfaction for the specialists. 6 UM questions that were posed to our network specialists did not meet the goal.
  - Pharmacy was unable to meet the threshold goal with primary care physicians. 1 question did not meet the goal.
  - Pharmacy was able to meet the threshold goal with specialists.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- Analysis of these results identified that there was a potential gap in provider education in both Eastern and Southern regions. These results were driven by the recently added Eastern region, with this being their first survey. **Suggested interventions are as follows:**
  - Collaborate with the Provider Relations (PR) team to participate in clinic site visits to share information about the Partnership Pharmacy program and the services available to providers.
  - Collaborate with the PR team to educate PCPs on the differences between the Partnership Pharmacy program and Medi-Cal Rx

- **Assessing Experience with the UM Process: Member Experience with the UM and Pharmacy Process (Page 466)**
  - *Please refer to Appendix C for further details of Member satisfaction data for 2025.*
  - This portion of the program evaluation was provided by the Grievance and Appeal
  - s (G&A) department through the G&A PULSE Report. The report contains an analysis of Member-reported Grievance concerns about any dissatisfactory experience related to Utilization Management (UM).
  - In 2025, there was an overall increase in grievances received when compared to 2024. The majority of areas that did not meet goal centered around provider-related concerns. The primary issues reported concerning the UM process were access-related issues. Notably, 57.3% of these access-related issues were associated with Partnership's Referral Authorization Form (RAF) process, while the remaining 42.7% were linked to the Treatment Authorization Request (TAR) process. Among the reported issues within the referral process, delays by providers (162) was the most reported concern.
    - Members alleged that their primary care providers were delaying submission of RAFs, consequently causing delays in obtaining appointments with specialists.
    - The most prominent driver behind Member dissatisfaction with the TAR process was related to Members alleging that their providers delayed submission of TARs to Partnership (87 reported concerns).
  - **Suggested interventions are as follows:**
    - Collaborate with the G&A team to include additional data points in the PULSE report for "Member Experience with the UM Program" - adding data for Member "County" and "Provider Substantiation" (Yes or No). This additional information will allow UM to further stratify the data and gain insights into trends in Member concerns.
    - Collaborate with the PR team in pursuing educational opportunities with our provider network on Partnership processes and resources to improve Member satisfaction with the authorization process.

Supplemental TAR Report to the 2025 UM Program Evaluation (Page 484)

- This includes a TAR breakdown of each UM team's respective TAR numbers by category and status type.
- Also includes a summary breakdown of the percentage of TARs that were approved, modified and approved, denied, and admin denied.
- Summary of the percentage of appeals that were upheld, overturned, and partially overturned.

Conclusion

Overall, Partnership's UM Leadership concludes there are no significant changes required for the UM program. Activities addressing the improvement opportunities will continue to be monitored, measured, and reported in future evaluations. We find that Partnership's UM program functions effectively and efficiently through a solid program structure, comprehensive set of policies, and

robust support, guidance, and engagement from senior level physicians and advisory committee members.

Summary of Opportunities and Proposed Interventions by UM for Approval

Priority	Opportunities Identified	Barriers	UM Program Evaluation Component	Interventions
1	**IRR concurrence rate for inpatient nurse reviewers**	Lack of consistency in applying inpatient criteria by UM Nurses	UM Program Processes	• Tracking and trending for repeated deficiencies to be observed and acted upon by UM Leadership on a quarter-by-quarter basis. • Conduct team-wide discussions on consistency in applying medical necessity criteria during internal Inpatient Rounds • Conduct annual training on InterQual for UM Nurses. • UM Nurse Scorecard template updated to include IRR components. The scorecard is used to score IRR and other competencies for each nurse on a monthly basis. • Transition quarterly IRR monitoring process to the UM Training & Education team to focus and standardize the application of inter-rater reviews and ensure that secondary reviews are consistent.
2	**Physician to Nurse staffing ratios**	Uncertain fiscal climate at State and Federal levels	UM Program Structure	• Continuing to assess and monitor staffing ratios • Continuing to assess opportunities for increased efficiency in evaluating TAR requirements. Increase staff ratio threshold from 1:5 (0.20) to 1:6 (0.167) based on 2025 process improvement and operational assessment
3	**Provider Experience with the UM Process**	Negative provider perceptions of Medi-Cal Rx may be conflated with Partnership's	UM Program Scope	• Collaborate with the Provider Relations (PR) team to participate in clinic site visits to share information about the Partnership Pharmacy program and the services available to providers. • Collaborate with the PR team to educate PCPs on the differences between the Partnership Pharmacy program and Medi-Cal Rx

AGENDA ITEM		DISCUSSION			RECOMMENDATIONS / ACTION
		Pharmacy processes.			
4	**Member Experience with the UM Process**	Absence of year-over-year comparative data for recent Eastern Region expansion counties con-strains analysis of factors contributing to lower Member satisfaction scores.	UM Program Processes	• Collaborate with the G&A team to include additional data points in the PULSE report for "Member Experience with the UM Program" — adding data for Member "County" and "Provider Substantiation" (Yes or No). This additional information will allow UM to further stratify the data and gain insights into trends in Member concerns. • Collaborate with the PR team in pursuing educational opportunities with our provider network on Partnership processes and resources to improve Member satisfaction with the authorization process.	

Tony invited the committee to review the above opportunities and interventions and provide feedback on their prioritization and offer any additional recommendations they may have for consideration. The committee did not request any changes to the prioritization of actions which were accepted as presented.

Discussion

- Dr. Quon asked if the ratio between the nurses and medical directors is dictated or a regulatory requirement by DHCS?
    - Tony said that it's not necessarily at that strict level and is left to Partnership's best judgement. What Partnership is required to do by NCQA is to establish a threshold and ensure that all processes and staffing align with that goal.
    - Dr. Quon made a suggestion to remove the ratio goal altogether, as the focus should be on making good decisions in a timely manner, and not that we have "X" number of nurses and "X" number of doctors. This would avoid Partnership pigeon-holing itself into a specific number that is unrealistic and unnecessary. Dr. Moore said this was a good thought, and although it can't be changed in this round, it can be taken back to NCQA to look at what the regulatory requirements are, as opposed to what the recommendation was. If all they require is the monitoring of the amount of work being done, then that would be easier to report on.
- Dr. Murphy asked if there are ways to automate parts of the claims review process? How is Partnership looking at automating review of claims that get rejected from a billing standpoint? Right now, there is a bifurcated approach where if the claim is not denied, then you don't have a TAR anymore. Another branch point would be that some sets of claims need an in-depth review while other sets do not need to be reviewed at all and don't require a TAR, and others that can be automated. He was wondering if there were vendor solutions?
    - Dr. Moore said on the claims side, we will be implementing a claims editor system. Currently we are under-utilizing efficient processes because we are in the process of changing our core system and don't want to build out some of the automation based on the older system that is on its way out. Our new system is scheduled to go live at the end of this

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION
	year. Our new vendor has certain efficiency aspects built out for us based on extensive evaluation of Partnership processes. Automations will be implemented where it makes sense to automate, but without making them deny people inappropriately or subjecting claims to medical review decision-making that we can't have the machine make. • Dr. Gwiazdowski (page 452) pointed out several items that are leading to confusion: o Under the Methodology/Data: Program Structure section, there are 3 bullet points (Physician to Nurse ratio, Physician to Pharmacist ratio, and then Staff to TAR ratio). Is staff meaning RNs or nurses? The tables that follow it look as though they're nurses, so he was curious as to how staff are defined. o **Tony said this would be our clinical nursing staff to medical director ratio. This will be updated for clarification.** o (Page 452) The third bullet under Program Structure says it was Staff to Treatment Authorization Ratio which suggests the staff is in the numerator and the TAR is in the denominator, but then in the tables it has TARs per nurse. o **Dr. Moore said in order to avoid redoing the entire table, the wording on page 452 should be flipped to say "Treatment Authorization Request to Clinical Nurse Staff ratio".** o Where we say "Physician to Nurse ratio" it has MD as it was before MD/DO. Should that be maintained from the bullet points down to the rest of what you are doing to avoid any confusion or do you think that will not be an issue? o **Tony said he will change this for consistency.** • Dr. Kubota asked if the nurses are RN's? o Tony said that only clinical nurses are included in the ratios and it excludes anyone who is non-clinical. The nurses include RN's and LVN's. • Dr. Gwiazdowski (page 475) asked if the overturned rate of appeals of 29% is considered high, low, or great? o Dr. Moore said the biggest reason for denial is because the proper documents were never submitted and then they submit them during the appeal process. Dr. Moore said the sweet spot is somewhere between 20% to 80% and that there is some legislation that says it should be between 10% to 90%. o Tony emphasized that these particular rate evaluations are a new part of the UM program evaluation, so we will now be able to track it year over year to determine what our overall performance is.	
Population Needs Assessment Presentation – *Hannah O'Leary, Manager of Population Health*		
• The Population Needs Assessment takes place every year and looks at the needs of our members from the past calendar year, 2025. • Key findings included economic instability, lack of access to quality health care, neighborhood and built environmental challenges, limited access to quality education, and social and community context changes. • Other community challenge findings included access to care, differences in health outcomes, transportation, environmental concerns (wildland fires), and chronic conditions. • Chico region had the greatest percentage of members accessing mental health services. • Continuing to struggle in some areas with breast cancer and cervical cancer screenings. • Reported some health disparities in a particular set of ethnic and racial categories in clinical measures. • Opportunity areas included organizational structure, social and environmental needs, member health and wellness, access to care, health disparities, and health education. • **Organization structure:**	*Motion to **approve as presented:*** Steven Gwiazdowski, MD, FAAP *Second:* Robert Quon, MD, FACP

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

- Hired a handful of different positions that will support their health equity department.
- Fully staffed health needs liaison team to cover all 24 counties.

- **Social and environmental needs:**
  - Has been some opportunities to distribute CalAIM distribute payment program: awarded over $52 million in grants. To local entities to build out our enhanced care management and community supports programs.
  - Many of the households in our counties reported having insufficient income. Partnership is continuing to work on increasing workforce opportunities.
  - Partnership continues to support its Asthma Emergency Department Visit Outreach Program
- **Access to Care:**
  - Some great work around working with our schools to increase behavioral health access
  - Continued working with Alinea for mobile mammography
  - Continued to work on providing education regarding the cervical cancer self-swab program
  - Continued growing together program that focuses on getting kids into well visits and to get vaccinated
  - Continued working on the provider recruitment and retention programs to increase access
- **Health Disparities:**
  - Continued our tribal health connections to support our tribal members who may not have great access to perinatal care
- **Health Education:**
  - Continued with our basic health population management programs
  - Community resource pages are still available and are a great resource for those who need support with identifies available resources in their area.
  - Wonderful member education events where members who were new to Partnership were able to ask questions and receive support.

Discussion:

- Dr. Gwiazdowski, page 540, noticed that the prevalence of anxiety translates to over 80% and wondered how this relates to use of social media. Other countries are doing it and wonders if Partnership can participate or spearhead a grant for giving money towards social media education. Schools can get involved to get kids to limit use. There's a big opportunity that we could do better.
  - Dr. Moore said it seems like it needs to be a policy intervention. It's not just kids, but also young adults and pregnant patients. Anxiety is one of the highest symptoms among pregnant patients. Policy is local and state level, which should be a systematic change, not just an individual choice.
- Jennifer Wilson, MD (page 548) asked if it's weird to have COPD and dementia listed under the conditions that children suffer from?
  - Hannah commented that it's a screenshot of a data dashboard that we are referring to with Dr. Netherda saying that it's based off of coding. Dr. Moore said this would be worth a follow up with the data analytics team to look at the underlying diagnoses that are feeding into the dashboard.

AGENDA ITEM	DISCUSSION	RECOMMENDATIONS / ACTION

VII. Adjournment

Dr. Moore adjourned the meeting at 9:18 a.m.

Respectfully submitted by: Chandler Ackerman, Program Manager I, QI

Signature of Approval: Date:

Robert Moore, MD, MPH, MBA
Chief Medical Officer

PARTNERSHIP HEALTHPLAN of CALIFORNIA

QI Department Update
April 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)	**Program Overview** Pay for performance program incentivizing improved performance on Clinical, Non-Clinical, and Unit of Service (UOS) measures in the Primary Care setting. **Program Update** • Payment for measurement year 2025 is underway. Final payment should be distributed by the end of May 2026. • The PCP QIP Team is working with EDW to process manual adjustments. Providers will be asked to complete validation of their updated scores during the third week of March. • Once this validation has been completed, final payment files will be drafted and validated then reviewed with the executive team for final sign off. • Provider notification for their intent to participate in the Optional Clinical Measure - Reducing Healthcare Disparity have been collected and the QIP Team will start to conduct their analysis for identifying their measure and population of focus.
Palliative Care Quality Incentive Program (Palliative Care QIP)	**Program Overview** Pay for performance program which offers significant financial incentives to support and improve the access to and quality of palliative care provided by our contracted palliative care providers. **Program Update** • Payment processing is in progress for 2025 measure period II (July-December) with preliminary reports scheduled to be sent out to providers mid-April. • The Palliative Care Clinician Workgroup will be held Thursday, April 9, 2026.
Perinatal Quality Incentive Program (PQIP)	**Program Overview** The Perinatal QIP offers financial incentives to participating Comprehensive Perinatal Services Program (CPSP) and select non-CPSP providers providing quality and timely prenatal and postpartum care to Partnership members Program Update **Program Update** • We are holding a Perinatal Symposium on April 13th out of Fairfield and broadcast to Auburn, Eureka and Redding offices for providers to attend in person.

	○ Nutrition education and treatment in the perinatal period ○ Comprehensive assessments: Integrating effective strategies to understand and meet your patient's needs during and after pregnancy ○ Maternal mood disorders: Screening, diagnosis, and treatment ○ Substance use disorders during and after pregnancy ○ Vascular disease: Who is at risk?
ENHANCED CARE MANAGEMENT QUALITY INCENTIVE PROGRAM (ECM QIP)	**Program Overview** The ECM QIP offers financial incentives to motivate, modify, and improve the health outcomes of seven identified groups of individuals by standardizing a set of care management services and interventions **Program Update** • Incentive payment processing is underway for 4th quarter 2025 with final incentive payments scheduled for distribution by end of April.
HOSPITAL QUALITY INCENTIVE PROGRAM (HQIP)	**Program Overview** The Hospital QIP offers financial incentives to improve performance related to Readmissions, Advance Care Planning, Clinical Quality, Patient Safety, Operations and Efficiency, and Patient Experience **Program Update** • No Update
EXTENDED CARE FACILITY INCENTIVE PROGRAM (EXT QIP)	**Program Overview** The EXT QIP offers financial incentives to support and improve the quality of long-term care provided to our members, with measures in the following domains: Clinical, Functional Status, Resource Use, and Operations / Satisfaction. **Program Update** • No Update

QUALITY DATA TOOLS

TOOL	UPDATE
PARTNERSHIP QUALITY DASHBOARD (PQD)	**Program Overview** The Partnership Quality Dashboard (PQD) is a Tableau designed to inform, prioritize, and evaluate quality improvement efforts. Dashboards and performance metrics built into the PQD provide the ability to track and trend QIP data. **Program Update** • PQD 2026 BRD has been approved and turned over to EDW team. Development work is in process with planned launch date in May 2026
EREPORTS	**Program Overview**

	eReports is a web application that allows providers to see their quality metrics in Partnership's PCP QIP program. eReports updates twice a week for near real-time visibility to quality metrics while PQD refreshes monthly for historical trending. **Program Update** • No update

PERFORMANCE IMPROVEMENT (PI)

ACTIVITY	UPDATE
STATE MANDATED WORK: *PERFORMANCE IMPROVEMENT PROJECT (PIP) & PLAN-TO-DO-STUDY-ACT (PDSA) CYCLE*	**Program Overview** All plans in California are required to conduct PIPs as part of their agreements. DHCS has assigned Partnership two PIPs: a non-clinical PIP for BH and a disparity PIP. DHCS can also require plans to do mandated improvement PDSA projects **Program Update** • Final 2025 PIP updates will be due August 2026. • P-D-S-A
QUALITY MEASURE SCORE IMPROVEMENT	**Program Overview** Internal measure-focused workgroups, which bring together perspectives across Partnership's services delivery continuum with the goal of strategically improving measures that align with the strategic priorities of Partnership HealthPlan. Current Priority Measures: 1. Child and Adolescent Well Care Visits (WCV) 2. Adolescent Immunizations (IMA-2) 3. Controlling High Blood Pressure (CBP) 4. Glycemic Status Assessment for People with Diabetes (GSD) 5. Timely Prenatal Care (PPC-Pre) **Workgroup Updates** • **Pediatrics:** No updates • **Women's Health & Perinatal:** Partnering with Improvement Advisors to discuss PPC Pre: timeliness of prenatal care measure requirements with identified providers. Met with 2 high performing providers to discuss their Chlamydia screening best practices. Fostering Connections series underway with a focus on timeliness of prenatal care. • **Chronic Disease:** Workgroup met on 3/26/2026. Current activities include building a resources page on the Partnership Website for Colorectal Cancer Screening. Controlling High Blood Pressure is a high priority for improvement, and the group is working to identify 2026 improvement actions. • **Behavioral Health:** No updates
IMPROVEMENT ACADEMY	**Program Overview**

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

Current Offerings

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

Program Update

- **QI Project Training Series (Spring 2026 cohort)**: The inaugural cohort started on 02/24/2026 and will end 05/05/2026.
    - Average attendance across the first three sessions is 60% of enrolled participants.
    - We are retaining 86% of participants between Sessions 1 and 2, and 74% between Sessions 2 and 3.
- **QI Project Training Series Fall 2026 Cohort** begins on 9/1/2026 and ends 11/10/2026. Registration will be open for the Fall cohort on 5/1/2026.

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

Program Update

- No update

ABCs of Quality Improvement
Program Overview
The ABCs of Quality Improvement (QI) is a full day in-person training designed to introduce participants to key QI methodologies with a specific focus on the Model for

	Improvement – a widely used framework for driving measurable change in health care settings. **Program Update** o No Update
JOINT LEADERSHIP INITIATIVE (JLI)	**Program Overview** The Performance Improvement team is scheduling 2026 Joint Leadership Initiative meetings with seven parent organizations across the Partnership network. Four of the seven organizations are in our expansion counties (Chico and Auburn Regions). This is a quality improvement strategy to collaborate with the largest parent organizations providing primary care who did not earn at least 75% of their PCP QIP scores in the previous year. This number could change once final 2025 PCP QIP scores are finalized. **Update** • **Santa Rosa Region** – o No providers qualify for JLI meetings for this region. • **Fairfield Region** – One JLI provider. o Solano Family Health Services – 4 meetings per year. ▪ QI: 3/25/2026. ▪ **Of the** • **Chico and Auburn Regions** – All organizations have had at least one meeting in the last 3 months and 75% have the next meeting scheduled.
REGIONAL IMPROVEMENT MEETINGS	**Program Overview** Regional Quality Improvement meetings are held quarterly at each of our 6 regional offices (Eureka, Redding, Chico, Auburn, Fairfield, and Santa Rosa) or online with the goal of bringing together regional health center quality leaders to share and discuss strategies to improve measures that regionally important and learn from Partnership regarding any program changes and/or priorities. **Update** • **Santa Rosa Region** – The Q1 meeting (2/24/26) focused on Chlamydia screening and featured peer learning opportunities with presentations from Santa Rosa Community Health and Marin Community Clinics. The Q2 meeting is scheduled for 6/2/26. • **Fairfield Region** – The QI meeting (3/17/26) focused on Colorectal Cancer Screening and featured a guest speaker from Operation Access. The Q2 meeting is scheduled for 6/2/26. • **Chico and Auburn Regions –** Both meetings were held in mid-March. The topic for discussion with both groups was strategies to avoid missed opportunities for Child and Adolescent Well Care Visits (WCV). • **Eureka Region –** No update • **Redding Region –** No update

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

QI PROGRAM & PROJECT MANAGEMENT

ACTIVITY	UPDATE
CONSUMER ASSESSMENT OF HEALTHCARE PROVIDERS AND SYSTEMS® (CAHPS) PROGRAM -MEDI-CAL PRODUCT LINE & ORG GOALS – FY 24/25 MEMBER EXPERIENCE AND ACCESS | *ORG GOALS – FY 25/26 MEMBER EXPERIENCE*	**Program Overview** Oversees NCQA Accreditation requirements for Member Experience (ME) 7 (Elements C and D). Conducts annual regulated CAHPS® surveys for Medi-Cal members and non-regulated surveys to assess patient experiences. Results drive improvements in care quality and member experience. **Program Updates** ***CAHPS® Regulated Measurement Year (MY) 2025 / Report Year (RY) 2026 Survey*** • Progress on the regulated survey remains on schedule, with the telephone interviewing phase currently underway. The survey window is expected to close in May, marking the end of the data collection period. ***CAHPS® Member Experience Gap Assessment:*** Rex Wallace Consulting (RWC) completed a comprehensive, rapid end-to-end assessment. Their assessment results and recommendations will be reviewed with core project stakeholders this month. Stakeholders will have the opportunity to engage directly with RWC to review department-level assessment findings and associated plan pain points linked to member satisfaction. Through this engagement, stakeholders will gain clarity on how their role and department contribute to CAHPS® performance ratings and will be introduced to the road map and/or recommended next steps. • Next Milestone (April 21): o Present Final Recommendations and prioritized action roadmap ***Fiscal Year 2025/2026 Organizational Goal 5: Member Experience (MX)*** • Fiscal Quarter 3 (Underway 66% Estimated Goal Completion and On-Track): Goal activities continue, led by champions from four departments: Transportation, Member Services, Population Health, and Quality Improvement. • For more insights on goal progress and milestone accomplishments for Q3, please visit the OpEx|PMO internal goal dashboard (Partnership4Me, under Smart Links).

Equity & Practice Transformation Project	**Program Overview**
	The DHCS Equity and Practice Transformation (EPT) Program is a statewide initiative aimed at advancing health equity while reducing COVID-19 driven care disparities. During the three (3) year program, practices receive payments for achieving population health milestones that enable the implementation of improvements across their infrastructure, data capabilities and care management processes to promote patient well-being, health equity and whole-person care.
	
	Currently, 22 providers are participating in the EPT Program, with total estimated funding of $13.3 million over the three-year project period. These providers are expected to receive payments tied to milestone achievements that support sustainable practice transformation.
	
	Program Updates
	• PHLC established minimum requirements for providers to remain in the program, due 05/01/2026, which include:
	  ○ 2026 PhmCAT
	  ○ Milestone 3: Empanelment Policy & Procedure
	  ○ Milestone 4: Data Governance & HEDIS Policy & Procedure
	  ○ Milestone 6: Data Implementation Plan
	  ○ Milestone 8: Disparity Reduction Plan
	• One Model of Care Document (Milestones 9-12)
	• DHCS distributed funds to all MCPs for November 2025 deliverables, with a required distribution deadline of 04/06/2026.
	• Checks totaling $1.98M were mailed to 21 providers on 03/19/2026; notices were sent to all EPT providers on the same day.
	• The next quarterly CaTS report for MY 07/31/24-06/30/25 is scheduled to be completed by the due date, 04/30/2026.

Preventive Care Bridge Project (Formerly: Locum Pilot Initiative)	**Overview of the Preventive Care Bridge Project** The Preventive Care Bridge Project was developed as a short-term solution to address access challenges by providing targeted locum support with the goal of improving performance on preventive care measures, specifically well-child visits and cervical cancer screenings. By proactively guiding providers to maximize the locum resources through clear onboarding, scope alignment, and data tracking, the pilot explores a potential model for supporting improved measure performance, reducing withholds and sanctions associated with unmet benchmarks, and enhancing the overall member experience. **Project Update** No new updates

Mobile Mammography Program

Program Overview

Aims to boost breast cancer screening (BCS) rates for providers performing below the 50th percentile benchmark. Partnership collaborates with Alinea Medical Imaging and providers to host Mobile Mammography events, helping members complete preventive screenings.

Program Updates

- Event Days for FY 25/26 Q4 (April – June)

Current Event Days
04/01/2026 – 06/30/2026

Region	# of Provider Organizations	# of Provider Sites	# of Provider Event Days	# of Community Event Days
Auburn	1	2	2	0
Chico	2	7	7	0
Eureka	9	16	19	0
Fairfield	1	2	2	0
Redding	7	8	8	1
Santa Rosa	2	2	2	0
Plan Wide	**22**	**37**	**40**	**1**

* Totals may not match across columns due to provider orgs hosting event days at multiple sites and regions within the quarter.
** Community event days are reported separately and not included in provider totals.

Partnering For Pediatric Lead Prevention Program (PPLP)

Program Overview

Provides LeadCare II POC devices to qualified providers and enrolls them in a year-long program with coaching and education. Offers lead poisoning prevention education to all and collaborates with local agencies.

Program Updates

No new updates

Exact Sciences: Promoting Colorectal Cancer Screenings

Offering Overview

This program represents a collaborative effort with Exact Sciences, who provides Bulk ordering options and follow-support for Colorectal Cancer Screenings.

Program Updates

	No new updates
QI TRILOGY PROGRAM	**Program Overview** Annually, the Quality Improvement (QI) department updates three core documents – often referred to as the QI Trilogy Documents, that collectively describe the program structure, priorities and performance. The Program Description outlines the overall QI framework, the Work Plan details active and planned initiatives aligned with strategic priorities, and the Program Evaluation assesses progress, outcomes and opportunities for improvement. **Program Updates** • Updates to the 2026-2027 QI Program Description have been completed. Internal Review will take place between 04/02/26-04/09/26, in preparation for submission to the NCQA Consultant on 04/20/26.Initial notices for the 2025-2026 QI Work Plan will be sent to Business Owners on 04/21/2026 with submissions due on 05/12/2026. • Sponsor Business Owner Tracker update requests for the 2025-2026 QI Program Evaluation will be sent to Business Owners on 04/28/2026. Initial notices will be sent on 05/12/2026 with submissions due on 05/29/2026. • QI Trilogy live trainings have been scheduled with invites sent to Sponsors, Business Owners, and Contributors: ▪ 2025-2026 QI Program Evaluation: 05/13/2026 at noon ▪ 2026-2027 QI Work Plan (Goal Submissions): 06/04/2026 at noon
SAGE GRANT	**Program Overview** The *Systems Advancement for General EHR* (SAGE) Grant is designed to assist healthcare providers in implementing or upgrading their EHR systems, to help modernize and enhance their ability to deliver high-quality, efficient, and member-centered care. This grant will help providers overcome common barriers to EHR adoption by offering financial support and implementation guidance. The recipient of the SAGE grant, Kimaw Medical Center, signed the agreement on 12/5/2025. The first payment installment of $125,000 was initiated. The SAGE Grant team will continue to conduct regular check-ins and monitor implementation milestones. The SAGE Grant Timeline can be found here. **Program Updates** • On 03/30/2026, Partnership hosted a peer-to-peer EHR upgrade discussion where United Indian Health Services and Sonoma County Indian Health shared lessons learned from migrating to OCHIN Epic, and Kimaw Medical Center discussed current progress and challenges.

D-SNP MEDICARE	**D-SNP** **Program Overview** The D-SNP Quality team is responsible for 1) Development and finalization of the Model of Care document, 2) Management of Partnership's CMS Medicare Star quality program, and 3) Developing D-SNP readiness for all Quality Improvement teams.
ACTIVITY	**UPDATE**

QUALITY ASSURANCE AND PATIENT SAFETY

ACTIVITY	**UPDATE**
POTENTIAL QUALITY ISSUES (PQI) FOR THE PERIOD: 2/26/2026 TO 4/1/2026	**Program Overview** To identify, report, and manage Potential Quality Issues (PQI), to determine opportunities for improvement in the provision of care and services to our members, and to direct appropriate actions for improvement based upon outcome, risk, frequency, and severity. **Program Update** • 39 referrals were received with 34 coming from Grievance and Appeals, 3 from Utilization Management, 1 from Care Coordination and 1 from QI Member Safety • 26 cases were processed and closed • 103 cases are currently open • There was no Peer Review Committee (PRC) in March, and there are three cases awaiting PRC review.
FACILITY SITE REVIEWS (FSR) & MEDICAL RECORD REVIEWS (MRR) FOR JAN-MARCH 2026	**Program Overview** Site Review and Medical Record Review performed for monitoring of providers. **Program Update** • As of 4/1/2026, we have a total of 537 reviews including PCP, OB, multiple check-ins and delegated reviews • **Primary and OB Reviews:**

Region	# of FSR conducted	# of MRR conducted	# of FSR CAP issued	# of MRR CAP issued
Auburn	1	0	0	N/A
Chico	7	5	0	1
Eureka	5	3	1	2
Fairfield	14	9	2	4
Redding	11	12	2	7
Santa Rosa	5	5	1	4

• New sites opened this period →

	○ 6 new sites have opened

HEALTHCARE EFFECTIVENESS DATA INFORMATION SET (HEDIS)

ACTIVITY	UPDATE
Annual HEDIS® Projects	**Program Overview** HEDIS is used to evaluate clinical quality in a standardized way. This program shares performance measurement rates with the intent of improving the quality of care delivered to members. **Program Update** • The MY2025 HEDIS Annual project is in process for DHCS Managed Care Accountability Set (MCAS) and NCQA Health Plan Accreditation (HPA) measure sets. • HEDIS Hybrid Medical Record Review is in progress with the Medical Record Review and Validated Audit scheduled to launch on 05/01/2026. • Non-standard supplemental data sources that required Primary Source Verification (PSV) were approved by both auditors for the following: ○ Year-Round Medical Record Review (YRMRR) for MY2025 for W30, PPC and WCC-BMI ○ DataLink ○ Sac Valley Med Share (SVMS): (Lab, Measurement and Encounter data) ○ Inovalon – Electronic Record on Demand (ERD) • MY2025 preliminary rates submission for DHCS and NCQA required reporting was completed by 04/10/2026.
HEDIS® Program Overall	**Program Updates** • **Measure Rate Generation for DHCS Programs:** Partnership participates in three (3) DHCS programs that require quarterly quality rate production using the California Technical Specifications (CaTS) measure specifications, which are HEDIS-like measure specifications. Partnership provides all participating practices member-level data for all CaTS measure rates on request through each program's dedicated inbox. • Equity and Practice Transformation (EPT) • Data provided in January 2026 for April 2024 – March 2025 time period for the twenty-three (23) EPT practices. • Next data submission due 04/30/2026 • Designated Public Hospitals QIP (QIP)

	• Reports submitted to DHCS in January 2026 for the (11) QIP hospitals participating. • Next data submission due 04/30/2026 • Alternative Payment Model (APM) • Winters Healthcare APM MY2024 Scorecard submitted to DHCS on 01/16/26 • Next data submission TBD

NATIONAL COMMITTEE FOR QUALITY ASSURANCE (NCQA) ACCREDITATION

ACTIVITY	UPDATE
NCQA Health Plan Accreditation (HPA)	**Program Overview** The State of California requires all Managed Care Plans (MCPS) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal Survey every three (3) years, and reporting HEDIS and CAHPS results every year for a Health Plan Rating (HRP) score. Partnership's next HPA Renewal Survey is scheduled for 09/15/2026. **Program Update** • The NCQA Project Management Team hosted an HPA Renewal Survey evidence preparation and collection training on 03/25/2026. The team also distributed communications for evidence collection process, which began on 03/30/2026. All annotated and bookmarked evidence is due 05/22/2026 unless otherwise discussed with the NCQA Program Management Team. • HPA Mock File Reviews were held with our NCQA consultant, Managed Healthcare Resources (MHR), in February and March 2026 with the Utilization Management, Grievance and Appeals, and Pharmacy departments. Mock File Reviews will also take place in April 2026 with Care Coordination and Network Services. Most file review requirements are Must-Pass requirements, and an organization must receive a MET score on all Must-Pass requirements to achieve or maintain accreditation. These Mock File Reviews will help to ensure Partnership remains in compliance throughout the look-back period. Some risks and opportunities for improvement were identified by MHR and results were shared with the applicable Business Owners (BOs). BOs have submitted Action Plans to address each finding/recommendation. • The HPA Compliance Dashboard is updated monthly and available on the Y:Drive. The NCQA Program Management Team presents the dashboard monthly to the NCQA Steering Committee and quarterly to BOs, with an intent to create project transparency, track key activities and facilitate timely escalation. The NCQA Program Management Team is working closely with the BOs to ensure all applicable evidence is revised or finalized to sustain compliance in accordance with NCQA's look-back periods, timelines, and expectations.
NCQA Health Outcome Accreditation (HOA)	**Program Overview** The State of California requires all Managed Care Plans (MCPs) to be both Health Plan (HP) and Health Outcome (HO) Accredited. The process involves completing a Renewal

	Survey every three (3) years. Partnership's next HOA Renewal Survey is tentatively scheduled for 05/16/2028. **Program Update** • The NCQA Program Management Team distributed the 2026 HOA Workbook to Business Owners (BOs) on 02/17/2026. BOs submitted their 2026 HOA Workbooks by or shortly after the due date, 03/06/2026. The NCQA Program Management Team continues to work with the selected departments to complete their annual HOA Workbook, clarify the agreed upon evidence documentation, analysis reports and production timeline, and to ensure no previously unknown issues are identified. The NCQA Program Management Team also facilitates collaboration between departments to deep dive into subsets of NCQA requirements, clarify functions, and determine roles and responsibilities. Due to competing priorities, activities have been prioritized based on the requirements' look-back periods and the scopes of review. • BOs responsible for implementing revisions of the documented processes by April 2026 to meet the 24-month look-back period requirement (starting in May 2026) are working on their respective updates with the NCQA Program Management Team assisting as needed. The documented processes will require timely review by the NCQA Consultant and approval at committee meetings prior to May 2026. • Impacted BOs were sent an email on 03/19/2026 regarding submission of required screenshots, which are due by 04/17/2026. A lack of compliant documentation with date/time stamp can result in a score of Not Met and zero points. • The NCQA Program Management Team created an HOA Renewal Survey Timeline, which was shared with the NCQA Steering Committee on 03/24/2026. The Timeline is available on the Y:Drive and will be reviewed with the BOs during the May 2026 NCQA BO Check-in Meetings.
NCQA Health Plan Accreditation (HPA) and Health Outcomes Accreditation (HOA)	• NCQA released the March HPA and HOA Triannual Policy Updates on 3/30/2026. The NCQA Project Management Team has provided updates on impacted standards with respective Business Owners (BOs). BOs are asked to review the updates, assess impact, and/or request clarification to ensure the evidence documentation is aligned with NCQA's scope of review, or must implement/finalize edits within 90 calendar days of the release date for any policy changes or clarifications.

Partnership Policy & Procedure Updates

May 2026

Policy Number	Policy/Procedures/Guidelines	Version Links
	*The following documents were reviewed by the Quality / Utilization Advisory Committee (Q/UAC) in **April 2026.*** ***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
MPBP8011	Scope of Primary Care – Behavioral Health Indications for Referral Guidelines	C CD RD
Care Coordination		
MCCP2036	Memorandum of Understanding (MOU) Requirements For	C CD RD
Pharmacy Operations		
MCRP4068	Medical Benefit Medication TAR Policy	C CD RD
MPRP4034	Pharmaceutical Patient Safety	C CD RD
MPRP4065	Drug Utilization Review (DUR) Program *(Internal Policy)*	CD RD
Quality Improvement		
MPQP1006	Clinical Practice Guidelines	C CD RD
MPXG5001	Clinical Practice Guidelines for the Diagnosis & Management of Asthma	C CD RD
MPXG5002	Clinical Practice Guidelines for Diabetes Cellulitis	C CD RD
MPQP1022	Site Review Requirements and Guidelines – Site Review *New Attachments – No Changes to A - E*	C CD RD
Utilization Management		
MPUD3001	Utilization Management Program Description	C CD RD
MCUP3133	Wheelchair Mobility, Seating and Positional Components	C CD RD
MCUP3037	Appeals of Utilization Management/ Pharmacy Decisions	C CD RD
MPUP3026	Inter-Rater Reliability Policy	C CD RD

Synopsis of Changes to Discussion Policies

Below is an overview of the policies that will be discussed at the Apr. 15, 2026 Quality/Utilization Advisory Committee (Q/UAC) meeting.
It is recommended that you look over the changes to each and note any questions or comments you may have to help keep a progressive meeting agenda.

Policy Number & Name	**Page #**	**Summary of Revisions** (include why the changes were made, *i.e.,* NCQA, APL, Medi-Cal guidelines, clarification, *etc.*)	**External Documentation** (Notice required outside of originating department)
Policy Owner: Behavioral Health – *Presenter: Eric Rushing. Manager of Mental Health Programs – Behavioral Health*			
MPBP8003 – Mental Health Services	144	• Added, "and dyadic Behavioral Health Services" to section I. 1. Changes were made to align with APL 26-002 wording. • Changed wording "medications" to "drugs" in section I. 5. Changes were made to align with APL 26-002 wording. • Updated DHCS BHIN 21-073 reference to updated BHIN 26-002. DHCS updated BHIN. • Added wording "Partnership covers NSMHS without prior authorization requirements.". This aligns with Partnerships NCQA requirements for no authorization required for MH services. • Added section K. Youth Trauma Screening Tools. Section added to align with new Youth Trauma Screening Tool requirements in DHCS APL 26-002 • Updated and Added wording related to EPSDT benefit to section H 1. Changes were made to align with APL 26-002 guidance. • Added wording "Partnership covers clinically relevant laboratory and radiologic studies…" to align with wording in APL 26-002. • Removed "up to 20" limitation on individual and/or group counseling sessions for pregnant and postpartum Members. Changes were made to align with APL 26-002 guidance. • Added sections N and O in Partnership is responsible for: SABIRT services and Preventive screenings for tobacco, alcohol and drugs. Changes were made to align with APL 26-002 guidance. • Updated wording in section R. 1. "and Partnership will notify members of such applicable policies." to align with wording in APL 26-002 • Removed superseded references and added reference to APL 26-002.	Health Services Claims Member Services
MPBP8011 – Scope of Primary Care – Behavioral Health Indications for Referral Guidelines	181	• Added, "and dyadic Behavioral Health Services" to section A. 1. Changes were made to align with APL 26-002 wording. • Changed wording "medications" to "drugs" in section A. 5. Changes were made to align with wording in APL 26-002. • Updated BHIN 21-073 reference to updated BHIN 26-002. DHCS updated BHIN.	Health Services Claims Member 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)
		• Added wording "If a PCP cannot perform the mental health assessment, they must refer the Member to the appropriate Provider and delivery system for mental health services…". Changes made to align with APL 26-002. • Added section e. Reference to Youth Mental Health Screening Tools in Policy MPBP8003. Changes made to align with APL 26-002. • Added sections a, b, c and d. PCPs should screen and refer members with SUD as follows: SABIRT services, Preventive screenings for tobaccos, MAT services, and Emergency and Post-Stabilization service. Changes were made to align with APL 26-002. • Removed superseded references and added reference to APL 26-002.	
Policy Owner: Quality Improvement – *Presenter: Rachel Newman, RN, Manager, Member Safety – Inspections*			
MPQP1022 – Site Review Requirements and Guidelines	190	This policy is coming back ahead of its annual review in large part to accommodate UM's MCUP2033 – Urgent Care Services policy. 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. Policy title changed from MCQP1022 to MPQP1022 due reflect applicability to Partnership Advantage, effective January 1, 2027." **Section III Definitions added:** "Supplemental Facility, Free Standing Urgent Care Provider, Free-Standing Urgent Care Center, Shared Medical Record Practice" to add clarification throughout the policy. **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.** **Attachments are being reordered and thus re-lettered Attachments J-N below are new additions:** J. Free Standing Urgent Care Clinic Facility Site Review Tool K. Urgent Care Medical Record Tool L. PCP Providing Urgent Care Facility Site Review Tool M. Palliative Care Facility Site Review Tool N. Palliative Care Medical Record Review Tool **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.5) • Sites with a failed review will be placed on an annual review.	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)
		• "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. 5) • 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. 7) • Medical Record Review (MRR) Scoring language is updated (p. 8): "If the minimum number of records is not available, Partnership will document the rationale and complete the MRR with the available records." • Obstetric Specialists and Non-Accredited Sites have been bundled and FSR and MRR language augmented under section "Specialized Site Reviews" (pp. 12) These are followed by additional MMR language pertaining to Free Standing Urgent Care Clinics (p. 12), and "PCP providing Urgent Care Services" (p. 12) "A Palliative Care report is run monthly by the Inspections Site Review Team." (p. 13) ○ 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 of UM Regulations*			
MCUP3133 – Wheelchair Mobility, Seating and Positional Components	**390**	**Section VI.A.3.a. and b.:** This policy was updated to include language for Charpentier billing as follows: • Partnership will process a TAR for a dually eligible Member in the same manner as it would process a TAR for a Medi-Cal-only Member, regardless of whether Medicare (or any other health coverage) has authorized the equipment or been billed. A TAR for such requests must include all medical justification and documentation that would normally accompany a Medi-Cal-only TAR and include the message "Medi/Medi: Charpentier/Rates", "Medi/Medi: Charpentier/Benefit Limitation", or "Medi/Medi: Charpentier/Both Rates and Benefit Limitation" in the Medical Justification section.	Claims Configuration RAC Provider Relations

Partnership HealthPlan of California
Meeting Minutes

COMMITTEE	Pharmacy and Therapeutics Committee Meeting (P&T)
DATE / TIME:	Thursday, April 09, 2026 / 7:30am – 10:00am PT

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

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
Matthew Morris, MD
Marshall Kubota, MD
Bettina Spiller, MD
Colleen Townsend, MD

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

Invited Guests Present:
Donell Colvin, CPhT
Mohamed Jalloh, PharmD,
Margherita Aikman Pharm.D CSH
Jeremy Kim, Touro Student

Department AA:
Jacquelyn Brackett

IT Ops & Systems:
Jose Puga
John Lemoine

Practicing Members Absent:
Antonio Olea, PharmD

PHC Members Absent:
Robert Moore, MD, MPH, MBA
Dave Katz, MD
Bradley Cox, DO
Richard Matthews, MD
Lisa Ward, MD
Jeffrey DeVido, MD
Teresa Frankovich, MD
Mark Netherda, MD
Aaron Thornton, MD
Michael George, MD

AGENDA ITEM	DISCUSSION / CONCLUSIONS	SPEAKER, APPROVED ACTION ITEMS	EFFECTIVE DATE
Opening Comments	o Introductions o Housekeeping (Announcement: Meeting is being recorded) o Conflict of Interest form will be emailed for signatures	*Presented by Stan Leung, PharmD*	
I. Approval of minutes	Quorum: Yes 5 out of 6 members attended Minutes: Approved	*Presented by Stan Leung, PharmD*	N/A
II. Standing Agenda **1. PHC Update**	PHC Updates provided by Dr. Jones: As many of you know, it is the season for regional medical director meetings. We have provided our community-based partners with many of the updates during these meetings on process and quality metrics at the county level, as well as health policy and pharmacy updates which Stan will elaborate on. We have completed four of them so far, including meetings in Redding and Fairfield, and we have three more to go. We have one in Santa Rosa on April 17, Truckee May 8, and then Chico May 1. As many on the P&T Committee are aware, on April 1, we had changes in the GLP-1 prior authorization criteria. Wegovy does not require a prior authorization when prescribed for MASH. For treatment of other diagnoses, prior authorization is required with the appropriate ICD-10-CM diagnosis. On Sunday, April 12th, Touro University will be holding a conference on immigration and immigrant health. Many of you have heard of the Rural Health Transformation (RHT) grants that were created by H.R. 1 that provide the $50 billion over five years distributed across all 50 states in various amounts. California got $233 million of that. Our regional directors have a plan to offer webinars and advice to their counterparts in healthcare centers in their specific regions on how those centers can apply and use the funding through Department of Health Care Access and Information (HCAI). Major categories that they are going to focus on in these webinars are specialty access, workforce pipeline, perinatal case management curriculum, recruitment, and retention of clinical and non-clinical staff, as well as IT system enhancements.	*Presented by Kermit Jones, MD JD*	N/A

	On April 2, we had our public health officers meeting and dinner. Our CEO spoke about how we can work together on some different approaches to supporting continuity of Medi-Cal coverage in the counties that we have presence. We also gave an overview of the coming rural health transformation program as well. Our director of Population Health, Dr Ruffin, gave an update on the status of different counties and accessing funding to support Community Health Assessment and Community Health Improvement Plan (CHA/CHIP) efforts. Our Health Equity Director, Dr. Jalloh, gave an update on the preparations for the community investment funding that has anticipated this year. On the rural health transformation program activities, we received information that the three areas of focus are going to be on a transformative care model, focusing on primary maternity, chronic disease, specialty care, workforce development, as well as technology.		
2. Additional Updates	The most pressing Medi-Cal Rx update to share is the provider enrollment requirement for Medi-Cal. DHCS is going to initiate a phased approach for full enforcement of this requirement starting on July 1. This means that pharmacy claims will only be processed and paid if the provider is enrolled with Medi-Cal. If a claim or even a TAR prior authorization is associated with a non-enrolled provider, that claim and that PA will not be honored. If the provider is enrolled with the Medicare program, that will not be sufficient to meet the requirement. Even if the provider submitted an application, that is also not going to fulfill the requirement. As the application can take up to 90 to 180 days to process, providers really need to submit their application as soon as possible to avoid delays and disruption for members. Currently, we receive a list of non-enrolled providers from Medi-Cal monthly. We are working with our internal departments as well as our external partners to strategically disseminate this information, identify those providers who need to be enrolled and submit their application. To provide some numbers, in a report that we received in March, there are over 8,500 known providers on this non-enrolled list. And the impact in terms of unique members is likely over	*Presented by Stan Leung, PharmD*	N/A

	200,000. So, it is a significant impact that this new requirement will have, obviously not just for Partnership but across California as well. We really want to encourage those who work with providers and to encourage those who have not enrolled to enroll with Medi-Cal through the PAVE system. The second update is on the PAD (Physician Administered Drug) policy change that is going to take effect in the first quarter of 2027, when Medi-Cal will no longer allow pharmacy-furnished PADs such as IVIGs, some of the biologics, like Remicade and Rituximab, will no longer be billed to the pharmacy benefit. Instead, Medi-Cal is shifting this benefit back to the managed care plan medical benefit. This certainly has financial implications for the managed care plans, but the pharmacy is also going to need to decide whether it is going to accept the rates, since Medi-Cal rates are really established for medical providers and not pharmacy providers. If the pharmacy decides that it is not going to contract with the managed care plans, this will also have downstream impacts for smaller medical practices that cannot afford to buy-and-bill, as well as hospital infusion centers or outpatient infusion centers that are already at capacity with their infusion services. This is still a developing issue. Medi-Cal is holding monthly stakeholder meetings to collect feedback and provide information. The key point is that Medi-Cal needs to recognize that the payment methodologies for medical and pharmacy providers are different, and they will need to work closely with managed care plan finance teams to set rates that address and reconcile the differences between the medical and pharmacy payment models. Lastly, Dr. Jones touched on the GLP-1 changes particularly with MASH. Wegovy is back on the formulary but only covered when it is used for MASH. Medi-Cal is not requiring evidence for that diagnosis such as biopsy or its proxy, the FibroScan, although the claims or the prescriptions as well as the attestation for MASH diagnosis are subject to audit and any prescriber or pharmacy that falsely makes claim that the patient has MASH in order to get it covered is committing fraud.		

3. DUR Update	**DUR - Fraud and Abuse of Controlled Substances (F&A)** Overview The Department of Health Care Services (DHCS) requires managed care plans to monitor and address potential fraud and abuse involving controlled substances by members, prescribing providers, and dispensing pharmacies. In response, Partnership (PHC) developed a monitoring program to identify members who receive opioid prescriptions from four or more prescribers and fill these prescriptions at four or more pharmacies. This program enables PHC to assess potential opioid fraud and abuse. Method A biannual review of pharmacy claims was conducted to identify members who had filled opioid prescriptions in the prior 180 days. Members receiving hospice, palliative care, cancer treatment, or residing in long-term care (LTC) facilities were excluded from the analysis. Claims for members who had opioid prescriptions from four or more different prescribers and filled these medications at four or more different pharmacies were flagged for further review. The goal was to assess potential fraud or abuse by the member, prescriber, and pharmacy. **Member-Level Fraud and Abuse Indicators:** • Early refills • Short-term fills versus chronic or stable fills • Prescription payments made out-of-pocket vs. by insurance • Use of providers or pharmacies located far from the member's home • Multiple prescribers with varying specialties **Prescriber-Level Fraud and Abuse Indicators:** • Prescribing large quantities or high doses of opioids • Frequency of early refills • Prescribing to patients who live more than 100 miles from the prescriber **Pharmacy-Level Fraud and Abuse Indicators:** • Dispensing early refills • Dispensing large quantities of opioids • Dispensing to members who live more than 50 miles from the pharmacy	*Presented by Kathleen Vo, PharmD*	N/A

For cases flagged as potentially fraud or abuse, further investigation was conducted to assess whether any extenuating circumstances contributed to the patterns observed, ensuring that legitimate explanations were overlooked.

This review process was designed to protect both patients and the healthcare system by identifying and addressing potential opioid misuse or fraudulent activity.

Results
After closely evaluating the 19 identified members, two members were flagged for potential opioid abuse.

Member 1: identified during prior lookback period (1.1.25 to 6.30.25) and current lookback period (7.1.25 to 12.31.25)

- 1.1.25 to 6.30.25: referred to RAC
  - 22 emergency room (ER) visits
  - 18 opioid fills related to ER visits; Medi-Cal Rx was not billed for 5 of the fills
  - 2 pharmacies are located more than 50 miles from their home.
- 7.1.25 to 12.31.25:
  - 20 emergency room (ER) visits
  - 13 opioid fills related to ER visits; Medi-Cal Rx was not billed for 3 of the fills
  - 1 pharmacy located more than 50 miles from their home

Member 2:

- 1.1.25 to 6.30.25: not identified due use of two pharmacies (same retail chain)
- 7.1.25 to 12.31.25: referred to RAC
  - 25 emergency room (ER) visits
  - 19 opioid fills related to ER visits; Medi-Cal Rx was not billed for 5 of the fills

Other members reviewed also had short-term opioid prescriptions associated with ER visits, surgeries, and hospitalizations; however, the frequency of these prescriptions were notably lower compared to Member 1 and Member 2.

Conclusion
We identified 28 members who received opioid prescriptions from four or more prescribers and filled these medications at

	four or more pharmacies. Of these members, 19 met the inclusion criteria for further review. Following a detailed review of both pharmacy and medical claims, two members were identified as having potential concerns for opioid abuse. Both members have been referred to the RAC for further review. For the next DUR review, we will continue the current process of reviewing claims for members who received opioid prescriptions from four or more different prescribers and filled these medications at four or more different pharmacies to identify potential fraud and abuse. **DUR: Concurrent use of opioids and benzodiazepines (COB)** <u>Overview</u> The Department of Health Care Services (DHCS) requires managed care plans to monitor members who are prescribed both opioids and benzodiazepines medications at the same time. In response, Partnership (PHC) implemented a prescriber fax intervention targeting members who were newly started on concurrent opioid and benzodiazepine therapy. The purpose of this intervention is to raise prescriber awareness and reduce the risk of concurrent use whenever clinically appropriate. <u>Method</u> A monthly retrospective review of pharmacy claims is conducted to identify members with concurrent fills for opioids and benzodiazepines who were newly initiated on either medication within the prior 30 days. **Concurrent use criteria:** Concurrent use is defined as overlapping fills of both an opioid and a benzodiazepine for 15 or more cumulative days within a 30-day lookback period. For each identified case, the quantity and number of new fills are evaluated, along with the number of prescribers involved. **Exclusion criteria:** • Members are excluded if they are: • Receiving hospice or palliative care • Undergoing cancer treatment		

	• Residing in long-term care (LTC) • Receiving substance use treatment • Enrolled in the Wellness & Recovery program **Prescriber Notification:** Letters are faxed to prescribers who issued either the opioid or benzodiazepine prescription to ensure all involved providers are aware of the concurrent prescribing. Each letter includes: • Best practices to minimize concurrent opioid–benzodiazepine use • The member's opioid and benzodiazepine fill history **Ongoing Monitoring:** For members who continue concurrent opioid and benzodiazepine therapy beyond 90 days with a total morphine milligram equivalent (MME) ≥ 90, or who experience dose escalation exceeding an MME ≥ 90, a second letter may be issued. In addition, medical claims will be reviewed for emergency department (ED) visits that may be related to concurrent use, and the primary care provider will be notified if such visits are identified. <u>Conclusion</u> Between 7.1.25 to 12.31.25, 17 members were identified as newly started on concurrent opioid and benzodiazepine therapy. 90-days following the prescriber outreach intervention, pharmacy claims showed 71% of these members discontinued their concurrent fills for opioids and benzodiazepines. Among the members who continued concurrent therapy, 40% demonstrated a reduction in either their opioid or benzodiazepine dose or day supply. For the next DUR review, we will continue conducting monthly pharmacy claims reviews to identify members who are newly started on concurrent opioid and benzodiazepine therapy. To establish a baseline for COB discontinuation and evaluate the impact of our prescriber outreach intervention, prescriber outreach will not be conducted for members newly started on concurrent therapy between January 2026 to June 2026. The comparison results will be presented at the October 2026 P&T Committee meeting.		

4. Drug Benefit Review

The classes for this quarter's review are:

- Antihistamine, Nasal, Cough and Cold, Respiratory, Misc.
- Anti-Infective Agents
- Genitourinary Agents
- Vaccines, Toxoids, Immunizations, Allergenic Extracts, Misc.

All actions at right were approved by the committee as presented, unless otherwise noted as "*approved as modified*."

All changes will be effective 7/01/2026 unless otherwise noted.

Class Reviews:

- Antihistamine, Nasal, Cough and Cold, Respiratory, Misc.
  - Updates to the following were presented, with approved action shown at right.
    - mepolizumab, 1 mg (Nucala™)
    - tezepelumab-ekko, 1 mg (Tezspire™ autoinjector pen & Tezspire™ prefilled syringe)
    - depemokimab (Exdensur™)

Presented by Susan Becker, PharmD, BCPS, Erin Montegary, PharmD and Angela Keough, PharmD

Presented by Angela Keough, PharmD

Antihistamine, Nasal, Cough and Cold, Respiratory, Misc Class Review, Approved Actions:

HCPCS	Drug
TAR Criteria Updates (see attached criteria for details)	
J2182	Injection, mepolizumab, 1 mg (Nucala™)
J2356	Injection, tezepelumab-ekko, 1 mg (Tezspire™ autoinjector pen & Tezspire™ prefilled syringe)
New TAR Criteria (see attached criteria for details)	
J3590 (NOC)	Injection, depemokimab (Exdensur™)

7/1/2026

	○ Anti-Infective Agents • Updates to the following were presented, with approved action shown at right. ▪ zopapogene imadenovec-drba suspension, per therapeutic dose (Papzimeos™) ▪ tedizolid phosphate, 1 mg (Sivextro™) ▪ daptomycin (xellia), unrefrigerated, not therapeutically equivalent to j0878 or j0873, 1 mg ▪ posaconazole, 1 mg (Noxafil™) ▪ rezafungin, 1 mg (Rezzayo™): removal of TAR req with addition of age limit of 18 years and older and quantity limits of 1000 units per 6 months. ▪ cidofovir, 375 mg (Vistide™) • 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.) ▪ pegylated interferon alfa-2a, 180 mcg per ml (Pegasys™) ▪ Endo 505(b)(2) daptomycin ▪ Tpoxx (injectable) (tecovirimat) • Updated Pharmacy MDL search tool to reflect No 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.) ▪ B.Braun 505(b)(2) piperacillin sodium/tazobactam sodium	*Presented by Susan Becker, PharmD, BCPS* **Anti-Infective Agents Class Review, Approved Actions:** **HCPCS** | **Drug** **New TAR Criteria (see attached criteria for details)** J3404 | Injection, zopapogene imadenovec-drba suspension, per therapeutic dose (Papzimeos™) **TAR Criteria Updates (see attached criteria for details)** J3090 | Injection, tedizolid phosphate, 1 mg (Sivextro™) J0872 | Injection, daptomycin (xellia), unrefrigerated, not therapeutically equivalent to j0878 or j0873, 1 mg J1837 | Injection, posaconazole, 1 mg (Noxafil™) **Addition of Claim Limits &/or Requirements *TAR required*** S0145 | Injection, pegylated interferon alfa-2a, 180 mcg per ml (Pegasys™) J3490 (NOC) | Endo 505(b)(2) daptomycin J3490 (NOC) | Tpoxx (injectable) (tecovirimat) **Addition of Claim Limits &/or Requirements *No TAR required*** J0349 | Injection, rezafungin, 1 mg (Rezzayo™) **Removal of TAR Requirements** J3490 (NOC) | B.Braun 505(b)(2) piperacillin sodium/tazobactam sodium J0349 | Injection, rezafungin, 1 mg (Rezzayo™) J0740 | Injection, cidofovir, 375 mg (Vistide™)	7/1/2026
	○ Genitourinary Agents • Updated Pharmacy MDL search tool to reflect No 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.) ▪ Mannitol-sorbitol irrigation solution	*Presented by Susan Becker, PharmD, BCPS* **Genitourinary Agents Class Review, Approved Actions:** **HCPCS** | **Drug** **Removal of TAR Requirements** J3490 (NOC) | Mannitol-sorbitol irrigation solution	7/1/2026

- Vaccines, Toxoids, Immunizations, Allergenic Extracts, Misc.
  - Updates to the following were presented, with approved action shown at right.
    - Updates to Immunoglobulin Products (IVIG, IMIG, SCIG) criteria with addition of two products (see below):
      - immune globulin, 500 mg (Alyglo™)
      - immune globulin, 100 mg (Yimmugo™)
    - chikungunya vaccine, recombinant (Vimkunya™): age limit updated to minimum 12 years and older from previous age limit of minimum 18 years and older
    - respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use (Abrysvo™): age limit updated to 18-59 years (from previous 19-59) for pregnancy qualification age range
    - influenza vaccine (Flucelvax™): updated configuration to reflect label age limit of minimum of 6 months and older

Presented by Erin Montegary, PharmD

Vaccines, Toxoids, Immunizations, Allergenic Extracts, Misc. Class Review, Approved Actions:	
HCPCS	**Drug**
TAR Criteria Updates (see attached criteria for details)	
J1552	Injection, immune globulin, 500 mg (Alyglo™) (addition of two products to Immunoglobulin Products (IVIG, IMIG, SCIG) criteria)
J1553	Injection, immune globulin, 100 mg (Yimmugo™) (addition of two products to Immunoglobulin Products (IVIG, IMIG, SCIG) criteria)
Updates to Claim Limits &/or Requirements *No TAR Required*	
90593	chikungunya vaccine, recombinant (Vimkunya™)
90678	Respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use (Abrysvo™)
90661	Influenza vaccine (Flucelvax™)

7/1/2026

- New HCPCS code review – listed at right, listed in two sections:
  - First time HCPCS code for drug (other than unclassified code)
  - HCPCS code changed but no change in coverage requirements for the drug itself.
  - Codes were announced as benefits by DHCS on 4/3/2026, with an effective date of 4/1/2026.

Presented by Erin Montegary, PharmD
NTR = No TAR Required

New HCPCS codes (no prior code or was previously unclassified		
HCPCS	HCPCS Description	Requirements
C9818	Suzetrigine, oral, 1 mg (Journavx™)	TAR
J3404	Injection, zopapogene imadenovec-drba suspension, per therapeutic dose (Papzimeos™)	TAR *(changed from case-by-case criteria to drug specific criteria)*
J9003	Leuprolide injectable (camcevi etm), 1 mg (Camcevi ETM™)	TAR
J9183	Gemcitabine intravesical system, 225 mgm (Inlexzo™)	TAR
J9277	Injection, pembrolizumab, 1 mg and berahyaluronidase alfa-pmph (Keytruda Qlex™)	TAR

4/1/2026

J1164	Injection, diltiazem hydrochloride in 0.72% sodium chloride, 0.5 mg	Covered with no limits	
J1098	Articaine ophthalmic, 8% solution, 0.4 ml (Cyklx™)	Pending product availability and state status.	
Q5161	Injection, denosumab-kyqq (aukelso/bosaya), biosimilar, 1 mg (Aukelso™ and Bosaya™)	TAR	
Q5162	Injection, denosumab-nxxp (bildyos/bilprevda), biosimilar, 1 mg (Bildyos™ and Bilprevda™)	TAR	
C9309	Injection, onasemnogene abeparvovec-brve, per treatment (Itvisma™)	TAR	
J1553	Injection, immune globulin (yimmugo), 100 mg (Yimmugo™)	TAR	

NTR = No TAR Required

New HCPCS codes replacing a prior code for same drug			4/1/2026
HCPCS	**HCPCS Description**	**Requirements & prior code**	
Q0238	Injection, tocilizumab-aazg, for hospitalized adult patients with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ecmo) only, 1 mg (Tyenne (IV)™)	TAR *(same as prior code Q5135)*	
J9278	Injection, carboplatin (avyxa), 1 mg (Kyxata™)	TAR *(same as prior code C9308)*	
J9601	Injection, linvoseltamab-gcpt, 1 mg (Lynozyfic™)	TAR *(same as prior code C9307)*	
J0463	Injection, atropine sulfate (fresenius and therapeutically equivalent), 0.01 mg	NTR *(same as prior code J0461)*	
J8502	Injection, aprepitant (aponvie), 1 mg (Aponvie™)	TAR *(same as prior code C9145)*	

	○ 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.	**Consent Items** **HCPCS** / **HCPCS Description** / **Changes to Biling Requirements** J9017 / Injection, arsenic trioxide, 1 mg / Remove Partnership age limit to match the state. (Partnership already matches State for no TAR required and required ICD-10 codes) J1572 / Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g., liquid), 500 mg / Restore J1572 to prior status of covered with an approved TAR. TAR requirement supersedes limits.	N/A
III. Old Business **a. Policy Updates**	1) MPRP4065: Drug Utilization Review (DUR) Program a. Presented for consent with no substantive edits. 2) MPRP4034: Pharmaceutical Patient Safety a. Presented for consent with no substantive edits. 3) MCRP4068: Medical Benefit Medication TAR Policy: This policy is coming back ahead of its annual review to meet NCQA requirements. a. Added language to Section VI.C- Members or their authorized representative may request a PAD that is not on the list of covered drugs or exceptions to the UM requirements based on medical necessity b. Added section VI.C.1 to align with Medi-Cal Rx requirements for provider enrollment. Effective June 1, 2026, prescribers submitting TARs for PADs must be enrolled in Medi-Cal	*Presented by Andrea Ocampo, PharmD*	5/13/2026

	FFS using a Type 1 NPI through PAVE. TARs associated with non-enrolled prescribers may be administratively denied. c. Added section VI.D.1.Providers are expected to include ICD-10 CM codes when applicable to support medical necessity determination d. Added section VI.I.1.f. Drug exclusions, restrictions, or PA requirements implemented under Medi-Cal Rx effective January 1, 2026 remain outside the scope of Partnership medical benefit review unless DHCS guidance explicitly assigns responsibility to the MCP		
IV. New Business	None		
V. Additional Items	Administrative Announcement: Practicing member Antonio Olea, PharmD has resigned from this P&T Committee, effective after April 2026.		
VI. Adjournment	Meeting adjourned at 9:50am		

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	Add-on maintenance treatment of severe asthma in adults and pediatric patients ≥12 years of age with an eosinophilic phenotype
Exclusion Criteria	• Monotherapy use (depemokimab is add on therapy to the current asthma treatment regimen) • Depemokimab will not be used concurrently with other monoclonal antibodies with similar indications such as dupilumab, benralizumab, mepolizumab, omalizumab, reslizumab or Tezepelumab
Required Medical Information	Clinic notes must include all the following: 1) Member has a diagnosis of severe asthma with an eosinophilic phenotype and has a blood eosinophil count equal to or greater than 150 cells/µL at screening or history of blood eosinophils ≥300 cells/µL within the last year 2) Member is adherent on medium or high-dose inhaled corticosteroids (ICS) and at least one additional asthma controller (such as long acting beta2 agonist (LABA), with or without oral corticosteroids (OCS) for at least 3 months 3) Member has persistent uncontrolled asthma as defined by at least one of the following: a. An Asthma Control Questionnaire (ACQ6) score of 1.5 or more, or an Asthma Control Test (ACT) score less than 20 at baseline b. A history of at least two asthma exacerbation events within prior 12 months c. A history of at least one severe asthma exacerbation resulting in hospitalization within prior 12 months d. Reduced lung function at baseline [pre-bronchodilator FEV1 below 80% in adults, and below 90% in adolescents] e. Member has inadequate asthma control (for example, hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimal dosages: i. Inhaled corticosteroid; and ii. Long acting beta2-agonist, leukotriene modifier, or sustained release theophylline)
Age Restriction	12 years of age or older
Prescriber Restriction	Prescribed by, or in consultation with an allergist, immunologist, or pulmonologist
Coverage Duration	Initial approval: 6 months Renewal: 12 months with documentation of clinical benefit with treatment when compared to baseline (see further details in "Other Criteria" section below)
Other Requirements & Information	<u>Renewal criteria:</u> 1) Current FEV1, peak flow and/or other pulmonary function test that may indicate improvement in airflow limitations 2) Asthma Control Questionnaire (ACQ6) or Asthma Control Test (ACT) after a minimum of 3 months after initiation of treatment with depemokimab to indicate improvement from baseline score

	Note: Pharmacy claim history will be reviewed for renewal requests, and rescue inhalers should not show increasing use. If the fill history does show an increase in use for rescue inhalers, then additional justification of depemokimab efficacy may be requested. 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:

HCPCS	Description	Dosing, Units
J3590	Unclassified biologics: depemokimab (Exdensur)	Asthma • ≥12 years • 100 mg once every 6 months.

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	1) Add-on maintenance treatment of severe asthma in adults with an eosinophilic phenotype. 2) Eosinophilic granulomatosis with polyangiitis (Churg-Strauss Syndrome or EGPA). 3) Hypereosinophilic syndrome (HES) for ≥ 6 months without an identifiable non-hematologic secondary cause. 4) Add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) with inadequate response to nasal corticosteroids. 5) Add-on maintenance treatment of chronic obstructive pulmonary disease (COPD) in adults who are inadequately controlled and have an eosinophilic phenotype.
Exclusion Criteria	• When used as monotherapy (mepolizumab is add on therapy to the current asthma and/or COPD treatment regimen) • When used concurrently with other monoclonal antibodies with similar indications such as benralizumab, dupilumab, omalizumab, reslizumab or tezepelumab • When used concurrently with ensifentrine for COPD
Required Medical Information	TARs must include the NDC &/or the stated dosage form that is being requested for administration during the medical visit (Pens *vs* Syringes *vs* Vials): • Nucala™ Autoinjector pen or prefilled syringes: FDA approved for self or caregiver administration with proper training. • Nucala™ Vials: FDA approved for administration by health care provider. Asthma: documentation that demonstrates all the following: 1) Member has asthma with an eosinophilic phenotype defined as blood eosinophils greater than or equal to 300 cells/µL within previous 12 months or greater than or equal to 150 cells/µL within six weeks of dosing and 2) Member has inadequate asthma control (for example, hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimal dosages a. Inhaled corticosteroid; and b. Long acting beta2-agonist, leukotriene modifier, or sustained release theophylline) EGPA: documentation that demonstrates all the following: 1) Member has a history or the presence of an eosinophil count of more than 1000 cells/µL or a blood eosinophil level of higher than 10 percent 2) Member has two or more of the following disease characteristics of EGPA: a. Biopsy showing histopathological evidence of eosinophilic vasculitis, perivascular eosinophilic infiltration, or eosinophil-rich granulomatous inflammation b. Neuropathy c. Pulmonary infiltrates d. Sinonasal abnormalities e. Cardiomyopathy f. Glomerulonephritis g. Alveolar hemorrhage h. Palpable purpura i. Antineutrophil Cytoplasmic Antibody (ANCA) positivity 3) Member has had at least one relapse (requiring increase in oral corticosteroids dose, initiation/increased dose of immunosuppressive therapy or

	hospitalization) within 2 years prior to starting treatment with Nucala or has a refractory disease. CRSwNP: documentation that demonstrates all the following: 1) History of prior nasal polyp removal surgery along with date of procedure. 2) Treatment failure with ≥ 8 weeks of a nasal corticosteroid 3) Recurrent and symptomatic CRSwNP (e.g. loss of smell/taste, nasal obstruction, rhinorrhea, facial pressure) indicated by: a. Visual analogue scale (VAS) score > 5 (access total clinical symptoms) AND b. Bilateral nasal polyp score (NPS) ≥ 5 or NPS ≥ 2 for a single nasal cavity (extent/severity of polyps based on endoscopic evaluation). HES: documentation that demonstrates all the following: 1) Clinic notes to confirmation the diagnosis of HES ≥ 6 months 2) Clinic notes to indicate that secondary potential causes of non-hematologic eosinophilia have been ruled out, such as but not limited to: a. FIP1L1-PDGFRα kinase positive b. Parasitic helminth infection c. Drug hypersensitivity d. HIV infection e. Non-hematologic malignancy 3) Signs and symptoms of organ involvement 4) At least 2 HES flares within the past 12 months 5) Current lab report with absolute eosinophil count (AEC) ≥1,500 cells/uL 6) Documentation of failure to induce remission with a corticosteroid (first line therapy) 7) Documentation of failure to induce remission with hydroxyurea or imatinib (Gleevec™) COPD: documentation that demonstrates all the following: 1) Member has COPD with both: a. postbronchodilator FEV1/FVC <0.7 on spirometry and b. BEC ≥150 cells/μL at screening or ≥300 cells/μL in the previous 12 months 2) Member has inadequate COPD control (for example, history of ≥2 moderate or ≥1 severe COPD exacerbations within the last year) despite current treatment with all 3 of the following medications at optimal dosages a. inhaled LABA b. LAMA c. ICS triple therapy • *COPD exacerbations are defined as:* o *Moderate: worsening of COPD symptoms that required treatment with systemic corticosteroids (oral or intravenous) and/or antibiotics.* o *Severe: an event that required an in-patient hospitalization (lasting at least 24 hours).*
Age Restriction	Asthma: 6 yrs and older EGPA: 18 yrs and older HES: 12 yrs and older CRSwNP: 18 yrs and older COPD: 18 yrs and older
Prescriber Restriction	None

Coverage Duration	Vials: 1 dose to allow administration of starting dose with the goal of transitioning to the autoinjector pen or prefilled syringe for maintenance treatment at home (provided by the pharmacy). Autoinjector pens & Prefilled syringes 1 time dose for training & observation of self-administration technique.

Other Requirements & Information	Mepolizumab (Nucala™) is available for self-administration in the form of an autoinjector and a prefilled syringe, which are typically administered by the member or a caregiver at home. When the member or caregiver can be trained for self-administration, Nucala™ autoinjector or prefilled syringes should be provided to the member by a pharmacy for administration at home whenever possible. Vials: Requests will be approved up to 1 month, if the healthcare provider prefers to administer the first dose for new start requests, by obtaining it through the practice until safety is determined. Autoinjector Pen & Prefilled syringes: Requests will be approved for one-time to allow training of the member &/or caregiver on self-administration. Continuing to provide an autoinjector pen or pens through the medical office will require information submitted with the TAR documenting the member is not a candidate for self- or caregiver administration at home. If administration by the provider is requested beyond the time frames shown above, the provider must include reason(s) on the renewal TAR stating why the member or caregiver cannot obtain the drug through the pharmacy benefit for self- or caregiver administration.

Medical Billing:

Dose limits & billing requirements (approved TAR is required):

HCPCS	Description	Dosing, Units
J2182	Injection, mepolizumab, per 1 mg (Nucala™ Autoinjector Pen & Prefilled syringe)	Asthma • 12 yrs and older: 100 mg (100 units) subcutaneously (SC) every 4 weeks • 6-11 yrs: 40 mg (40 units) SC every 4 weeks
		EGPA • 18 yrs and older: 300 mg (300 units) SC every 4 weeks
		HES • 18 yrs and older: 300 mg (300 units) SC every 4 weeks
		CRSwNP • 18 yrs and older: 100 mg (100 units) SC every 4 weeks
		COPD • 18 yrs and older: 100 mg (100 units) SC every 4 weeks
		Maximum Dose: 300 mg (300 HCPCS units per service date)

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Unless otherwise specified as having renewal requirements, criteria apply to new starts only. Include documentation of continuation of care if member is not new to treatment.

PA Criteria	Criteria Details
Covered Uses	1) Add-on maintenance treatment of severe asthma. 2) Add-on maintenance treatment of chronic rhinosinusitis with nasal polyps (CRSwNP) with inadequate response to nasal corticosteroids.
Exclusion Criteria	• Monotherapy use (tezepelumab is add-on therapy to the current asthma treatment regimen) • Tezepelumab will not be used concurrently with other monoclonal antibodies with similar indications such as dupilumab, mepolizumab, omalizumab, reslizumab or benralizumab
Required Medical Information	TARs must include clinical documentation to substantiate the following: Asthma: 1) Patient has a physician-diagnosed asthma for at least 12 months 2) Patient is adherent on medium or high-dose inhaled corticosteroids (ICS) and at least one additional asthma controller (such as long acting beta2 agonist (LABA), with or without oral corticosteroids (OCS) 3) Patient has persistent uncontrolled asthma as defined by at least one of the following: a. An Asthma Control Questionnaire (ACQ6) score of 1.5 or more, or an Asthma Control Test (ACT) score less than 20 at baseline b. A history of at least two asthma exacerbation events within prior 12 months c. A history of at least one severe asthma exacerbation resulting in hospitalization within prior 12 months d. Patient has inadequate asthma control (for example, hospitalization or emergency medical care visit within the past year) despite current treatment with both of the following medications at optimal dosages: i. Inhaled corticosteroid; and ii. Long acting beta2-agonist, leukotriene modifier, or sustained release theophylline). 4) State the specific dosage form that will be administered during the medical office visit: a. Tezspire™ Autoinjector pen (may be administered by patient or caregiver with proper training) OR Tezspire™ Prefilled Syringe (administered by health care provider) CRSwNP: 1) History of prior nasal polyp removal surgery along with date of procedure. 2) Treatment failure with ≥ 8 weeks of a nasal corticosteroid 3) Recurrent and symptomatic CRSwNP (e.g. loss of smell/taste, nasal obstruction, rhinorrhea, facial pressure) indicated by: • Visual analogue scale (VAS) score > 5 (access total clinical symptoms) AND • Bilateral nasal polyp score (NPS) ≥ 5 or NPS ≥ 2 for a single nasal cavity (extent/severity of polyps based on endoscopic evaluation).
Age Restriction	Asthma: 12 yrs and older

	CRSwNP: 18 yrs and older

Prescriber Restriction	Must be prescribed by or in consultation with a pulmonologist, allergist or immunologist

Coverage Duration	Prefilled syringes: 1 dose to allow administration of starting dose with the goal of transitioning to the autoinjector or prefilled syringe for maintenance treatment at home (provided by the pharmacy). Autoinjector pens: 1 time dose for training & observation of self-administration technique

Other Requirements	Tezepelumab (Tezspire™) is available for self-administration in the form of an autoinjector pen, which are typically administered by the member or a caregiver at home. The member or caregiver can be trained for self-administration, Tezspire™ autoinjector pen should be provided to the member by a pharmacy for administration at home whenever possible. Prefilled syringes: Requests will be approved for one-time, if the healthcare provider prefers to administer the first dose for new start requests, by obtaining it though the practice. Autoinjector pens: Requests will be approved for one-time to allow training of the member &/or caregiver on self-administration. Continuing to provide auto-injector pens through the medical office will require information submitted with the TAR documenting the member is not a candidate for self- or caregiver administration at home. If administration by the provider is requested beyond the time frames shown above, the provider must include reason(s) on the renewal TAR stating why the member or caregiver cannot obtain the drug through the pharmacy benefit for self- or caregiver administration.

Medical Billing:

Dose limits & billing requirements (approved TAR is required):

HCPCS	Description	Dosing, Units
J2356	Injection, tezepelumab-ekko, 1 mg (Tezspire™ auto-injector pen & Tezspire™ prefilled syringe)	• Recommended (& maximum) dose: 210 mg Asthma: • 12 yrs and older: 210 mg (210 units) subcutaneously (SC) once every 4 weeks CRSwNP: • 18 yrs and older: 210 mg (210 units) SC every 4 weeks
		1 HCPCS unit = 1 mg, therefore a 210 mg dose is billed as a count of 210 units of service.

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PA Criteria	Criteria Details
Covered Uses	For Acute bacterial skin and skin structure infections (ABSSI) caused by susceptible isolates of gram positive organisms: S. aureus (methicillin susceptible & resistant), S. pyogenes, S. agalactiae, S. dysgalactiae, S. anginosis, E. faecalis (vancomycin susceptible only for oritavancin, VRE for tedizolid).
Exclusion Criteria	None
Required Medical Information	• Culture and sensitivity report showing susceptible isolate • Applicable labs and/or tests documenting antibiotic selection. • Relevant clinical notes such as hospital discharge summary or infectious disease consult notes • Documentation of trial and failure/contraindication to vancomycin or alternative antibiotic that organism is susceptible to, may include, but not limited to: TMP/SMX, doxycycline, dicloxacillin, cephalexin, daptomycin, nafcillin, cefazolin, clindamycin, linezolid, oral tedizolid • Sivextro: current weight (must be ≥1kg)
Age Restriction	Sivextro: ≥26 weeks gestational age Orbactiv: ≥18 years
Prescriber Restriction	None
Coverage Duration	One treatment course Sivextro: 6 days Orbactiv: one-time single dose (1200mg)
Other Requirements & Information	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, Units
Sivextro	J3090	Injection, tedizolid phosphate, 1 mg	200mg (200 units) daily for 6 days, maximum of 1200 units per course
Orbactiv	J2407	Injection, oritavancin (orbactiv), 10 mg	1200mg (120 units) one time per treatment course

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	The treatment of recurrent respiratory papillomatosis (RRP)
Exclusion Criteria	1. RRP caused by HPV subtype other than 6 or 11 2. Active, significant, autoimmune disease 3. Ongoing use of systemic corticosteroids at a dose of ≥10mg of prednisone equivalents, or other systemic immunosuppressive medications
Required Medical Information	Documentation of ALL of the following (1-10): 1. Clinic notes which include past medical history of RRP including disease progression and the number and dates of all surgical interventions performed within the previous 12 months 2. Member has current symptoms of RRP disease such as airway compromise, voice impairment or dysphagia (such as a copy of the Derkay Severity Score) 3. Presence of laryngotracheal papillomas via endoscopy 4. Histological diagnosis of papilloma confirmed by pathology report from a CLIA-certified (or comparable) laboratory 5. Confirmation of HPV subtype 6 or 11 6. Documentation that member has received Gardasil-9 if they are between the ages of 9-45 years old, or reasons why the Gardasil-9 vaccine cannot be administered. Vaccination with Gardasil-9 should be strongly considered for members over the age of 45 as well. 7. Baseline Derkay Severity Score based on endoscopic findings 8. Member must meet ONE of the following: a. Has received ≥3 clinically indicated surgical interventions in the previous 12 months, OR b. Severe disease burden (Derkay score ≥20 for anatomic score), OR c. Tracheobronchial or pulmonary disease, OR d. Rapid regrowth after surgery (disease requiring repeat surgical intervention within 8–12 weeks of prior debulking), OR e. Need for tracheostomy or long term ventilatory support due to disease burden 9. Confirmation that the member will receive surgical debulking to maintain minimal residual disease prior to the first dose, and again prior to the 3rd and 4th doses if indicated 10. Member has no severe uncontrolled medical illness 11. Member has no active infection 12. Negative pregnancy test 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	18 years and older
Prescriber Restriction	Otolaryngologist

Coverage Duration	One treatment course per authorization: 4 doses over 12 weeks

Other Requirements & Information	Renewal Requirements: ALL of the following (1-3) 1. ≥12 months have elapsed since completion of the prior Papzimeos course 2. Documentation of a positive response to prior Papzimeos, such as ONE of the following: a. Reduction in surgical frequency compared to baseline b. Reduction in Derkay score compared to baseline 3. Documentation of disease recurrence after favorable response, such as ONE of the following: a. Increasing Derkay score b. Increasing surgical frequency c. Symptomatic recurrence 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
J3404	Injection, zopapogene imadenovec-drba suspension, per therapeutic dose	5×10^{11} particle units (PU) per injection administered as subcutaneous injections given on day 0, and repeated on week 2, week 6 and week 12 for a total of 4 doses. Approvals should be for 4 units total

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	• Complicated skin and skin structure infections (cSSSI) caused by susceptible isolates of the following Gram-positive bacteria: *Staphylococcus aureus* (including methicillin-resistant isolates), *Streptococcus pyogenes, Streptococcus agalactiae, Streptococcus dysgalactiae subsp. equisimilis*, and *Enterococcus faecalis* (vancomycin-susceptible isolates only) • *Staphylococcus aureus* bloodstream infections (bacteremia), including those with right-sided infective endocarditis, caused by methicillin susceptible and methicillin-resistant isolates.
Exclusion Criteria	• Pneumonia • Left-sided infective endocarditis • Infections in which IV treatment is not indicated
Required Medical Information	<u>All Diagnoses</u>: 1) Culture and Sensitivity lab report(s) when appropriate 2) Patient Med Allergy list if relevant 3) Treatment history for same infection 4) Clinic notes (or hospital admit and discharge) with assessment and plan <u>Complicated skin and skin structure infections</u>: 1) Documentation of trial and failure (or contraindication) to oral antibiotics appropriate to treat condition, such as: a. Doxycycline b. Minocycline c. SMZ/TPM (Septra DS) d. Erythromycin e. Penicillins f. Cephalosporins g. Linezolid 2) Trial and failure or medical reasons why preferred daptomycin products cannot be used (preferred daptomycin products do not require a TAR and can be billed with HCPCS codes: J0878, J0877, J0874 and J0873) <u>MRSA (either cSSSI or bacteremia)</u> 1) IV treatment must be indicated 2) Documentation of failure, or reasons why vancomycin cannot be used 3) An Infectious Disease consult may be required 4) Trial and failure or medical reasons why preferred daptomycin products cannot be used (preferred daptomycin products do not require a TAR and can be billed with HCPCS codes: J0878, J0877, J0874 and J0873)
Age Restriction	≥ 1 year
Prescriber Restriction	None

Coverage Duration	Duration depends on diagnosis and treatment plan
Other Requirements & Information	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:

<table>
<tr><th>Product</th><th>HCPCS</th><th>Description</th><th>Dosing, Units</th></tr>
<tr><td>Daptomycin</td><td>J0872</td><td>Injection, daptomycin (xellia), unrefrigerated, not therapeutically equivalent to J0878 or J0873, 1 mg</td><td>Weight based dosing, administered once every 24 hours
<table>
<tr><th>Age</th><th>cSSSI
(7-14 days)</th><th>Bacteremia
(2-6 weeks)</th></tr>
<tr><td>>17 yrs</td><td>4mg/kg</td><td>6mg/kg</td></tr>
<tr><td>12-17 yrs</td><td>5mg/kg</td><td>7mg/kg</td></tr>
<tr><td>7-11 yrs</td><td>7mg/kg</td><td>9mg/kg</td></tr>
<tr><td>2-6 yrs</td><td>9mg/kg</td><td rowspan="2">12mg/kg</td></tr>
<tr><td>1-<2 yrs</td><td>10mg/kg</td></tr>
</table></td></tr>
</table>

Note: the following daptomycin products do not require a TAR:
J0878: Injection, daptomycin, 1 mg (Cubicin™)
J0877: Injection, daptomycin (hospira), not therapeutically equivalent to J0878, 1 mg
J0874: Injection, daptomycin (baxter), not therapeutically equivalent to J0878, 1 mg
J0873: Injection, daptomycin (xellia), not therapeutically equivalent to j0878 or j0872, 1 mg

Requirements for posaconazole IV (Noxafil™) 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 invasive aspergillosis • Prophylaxis of invasive *Aspergillus* and *Candida* infections in patients who are at high risk of developing these infections due to being severely immunocompromised, such as hematopoietic stem cell transplant (HSCT) recipients with graft versus-host disease (GVHD) or those with hematologic malignancies with prolonged neutropenia from chemotherapy
Exclusion Criteria	None
Required Medical Information	1) Clinic notes and relevant imaging and laboratory results to confirm primary and secondary diagnoses, treatment history, and current treatment plan with anticipated duration of therapy 2) Documentation of trial and failure or reasons why other treatment options cannot be used. Preferred, first-line treatment options may include the following: amphotericin B, anidulafungin, caspofungin, micafungin, fluconazole, itraconazole, voriconazole (TAR may be required for other treatment options.) 3) Documentation to confirm NPO status, unable to take tablets/capsules or oral suspension 4) Current weight (must be ≥10kg)
Age Restriction	≥ 2 years and older
Prescriber Restriction	Prescribed or recommended by Infectious Disease specialist or HIV specialist
Coverage Duration	TBD based on indication
Other Requirements & Information	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:

HCPCS	Description	Dosing, Units
J1837	Injection, posaconazole, 1 mg (Noxafil)	Adults: 300mg BID for 1 day, then 300mg daily thereafter for 6-12 weeks (treatment) or based upon recovery from neutropenia or immunosuppression (prophylaxis) Pediatric: 6mg/kg up to a maximum of 300mg BID for 1 day, then 6mg/kg up to a maximum of 300mg daily thereafter for 6-12 weeks (treatment) or based upon recovery from neutropenia or immunosuppression (prophylaxis)

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	1) FDA approved indications: • Antiviral Prophylaxis • Chronic Inflammatory Demyelinating Polyneuropathy • Dermatomyositis/Polymyositis, Severe, Life Threatening or Refractory • Hypogammaglobinemia, prophylaxis against bacterial infection with hypogammaglobinemia and/or recurrent bacterial infections with malignancy or primary humoral immunodeficiency disorder (PI/PID) or Common variable immunodeficiency (CVID) • Acute and Chronic Immune Thrombocytopenia (ITP) • Kawasaki Syndrome • Multifocal Motor Neuropathy 2) Medically accepted off-label indications as evidenced in compendia or treatment guidelines, such as but not limited to: • Pemphigus foliaceus and vulgaris, refractory • Toxic shock syndrome, streptococcal • Antibody mediated rejection, treatment • Guillain-Barre syndrome • Acute exacerbation of myasthenia gravis Please note the following are preferred IVIG products with Partnership HealthPlan: Gammagard, Gammaplex, Gamunex-C, Octagam, Privigen, Flebogamma, Bivigam Non-preferred IVIG options: Asceniv, Alyglo, Panzyga, Yimmugo
Exclusion Criteria	None
Required Medical Information	<u>Requirements for ALL indications</u>: (1) Clinic notes to confirm the diagnosis submitted (see specific requirements below). (2) Treatment plan from appropriate specialist, including: • Weight (kg, lb) • Dosing schedule • Previous treatments with other indicated therapies (if any), with evaluation of response. (3) If requesting use of Asceniv, Alyglo, Panzyga, or Yimmugo, please submit additional information regarding reason(s) why alternative products cannot be used. <u>Additional Diagnosis-Dependent Requirements:</u> 1) <u>Antiviral prophylaxis:</u> a. Hepatitis A –pre or post-exposure within 2 weeks for patients who are: • Immunocompromised • Chronic liver disease • Ages ≥ 12 months who are unvaccinated • High-risk exposure situations within a facility (e.g. school, hospital), international travel, or during pregnancy. b. Measles – post exposure within 6 days of exposure and unable to receive a MMR vaccine within 72 hours for patients who meet one of the following parameters: • Infants < 12 months

- Pregnant women or persons without evidence of immunity (rapid IgG antibody test is acceptable).
- Severely Immunocompromised (e.g. bone marrow transplant procedure <12 months after finishing immunosuppressive therapy, graft vs host disease, HIV/AIDs with so CD4 <15% or CD4 <200 lymphocytes/mm3 for ages >5 yrs).

c. Varicella – post exposure, if varicella-zoster immune globulin, such as Varizig is unavailable for:
- Persons without evidence of immunity

2) <u>Chronic inflammatory demyelinating polyneuropathy:</u>
a. Confirmation of diagnosis based on the European Academy of Neurology (EAN/PNS) guidelines
b. Electro diagnostic findings of peripheral nerve demyelination
c. Exclusion of other similar disease states that overlap with similar symptoms, such as but not limited to:
- Neuropathy probably caused by B. burgdorferi infection (Lyme disease), diphtheria, drug or toxin exposure
- Hereditary demyelinating neuropathy
- Prominent sphincter disturbance
- Diagnosis of multifocal motor neuropathy (MMN)
- IgM monoclonal gammopathy with high titer antibodies to myelin-associated glycoprotein (MAG)
- Other causes for a demyelinating neuropathy including POEMS syndrome, osteosclerotic myeloma, and diabetic and nondiabetic lumbosacral radiculoplexus neuropathy; peripheral nervous system lymphoma and amyloidosis may occasionally have demyelinating features

d. Inflammatory Neuropathy Cause and Treatment (INCAT) score, Inflammatory Rasch-built Overall Disability Scale (I-RODS) or similar measurement of impairment
e. Documentation of failure to respond to glucocorticoids (oral or injectable) or reason(s) why glucocorticoids cannot be used such as but not limited to:
- Contraindication
- Severe disability
- Pure motor phenotype
- Fast progressive disease

3) <u>Dermatomyositis/Polymyositis, severe, life-threatening or refractory:</u>
a. Confirmation of diagnosis with at least one of the following:
i. Cutaneous manifestations (e.g. Heliotrope, Gottron's sign, erythema on extremity joints)
ii. Muscle biopsy
iii. Skin biopsy
iv. Electrocardiogram
v. European League Against Rheumatism/American College of Rheumatology (EULAR/ACR) criteria or Bohan and Peter criteria AND

b. Confirmation of diagnosis with at least 4 of the following:
i. Symmetrical muscle weakness in the shoulders/upper arms or hips/upper legs and trunk
ii. Elevation of serum levels of skeletal muscle-associated enzymes: CK, aldolase, lactate dehydrogenase (LD or LDH), transaminases (ALT/SGPT and AST/SGOT)
iii. Muscle pain on grasping or spontaneous pain
iv. The triad of muscle-related changes on EMG:

- Short, small, low-amplitude poly-phasic motor unit potentials
- Fibrillation potentials, even at rest
- Bizarre high-frequency repetitive discharges

v. Positive for any of the myositis-specific autoantibodies
vi. Nondestructive arthritis or arthralgia
vii. Signs of systemic inflammation
viii. Muscle biopsy findings compatible with inflammatory myositis

c. Documentation of failure to respond to or contraindicated to:
   i. Glucocorticoids after an appropriate trial (≥ 3 months)
   ii. Glucocorticoids plus methotrexate or azathioprine after an appropriate trial AND
   iii. Rituximab (Rituxan™)

4) Hypogammaglobulinemia, prophylaxis against bacterial infection:
   a. Documentation to confirm:
      i. Decrease of IgG (at least 2 SD below the mean for age)
      ii. Decrease in at least one of the isotypes IgM or IgA
      iii. Onset of immunodeficiency ≥ 4 years of age
      iv. Absent isohemagglutinins (A and B blood group antigens) and/or poor response to vaccines
      v. History of recurrent bacterial and/or viral infections
      vi. Other causes of hypogammaglobulinemia have been excluded
   b. Treatment plan with anticipated:
      i. Dose
      ii. Frequency
      iii. Transition to subcutaneous treatment, if started treatment with intravenous administration

5) Acute and Chronic Immune thrombocytopenia (ITP):
   a. Clinic notes must confirm low platelet count is due to ITP vs other causes such as malignancy or bone marrow failure, AND
   b. One or more of the following:
      i. Documentation of inadequate response to treatment course with an oral glucocorticoid (dexamethasone, or prednisone), contraindication or intolerance OR
      ii. Severe bleeding symptoms OR
      iii. Planned surgery or invasive procedure OR
      iv. Platelets count between 30,000/microL-50,000/microL in patients ≥18 yrs with one additional high risk factor for bleeding (i.e. peptic ulcer, use of anticoagulants, high risk of falling or chronic Hep. C associated thrombocytopenia OR
      v. Current lab report showing platelet count <30,000/microL, for ages <18 yrs OR <20,000/microL, for ages ≥18 yrs:
         - With at least one risk factor, such as but not limited to:
            - Use of antiplatelet medication or anticoagulation medication
            - Bleeding disorder (e.g. von Willebrand disease)
            - Active lifestyle subject to frequent trauma
            - Close monitoring or medical care is limited
            - Urgent surgery
            - Head trauma

6) Kawasaki syndrome:
   a. Age ≤5 years
   b. Fever of unknown origin or cause ≥ 5 days
   c. Lab report with:
      i. C-reactive protein (CRP)test < 3 mg/dL AND Erythrocyte sedimentation rate (ESR) <40 mm/hr OR

ii. CRP ≥3 mg/dL AND/OR ESR ≥40 mm/hr

d. Positive echocardiogram:
   i. Z-score of the left anterior descending coronary artery or right coronary artery is ≥2.5, a coronary artery aneurysm is observed OR
   ii. ≥3 other suggestive features exist including decreased left ventricular function, mitral regurgitation, pericardial effusion OR
   iii. Z-scores in the left anterior descending coronary artery or right coronary artery of 2 to 2.5.

7) Multifocal motor neuropathy (MMN):
   a. Confirmation of diagnosis based on the European Academy of Neurology (EAN/PNS) guidelines
   b. Exclusion criteria are the following:
      - Upper motor neuron signs
      - Marked bulbar involvement
      - Sensory impairment more marked than minor vibration loss in the lower limbs
      - Diffuse symmetric weakness during the initial weeks
   c. Rasch disability scale for MMN (MMN-RODS(C)) prior to treatment.

Accepted Off-Label use with high level of evidence and/or used in current standards and practices:

8) Guillain-Barre syndrome (GBS):
   a. Clinic notes documenting confirmation of diagnosis, such as but not limited to:
      - Loss of deep tendon reflexes
      - Symmetrical weakness
      - Pain, numbness, tingling in feet
      - Cerebrospinal fluid analysis (more protein observed and few WBC)
      - Electrodiagnostic studies to indicate abnormalities consistent with GBS
      - Dysautonomia
   b. GBS disability score between 3-5 or rapid progression

9) Antibody mediated rejection (AMR), heart, kidney or lung transplant treatment:
   a. See criteria above, listed in the section "Requirements for all indications"

10) Pemphigus foliaceus and vulgaris, refractory:
   a. Documentation of failure to both (i and ii):
      i. Glucocorticoids with an immunosuppressant (i.e. azithromycin, mycophenolate, cyclophosphamide, dapsone, methotrexate).
      ii. Glucocorticoids with rituximab

11) Toxic Shock Syndrome, streptococcal:
   a. Documentation indicating complications associated with toxic shock syndrome due to invasive group A streptococcus pyogenes (GAS) streptococcal toxic shock syndrome.

12) Myasthenia gravis (acute exacerbation):
   a. Documentation indicating treatment required for:
      i. Myasthenia gravis crisis
      ii. Preoperatively
      iii. Bridge therapy while transitioning to slower onset corticosteroid

	sparing immunotherapy
Age Restriction	Per FDA package labeling for each product
Prescriber Restriction	Prescribed by an appropriate specialist (disease state under treatment is within the standard scope of the specialty), or by a PCP with appropriate specialist's consultations & recommendation.
Coverage Duration	Dependent upon the indication submitted
Other Requirements & Information Needed for Continuation of Care	Requests for off-label use: See PHC criteria document *Case-by-Case TAR Requirements and Considerations.* 1) CIDP: a. Inflammatory Neuropathy Cause and Treatment (INCAT) score, Inflammatory Rasch-built Overall Disability Scale (I-RODS) or similar measurement of impairment. i. If symptoms do not improve or continue to progress after an initial two-to-three-month treatment trial, the patient should be reevaluated to verify the diagnosis of CIDP. 2) Hypogammaglobulinemia, prophylaxis against bacterial infection: a. Treatment plan, including expected timeframe for transition from intravenous (IV) to subcutaneous (SC). b. If IV route is to be ongoing without transition to SC, please provide the reason(s) why SC formulations cannot be used. 3) MMN: a. Current Rasch disability scale for MMN (MMN-RODS(C)) prior to renewal request. <u>ITP Renewals</u>: Standard is usually 1-2 treatments, and if no response, alternatives should be considered. Documentation of ongoing moderate or severe bleeding symptoms with persistent platelet count <20,000/microL is required for consideration of additional treatment with IgG. <u>Guillain-Barré Renewals</u>: Limited to a single treatment (standard of care) except when extenuating circumstances are submitted which indicate an additional treatment is medically necessary. Requesting a second treatment for treatment-related fluctuation: clinical documentation must be submitted to indicate very severely affected patient with no improvement or further deterioration at 2 weeks since initial treatment.

Medical Billing:

A) Accepted HCPCS codes (with an approved TAR):

Product	HCPCS	HCPCS Description
Intravenous Infusion		
Alyglo	J1552	Injection, immune globulin (alyglo), 500 mg
Yimmugo	J1553	Injection, immune globulin (yimmugo), 100 mg
Asceniv	J1554	Injection, immune globulin (asceniv), 500 mg
Bivigam	J1556	Injection, immune globulin (bivigam), 500 mg
Flebogamma; Flebogamma DIF	J1572	Injection, immune globulin, (flebogamma/flebogamma dif), intravenous, non-lyophilized (e.g., liquid), 500 mg
Gammagard S/D; Carimune NF	J1566	Injection, immune globulin, intravenous, lyophilized (e.g., powder), not otherwise specified, 500 mg
Gammaplex	J1557	Injection, immune globulin, (gammaplex), intravenous, non-lyophilized (e.g., liquid), 500 mg
Octagam	J1568	Injection, immune globulin, (octagam), intravenous, non-lyophilized (e.g., liquid), 500 mg
Panzyga	J1576	Injection, immune globulin (panzyga), intravenous, non-lyophilized (e.g., liquid), 500 mg
Privigen	J1459	Injection, immune globulin (privigen), intravenous, non-lyophilized (e.g., liquid), 500 mg
Either Intravenous or Subcutaneous Infusion, depending on diagnosis for use		
Gammagard	J1569	Injection, immune globulin, (gammagard liquid), non-lyophilized, (e.g., liquid), 500 mg • IV or SC: Primary Immunodeficiency • IV only: All other indications
Gammaked; Gamunex-C	J1561	Injection, immune globulin, (gamunex-c/gammaked), non-lyophilized (e.g., liquid), 500 mg • IV or SC: Primary Immunodeficiency • IV only: All other indications
Intramuscular Injection		
GamaSTAN S/D	J1460	Injection, gamma globulin, intramuscular, per 1 cc
	J1560	Injection, gamma globulin, intramuscular, per 10 cc
Subcutaneous Infusion		
Cutaquig	J1551	Injection, immune globulin (cutaquig), 100 mg
Cuvitru	J1555	Injection, immune globulin (cuvitru), 100 mg
Hizentra	J1559	Injection, immune globulin (hizentra), 100 mg
Hyqvia	J1575	Injection, immune globulin/hyaluronidase, (hyqvia), 100 mg immune globulin
Xembify	J1558	Injection, immune globulin (xembify), 100 mg

B) General dosing information, by indication – a compilation from the drug monographs available through Wolters Kluwer Facts & Comparisons®

Indication	Dosing
FDA Approved Indications	
Antiviral prophylaxis	Dosing and frequency determined by wt (kg), type (Hepatitis A, measles, varicella) and time of potential exposure, current IVIG products used to treat the patient.
Chronic inflammatory demyelinating polyneuropathy	Initial: 2 g/kg IV divided in doses over 2-5 days or 400 mg/kg IV once a day for 5 days (max daily dose of 1 g/kg). Maintenance: 1 g/kg IV divided over 1-2 days every 3 weeks. Transitioning to SC: Start 1 week after last IVIG infusion, at 200 mg/kg – 400 mg/kg per week, over 1-2 sessions over 1 to 2 days.

Indication	Dosing
FDA Approved Indications, continued	
Dermatomyositis/polymyositis, severe, life threatening or refractory	1 g/kg per day IV x 2 days every 4 weeks or 1 g/kg per day once every 2 weeks
Hypogammaglobulinemia prophylaxis against bacterial infection	Acquired secondary to malignancy: 200 mg/kg – 400 mg/kg IV once every 3-4 weeks Primary humoral immunodeficiency disorder: 200 mg/kg – 800 mg/kg IV once every 3-4 weeks
Immune thrombocytopenia	≥ 18 yrs: 1 g/kg IV once a day for 1 -2 days, may hold second dose with adequate platelet response (eg, plt > 50,000 mm^3) after 24 hrs or 400 mg/kg IV daily x 5 days 2-17 yrs: Dose is dependent on product used for treatment, age, wt (kg) and dosing frequency chosen for acute or chronic treatment.
Kawasaki Syndrome	Infants and children (specific age range in not referenced): 2000 mg/kg IV over 8-12 hr, given within 10 days of disease onset. If signs and symptoms persist ≥ 36 hrs, 1000 mg/kg – 2000 mg/kg may be considered.
Multifocal motor neuropathy	Initial dosing: 2 g/kg IV divided over 2-5 consecutive days or 400 mg/kg IV once a day x 5 days (max daily dose: 1 g/kg) and maintenance dose of 1 g/kg – 2 g/kg every 2-6 weeks or if high dose was tolerated dosing 1 g/kg IV once daily x 2 days can be considered.
Off-Label Indications	
Pemphigus foliaceus and vulgaris, refractory	2 g/kg IV given in divided doses over 2-5 days or 400 mg/kg IV once a day x 5 days. May repeat every 4-6 weeks based on clinical response.
Guillain-Barré syndrome	Start treatment within 4 weeks of symptoms. 400 mg/kg IV x 5 days only. Retreatment is not recommended.
Myasthenia gravis, acute exacerbation	2 g/kg IV administered in divided doses given over 2-5 consecutive days or 400 mg/kg IV once a day x 5 days or 1 g/kg IV once a day for 2 days.
Toxic shock syndrome, streptococcal (adjunctive agent)	1 g/kg IV on day 1, followed by 500 mg/kg IV once daily on days 2 and 3
	Heart transplantation: 2 g/kg IV divided in 2-4 doses, given on consecutive days. If plasmapheresis is utilized, give 100 mg/kg IV after each session. This regimen may be repeated monthly if needed. Kidney transplantation: <1 year after transplant: 1 g/kg – 2.4 g/kg IV in divided doses over 1-3 consecutive days (max daily dose of 1 g/kg). If plasmapheresis is utilized, give 100 mg/kg IV after each session and remaining total dose after final session over 1-2 days. >1 year after transplant: 200 mg/kg IV every 2 weeks for 3 doses Lung transplant: 500 mg.kg – 2 g/kg IV (doses >1 g/kg are usually divided into 2 doses given over 2 days) and may be repeated monthly if needed.

MEETING MINUTES

Meeting Name: Provider Education & Networking (PEN) Meeting

Date: 4/2/2026 **Time:** 12:00PM-1:30PM

Location: Regional Offices in Redding, Fairfield, Auburn, Eureaka, Chico, Santa Rosa and Webex

Attendees: See Attached Attendee List

Agenda Topic	Minutes	Action Items
1) **California Advancing and Innovating Medi-Cal (CalAIM)** Speaker: Matthew Harris	• Enhanced Care Management • Adult and Youth Populations of Focus • Community Support • CS and ECM Referrals to Partnership	*N/A*
2) **Legislative Update** Speaker: Buck Ellingson	• Medi-Cal Changes Timeline • Medi-Cal Changes in 2026 and 2027 • Work and Community Engagement Requirement Exemptions • Rural Health Transformation Fund	*N/A*
3) **Keep Your Medi-Cal Campaign** Speaker: Amanda Bernal	• Keep your Medi-Cal • What's Next?	*N/A*
4) **Telehealth Program Overview** Speaker: Hannah Petersen	• Modes and Partners in Telehealth • Specialty Referral Workflow • eConsult Services • eConsult Program with ConferMED • Benefits with ConferMED • Direct Telehealth	*N/A*

	• Direct to Member Specialty Telemedicine • How Referral Team Refers to TeleMed2U for Direct Telehealth • How to Refer to UC Davis for Direct Telehealth Program Modalities Recap	
5) Mandatory Handout Fliers Speaker: Cheng Saechao	• Partnership HealthPlan of California • Protected Health Information Sending Secure Email • Partners in Fighting Fraud, Waste & Abuse: Doing your Part as a Provider • Authorization and Billing Guidelines • Partnership Website and Provider Portal Features • Cultural and Linguistic Resources • A Shared Responsibility of Protecting Member/Patient Information • Interpretive Language Services • Whole Child Model for CCS-Eligible Members Partnership HealthPlan of California Policy MC305	*N/A*

Decisions Made		
Notes	**Follow-Up Items**	**Assigned To**
• **Q**: Has there been any support mechanism for the Medi-Cal changes that are to come? **A:** DHCS wants to automate as much as possible they are planning on using data from EDD-If they are successful, it could reduce workloads from county offices. Time will tell while coming into 2027/2028-Buck Ellingson • **Q:** Wanting to clarify that people will not be losing their benefits until January of 2027? **A:** Retroactive-Yes, next year and it will depend on how long it takes the county offices to get through enrollment. We also don't know if legislation will be successful-Buck Ellingson	*N/A*	*N/A*

• **Q:** Cal Premiums will be $30 per month per adult? **A**: Yes. -Buck Ellingson • **Q:** Is there a way to get ahead of this to help members? Is there a way to find out when their 6 months is coming up? **A:** Right now, we are supposed to be getting 60 days prior to the renewal to share with providers, but we are trying to focus on getting this information as early as possible. -Buck Ellingson • **Q:** Does authorization have to be sent from the PCP? **A:** Yes, the PCP does need to send in the referral - Hannah **Q:** Do ECM/CS providers have access to the system so they can upload documents for the patient? **A:** Was asked to email this question to get better clarification-Hannah		

Next Meeting	
Date	**Suggestions for Agenda**
N/A	*N/A*

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

Committee:	Credentials Committee
Date:	March 11, 2026, 7:00 A.M.
Members Present: by phone conference*	Steven Gwiazdowski, MD; 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; Danika Ahedo, Supervisor of Credentialing; J'aime Seale, Credentialing Team Lead; Nolan Smith, Credentialing Specialist II; Morgan Brambley, Credentialing Specialist I; Amanda Arguello, Lead Trainer Network Services

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
I. Meeting called to order. a. Voting member reminder.	I. Partnership Medical Director Quality Improvement, Mark Nethereda, 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.			3/11/2026 3/11/2026
II. Review and approval of February 11, 2026, Credentials Meeting Summary.	II. The Credentials Committee meeting Summary for February 11, 2026, was reviewed by the Committee.	II. Summary was reviewed. A motion for approval of the Summary was made by Bradley Sandler, MD and seconded by Steven Gwiazdowski, MD. Meeting Summary were unanimously approved without changes.		3/11/2026
III. Old Business. a. Update on provider *Information Only*	III. Old Business – a. Dr. Netherda explained to the Credentials Committee that the requested information from Partnership legal counsel is still ongoing review. A letter was also forwarded to the provider and awaiting response. Dr. Netherda notified the Credentials Committee that further discussion for the provider will be deferred to the April 8,	III. Old Business a. *Information Only*	4/8/2026	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	2026, Credentials meeting until information is received.			
b. Update on provider	b. Dr. Netherda referred the Credentials Committee to a provider. The provider is requesting to be credentialed with group for Internal Medicine. The previous information received during the February 11, 2026, meeting was not sufficient due to discrepancies found. The provider revised information to show they only wanted to see 18+ patients, however, Dr. Netherda explained a verbal confirmation was received from the provider stating they wished to see 12-18 year old patients for obesity and substance use disorder services. Dr. Lisa Ward also provided information to the committee stating that the provider will be treating pediatric patients as a primary care physician. Instead, the provider will only focus on patients 12-18 years old for obesity/SUD issues. Dr. Gorchoff asked if the provider's training or experience includes treating 12-18+ patients for obesity/SUD issues? Dr. Ward responded that the provider has been treating 12-18+ patients on these disorders for several years. Dr. Ribordy is concerned that the providers' pediatric training could be mischaracterized as training includes pediatric surgery and anesthesia only. Dr. Netherda agreed with Dr. Gorchoff, asking where the provider has completed SUD training as well as experience. Dr. Gwiazdowski added that residencies normally include areas with training in child psychiatry. Dr. Ribordy asks would this be for mental health only. Dr. Gwiazdowski answers mental health could be restricted to SUD and weight management. Dr. Gorchoff stated more information is needed to indicate if the provider has this training, how many patients has been seen and how long they have provided services for obesity and SUD. Dr. Herman added that talking to pediatric patients for Obesity and SUD are not profoundly different from treating adults. A physician providing these services would provide counseling, talking and motivational interviewing. Dr. Moore added further information from the provider's CV and Board Certification. Dr. Moore found the provider is Board Certified for Public health and Preventative	b. The Committee reviewed the information for the provider. A motion defer to April 8, 2026, was made by David Gorchoff, MD and seconded by Bradley Sandler, MD. The Committee unanimously approved.	4/8/2026	

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	Medicine but wants more information from the CV. Dr. Netherda and Dr. Ward stated they will reach out to the provider to get clearer information on what they will practice. Motion to defer to April 08, 2026, meeting for further discussion.			
IV. New Business	IV. New Business	IV. New Business		
a. Review and Approval of Routine Practitioner List.	a. Dr. Netherda referred 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 David Gorchoff, MD and seconded by Bradley Sandler, MD. The Committee unanimously approved the routine list.		3/11/2026
b. MPCR200 Clean/Routine Practitioners and Ancillary Practitioners	b. Dr. Netherda explained to the Credentials Committee 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 Steven Gwiazdowski, MD and seconded by Bradley Sandler, MD. The Committee unanimously approved the MPCR200 Clean/Routine and Ancillary Practitioners list.		3/11/2026
c. Review and Approval of Revised Policies.	c. Review and Approval of Revised Policies presented by J'aime Seale. J'aime Seale explained the policies presented to the Credentials Committee are MPCR16 - Lactation Consultant Credentialing Policy, MPCR101 - Ensuring Non-discriminatory Credentialing and Re-credentialing processes, MPCR300-A - Physician Credentialing and Re-credentialing Requirements attachment A, MPCR301 - Non-Physician Clinician Credentialing and Re-credentialing Requirements, MPCR400 - Provider Credentialing and Re-credentialing Verification Process and Record Security, MPCR602 - Reporting Actions to Authorities. All policies except MPCR101 and MPCR300-A are consent calendar. MPCR 101 has a revision with NCQA language added. MPCR300-A contains an updated attachment to the MPCR300 policy with a new board PNCB that can be used for primary sourcing.	c. The Committee reviewed the Revised Policies. A motion to approve the revised policies was made by Steven Gwiazdowski, MD and seconded by Bradley Sandler, MD. The Committee unanimously approved.		3/11/2026
d. Exception for provider	d. Dr. Netherda explained to the Credentials Committee provider is requesting to be credentialed to provide	d. The Committee reviewed the exception for provider. A motion to approve the provider to render services for		3/11/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	Wound Care with group. There were contradictions presented to credentialing staff regarding the provider's residency completion. The provider stated they did not complete full residency. However, the AMA showed the provider completed their residences. Credentialing staff also received residency verification, and the information was confirmed that the provider completed four-year residency in good standing. Due to contradictions Dr. Netherda requested the committee to approve for practice of wound care.	wound care was made by Brian Montenegro, MD and seconded by Michele Herman, MD. The Committee unanimously approved.		
V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.	V. Ongoing Monitoring of Sanctions Report and Practitioner Monitoring List.		
a. Review and Approval of Ongoing Monitoring of Sanctions Report.	a. Review and Approval of Ongoing Monitoring of Sanctions Report. The Credentials Committee was asked to review and approve the Ongoing Monitoring of Sanctions Report.	a. The Credentials Committee members reviewed the report. A motion for approval of the Ongoing Monitoring of Sanctions Report was made by Steven Gwiazdowski, MD and seconded by David Gorchoff, MD. The Committee unanimously approved.		3/11/2026
b. Practitioner Monitoring List, Update for provider. *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 received stating probation, sanctions or corrective actions plans have ended will remove the provider from our monitoring and the provider will be contacted via letter that their monitoring with Partnership HealthPlan has stopped. Dr. Netherda also informed the Credentials Committee of the previous provider. The provider was approved with monitoring during the December 10, 2025, meeting. CA Physician Assistant Board added the same infraction related to prescribing and poor record keeping for controlled substances to their CA license as has been added to their NV license. The board's decision had placed the provider on 35 months' probation with various terms and conditions. The provider will not be able to practice until the supervising physician and practice plan are approved the board. The decision shall become	b. *Informational only*.		3/11/2026

AGENDA ITEM	DISCUSSION / CONCLUSIONS	RECOMMENDATIONS / ACTION	TARGET DATE	DATE RESOLVED
	effective on 3/27/2026 by the CA Physician Assistant Board. Partnership shall continue to monitor CA Physician Assistant Board's decision. *Information Only.*			
VI. Review and Approval of Consent Calendar Items. a. Report of Long-Term Care Facility, Hospital, and Ancillary provider list. b. Quarterly Delegation Audits c. Annual Delegation Audits	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. b. Dr. Netherda presented the Annual Delegation Audits for Carelon Behavioral Health, Woodland Clinic, Dignity Health Medical Group – North State, Dignity Health Medical Group – Sierra Nevada, Mercy Medical Group, Lucile Packard Children's Hospital, SPMF – Sutter West Bay Medical Group Employed, Palo Alto Medical Foundation CPN, Palo Alto Medical Foundation Employed, SPMF: Sutter Medical Group of the Redwoods CPN, SPMF: Sutter Medical Group of the Redwoods Employed, SPMF: Sutter West Bay Medical Group CPN, Solano CPN, Sutter Independent Physicians, SMFAS, SMG SacPlacer, SMG Solano, SMG Yolo, University of California Davis Health, UCSF Medical Group and Vision Service Plan. c. Dr. Netherda presented the Annual Delegation Audits for Sutter Valley Medical Foundation. The audit included Partnerships review and evaluation of the credentialing information integrity results.	VI. Review and Approval of Consent Calendar Items. a/b/c. The Credentials Committee members reviewed the list of Consent Calendar Items. A motion for approval was made by Steven Gwiazdowski, MD and seconded by Bradley Sandler, MD. The Credentialing Committee unanimously approved.		3/11/2026
VII. Meeting Adjourned.	VII. Meeting adjourned.			3/11/2026

Credentials Meeting Summary for 3/11/2026 respectfully prepared and submitted by J'aime Seale, Credentialing Lead.

Chairman Signature of Approval _____ ***Date*** _____***3/11/2026***_____

Mark Netherda, MD Medical Director Quality Improvement *Credentialing Chairman*

App. T	Full Name	NPI Number	Provider Type	Name/Street	County Na	Specialty Description	Board Name	Initial Cert Date	Board Certif	Hospital Nan	Staff Cat
R	Abbe, Brie A.,CNM	1457020398	SPEC	Mendocino Community	Mendocinc	Certified Nurse Midwife	American Midwifery Certification Board	08/01/2021	Yes	None	
I	Acebo, Samuel A.,CRNA	1083131445	SPEC	North Valley Surgical C	Butte	Certified Registered Nurse Anesthesiologst	National Board of Certification & Recertification for Nurse Anes	07/17/2017	Yes	Admitting Ag	None
I	Adhye, Abhijit A.,MD	1992763205	PCP	Napa Lifestyle and Wel	Solano	Bariatric Medicine	None		No	Queen of the	Active
R	Aggarwal, Archana MD	1326024084	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Internal Medicine	10/18/2006	Yes	Admitting Ag	None
R	Aguigam-Leach, Linsey S.,FNP-I	1790358257	PCP	OLE Health	Solano	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	03/31/2021	Yes	None	
R	Alexander, Laura L.,SUDCC	1528397221	W&R	Ford Street Project	Mendocinc	Wellness and Recovery	California Substance Use Disorder	07/30/2025	Yes	None	
R	Ali, Ruby S.,MD	1093990426	SPEC	NBHG: Neurology and	Solano	Neurology	AOB of Neurology-Psychiatry	09/28/2009	Yes	NorthBay Me	Active Att
I	Alves, Mya A.,PA-C	1417644121	PCP	UIHS - Potawot Health	Humboldt	Physician Assistant Certified	National Commission on Certification of Physician Assistants	05/01/2023	Yes	None	
I	Anderson, Lorie A.,FNP-C	1679097588	SPEC	Telehealth Specialty Me	Placer	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	05/04/2017	Yes	None	
I	Ankrah, Nii-Kwanchie MD	1730574302	SPEC	Interventional Radiatior	Solano	Radiation Oncology	None		No	Mercy Medic	Active
I	Arambulo, Maria Flordeliz MD	1013169986	SPEC	Telehealth Specialty Me	Placer	Endocrinology, Diabetes, & Metabolism	ABMS of Internal Medicine	11/02/2015	Yes	Admitting Ag	None
I	Arnold, Joanne ANP-BC	1487957338	SPEC	Interventional Radiatior	Solano	Adult Nurse Practitioner	American Nurses Credentialing Center	01/06/2014	Yes	None	
I	Awadalla, Farah C.,MD	1669608790	SPEC	Yuba City Dermatology	Sutter	Dermatology	ABMS of Dermatology	07/26/2012	Yes	Admitting Ag	None
I	Awwad, Ayah PA-C	1497257224	PCP	One Community Health	Yolo	Physician Assistant Certified	National Commission on Certification of Physician Assistants	04/17/2025	Yes	None	
I	Barnes, Jessica BCBA	1750857157	BHP	Trumpet Behavioral He	Solano	BCBA	Behavior Analyst Certification Board	11/30/2019	Yes	None	
R	Barrow, Sandra MD	1437380987	SPEC	Nephrology Associates	Sonoma	Nephrology	ABMS of Internal Medicine	10/02/2014	Yes	Providence S	Active
R	Bastien, Jessica K.,BCBA	1114426731	BHP	Pantogran LLC dba Ce	Placer	Behavioral Health	Behavior Analyst Certification Board	01/14/2021	Yes	None	
R	Bayne, Christopher O.,MD	1235385246	SPEC	Shriners Hospitals for C	Yolo	Orthopaedic Surgery	ABMS of Orthopaedic Surgery	07/28/2016	Yes	Shriners Hos	Consultin
I	Behrens, Kelly J.,Psy.D	1518158997	BHP	Jigsaw Diagnostics	Solano	Clinical Psychologist	None		No	None	
I	Bengs, Benjamin C.,MD	1376524033	SPEC	Enloe Orthopedic & Tra	Butte	Orthopaedic Surgery	ABMS of Orthopaedic Surgery	07/23/2010	Yes	Admitting Ag	None
R	Benn, Andrew J.,MD	1851329270	SPEC	John Muir Cardiovascu	Solano	Cardiovascular Disease	ABMS of Internal Medicine	11/06/1991	Yes	John Muir He	Active
R	Bensch, Gregory W.,MD	1710950589	SPEC	Allergy, Immunology & .	Solano	Allergy & Immunology	ABMS of Allergy and Immunology	08/09/1999	Yes	Admitting Ag	None
I	Berger, Devin BCBA	1134696016	BHP	California Psychcare, Ir	Sacramen	BCBA	Behavior Analyst Certification Board	05/31/2018	Yes	None	
R	Bowles, Ryan L.,SUDCC II-CS	1912352063	W&R	Ford Street Project - UI	Mendocinc	Wellness and Recovery	California Substance Use Disorder	06/20/2024	Yes	None	
R	Bravo, Carolyn R.,CNM	1588033054	SPEC	Marin Community Clinic	Marin	Certified Nurse Midwife	American Midwifery Certification Board	06/01/2015	Yes	None	
R	Brown, Margot K.,MD	1689092165	BOTH	Sonoma County Indian	Sonoma	Family Medicine	ABMS of Family Medicine	07/01/2017	Yes	Admitting Ag	None
I	Buelle, David CADC II	1760160717	W&R	Drug Abuse Alternative	Sonoma	Wellness and Recovery	California Consortium of Addiction Programs Professionals	10/24/2023	Yes	None	
I	Calzada, Adan BCBA	1962904839	BHP	Momentum Behavior S	Sonoma	BCBA	Behavior Analyst Certification Board	06/05/2021	Yes	None	
I	Cameron, Frances E.,AMFT	1043906241	W&R	Family Spring Psycholc	Solano	Associate Marriage and Family Therapist	None		No	None	
R	Campbell, Maureen FNP-C	1326763319	SPEC	Capital Nephrology Me	Yolo	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	09/19/2022	Yes	None	
R	Caprini, Millie CADC II	1801429659	W&R	Visions of the Cross/ W	Shasta	Wellness and Recovery	California Consortium of Addiction Programs Professionals	11/25/2003	Yes	None	
R	Castillo Bernal, Keely BCBA	1275029605	BHP	Kyo Autism Therapy LL	Yolo	BCBA	Behavior Analyst Certification Board	11/30/2019	Yes	None	
I	Castillo II, Gerardo BCBA	1447673116	BHP	BM Behavioral Center,	Solano	BCBA	Behavior Analyst Certification Board	11/30/2015		None	
I	Catalan, Alisha BCBA	1841769759	BHP	California Sprout MC 1	Solano	BCBA	Behavior Analyst Certification Board	07/30/2022	Yes	None	
R	Chacon, Elizabeth L.,FNP-C	1518548171	SPEC	West Coast Kidney	Solano	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	03/15/2021	Yes	None	
I	Chakrapani, Rinita R.,MD	1134573561	PCP	Tehama County Health	Tehama	Internal Medicine	ABMS of Internal Medicine	08/28/2019	Yes	Admitting Ag	Active
R	Chang, Gene-Yuan MD	1467731828	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Internal Medicine	11/09/2016	Yes	Eden Hospit	Active
R	Chang, Gwendolen Y.,MD	1386807402	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Internal Medicine	10/10/2013	Yes	Eden Hospit	Courtesy
R	Chen, Ya-Kuan Yvonne MD	1306959135	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Internal Medicine	11/08/2000	Yes	Eden Hospit	Courtesy
R	Cheung, Eric L.,MD	1497998777	SPEC	Nephrology Associates	Sonoma	Nephrology	ABMS of Internal Medicine	10/02/2014	Yes	Providence S	Active
I	Chillar, Ram K.,MD	1881702645	BOTH	Sutter Coast Communit	Del Norte	Internal Medicine	ABMS of Internal Medicine	01/01/1971	Yes	Admitting Ag	None
I	Chow, Curtis PA-C	1750461794	PCP	SCHC: Anderson Fami	Shasta	Physician Assistant Certified	National Commission on Certification of Physician Assistants	412/22	Yes	None	
R	Cohen, Danielle BCBA	1750779179	BHP	Autism Advocacy and I	Lake	BCBA	Behavior Analyst Certification Board	05/31/2014	Yes	None	
R	Cunningham, Elizabeth A.,MD	1891763553	SPEC	Bay Area Surgical Spe	Napa	Surgery	ABMS of Surgery	02/26/1996	Yes	Queen of the	Active
R	Dao, Quan OD	1669096384	SPEC	Redwood Eye Center	Solano	Retinal Myopathy	Meets MPCR#17, verified residency by Residency Letter		No	Admitting Ag	None
I	De La Rosa, Vanessa BCBA	1487332565	BHP	Momentum Behavior S	Sonoma	BCBA	Behavior Analyst Certification Board	03/12/2025	Yes	None	
R	De Pala, Armando V.,Jr., MD	1912938085	PCP	Providence Medical Gr	Sonoma	Pediatrics	Meets MPCR#17, Previously Board Certified in FM, IM, or PEI	11/13/1991	No	Admitting Ag	Active
I	Derentz, Ann BCBA	1891252003	BHP	Pantogran LLC dba Ce	Yolo	BCBA	Behavior Analyst Certification Board	11/30/2018	Yes	None	
R	DeVane, Matthew S.,DO	1770511040	SPEC	John Muir Cardiovascu	Solano	Cardiovascular Disease	ABMS of Internal Medicine	11/03/1999	Yes	John Muir He	Active
I	Dhariwal, Samreen K.,PA-C	1033979943	PCP	One Community Health	Yolo	Physician Assistant Certified	National Commission on Certification of Physician Assistants	10/16/2024	Yes	None	
I	Dheyab, Abduljabbar A.,MD	1053607580	SPEC	Pulmonary Medicine As	Yolo	Pulmonary Diseases	ABMS of Internal Medicine	11/13/2018	Yes	Sutter Medic	Provisiona
R	Di Franco, Pamela G.,FNP-BC	1104480581	PCP	Mendocino Community	Mendocinc	Family Nurse Practitioner	American Nurses Credentialing Center	12/09/2019	Yes	None	
R	Diel, Joanna R.,FNP-C	1932759461	PCP	Petaluma Health Cente	Sonoma	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	08/23/2019	Yes	None	
I	Doan, Joseph MD	1528445210	SPEC	Sierra Nevada Specialt	Nevada	Nephrology	ABMS of Internal Medicine	12/15/2020	Yes	Admitting Ag	None
I	Domoe, Angelina BCBA	1013437847	BHP	Trumpet Behavioral He	Solano	BCBA	Behavior Analyst Certification Board	01/29/2022	Yes	None	
I	Dupuis, Tamara A.,PNP	1013789122	PCP	Harvest Pediatrics	Napa	Certified Pediatric Nurse Practitioner	Pediatric Nursing Certification Board	04/20/2015	Yes	None	
R	Ea, Roth DPM	1467984096	SPEC	Basso Podiatry Group,	Yolo	Foot Surgery	AB of Foot and Ankle Surgery	03/11/2020	Yes	Mercy Gener	Active
R	Erickson, Laura M.,OT	1871878538	Allied	Shasta Orthopedics & S	Shasta	Occupational Therapy	None		No	None	
I	Fagbamigbe, Oluwatoyosi O.,FN	1609673474	SPEC	Interventional Pain Solu	Butte	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	12/16/2024	Yes	None	
I	Falk, Erica Doula	1376153858	SPEC	Calming Seas Healing		Doula	None		Not Applical	None	
R	Farahmand, Guity MD	1700017175	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Internal Medicine	11/12/2015	Yes	Eden Hospit	Courtesy
I	Farhangfar, Kamyar MD	1821145426	PCP	Elica Health Centers - I	Placer	Internal Medicine	ABMS of Internal Medicine	08/20/2002	Yes	Admitting Ag	None
I	Ferguson, Shannon M.,FNP-BC	1194691733	PCP	Fairchild Medical Clinic	Siskiyou	Family Nurse Practitioner	American Nurses Credentialing Center	11/04/2025	Yes	None	
I	Ferretti, Alicia M.,SUDRC	1851188072	W&R	Archway Recovery Ser	Solano	Substance Use Disorder Registered Counsel	California Substance Use Disorder	03/27/2025	Yes	None	
I	Ferrier, James A.,MD	1023118858	SPEC	Banner Health Clinic	Lassen	Orthopaedic Surgery	ABMS of Orthopaedic Surgery	07/11/1997	Yes	Banner Lass	Consultin
R	Fialk, James L.,LAc	1881946028	SPEC	Wellspring Integrative H	Sonoma	Acupuncture	None		No	None	
I	Fleischer, Malorie PA-C	1497466635	SPEC	Urogynecology Consult	Placer	Physician Assistant Certified	National Commission on Certification of Physician Assistants	10/26/2022	Yes	None	
I	Flores, Arlene DO	1750031670	PCP	Adventist Health Ukiah	Mendocinc	Family Medicine	Meets MPCR#17, verified residency by Residency Letter			Adventist - U	Active
R	Fogg, Andrew W.,DC	1699761684	SPEC	Active Care Chiropracti	Humboldt	Chiropractic	None		No	None	
I	Ford, Hannah SUDCC	1386321107	W&R	Archway Recovery Ser	Solano	SUDCC	California Substance Use Disorder	11/24/2025	Yes	None	

App. T	Full Name	NPI Number	Provider Type	Name/Street	County Na	Specialty Description	Board Name	Initial Cert Date	Board Certif	Hospital Nan	Staff Cat
R	Fournier, Christa L.,FNP-C	1669897542	PCP	Scott Valley Rural Heal	Siskiyou	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	01/22/2014	Yes	None	
I	Fowler, Brooklyn BCBA	1437627445	BHP	Trumpet Behavioral He	Solano	BCBA	Behavior Analyst Certification Board	06/12/2025	Yes	None	
R	Francis, Adam C., MD	1801186648	PCP	West County Health Ce	Sonoma	Family Medicine	ABMS of Family Medicine	07/01/2014	Yes	Admitting Ag	None
R	Francis, Jennifer N.,FNP-C	1770148108	PCP	Santa Rosa Community	Sonoma	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	06/18/2019	Yes	None	
I	Frank, Lana CADC II	1114260387	W&R	Recover Medical Group	Solano	Wellness and Recovery	California Consortium of Addiction Programs Professionals	01/09/2016	Yes	None	
I	Fraser, Phillip RADT	1922963289	W&R	Archway Recovery Ser	Solano	Wellness and Recovery	California Consortium of Addiction Programs Professionals	04/24/2023	Yes	None	
I	Fratkin, Michael D.,MD	1508892738	BHP	Thrive Wellness Medic	Humboldt	Behavioral Health	None		No	Providence S	Affiliate
I	Gallegos, David BCBA	1306454780	BHP	David Gallegos	Solano	Board Certified Behavior Analyst	Behavior Analyst Certification Board	08/12/2024	Yes	None	
I	Ganjehei, Leila MD	1336436583	SPEC	NBHG: NorthBay Healt	Solano	Cardiovascular Disease	ABMS of Internal Medicine	09/26/2017	Yes	Admitting Ag	None
I	Gerard, Andre B.,MD	1891722500	PCP	Mendocino Community	Mendocinc	Family Medicine	ABMS of Family Medicine	07/17/2004	Yes	Admitting Ag	None
I	Gibbs, Matthew M.,PA-C	1477088243	PCP	Adventist Health Ukiah	Mendocinc	Physician Assistant Certified	National Commission on Certification of Physician Assistants	12/23/2016	Yes	None	
R	Gilani, Hussain A.,MD	1588800080	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Internal Medicine	10/23/2012	Yes	Eden Hospit	Courtesy
I	Gill, Ammara T.,MD	1447482096	SPEC	Providence Medical Gr	Sonoma	Hematology	ABMS of Internal Medicine	10/30/2018	Yes	Admitting Ag	None
I	Gill, Sharonjeet BCBA	1104327428	BHP	California Sprout MC 1	Solano	BCBA	Behavior Analyst Certification Board	05/03/2021	Yes	None	
I	Glashan, Sara K.,RN	1922855907	W&R	Drug Abuse Alternative	Sonoma	Wellness and Recovery	None		No	None	
R	Goldstein, Lawrence J.,MD	1972571636	SPEC	Bay Area Surgical Spe	Napa	Vascular Surgery	ABMS of Surgery	05/25/1994	Yes	Admitting Ag	None
R	Goldyn, Lawrence M.,MD	1780605097	PCP	Mendocino Coast Clinic	Mendocinc	Internal Medicine	ABMS of Internal Medicine	08/22/2000	Yes	Admitting Ag	None
I	Gonzalez Avina, Mireya BCBA	1982194692	BHP	Behavior Matters Califc	Solano	BCBA	Behavior Analyst Certification Board	09/11/2025	Yes	None	
R	Grafe, Michael W.,MD	1922194711	SPEC	Redwood Orthopaedic	Sonoma	Orthopaedic Surgery	ABMS of Orthopaedic Surgery	07/14/2008	Yes	Santa Rosa I	Active
R	Greenberg, Joseph H.,MD	1912085937	SPEC	Joseph Greenberg, MD	Marin	Dermatology	ABMS of Dermatology	10/27/1973	Yes	Admitting Ag	None
R	Griffith, Salvacion G.,PT	1427369149	Allied	NBHG: Orthopaedics a	Solano	Physical Therapy	None		No	None	
I	Guillory, Emily R.,SUDRC	1437945474	W&R	Drug Abuse Alternative	Sonoma	Substance Use Disorder Registered Counsel	California Substance Use Disorder	11/13/2025	Yes	None	
I	Guyon, Kayleigh A.,SLP	1104669472	Allied	Total Spectrum Speech	Sacramen	Speech Pathology	None		No	None	
I	Hakopyan, Ellen Doula	1710798616	SPEC	EH Nursing ad Wellnes	Solano	Doula	None		No	None	
R	Hawkins, Peter G.,MD	1962820621	SPEC	Rohnert Park Cancer C	Sonoma	Radiation Oncology	ABMS of Radiology	03/27/2021	Yes	Admitting Ag	None
R	Heinrich, Leah AGPCNP-BC	1043934482	PCP	Providence Medical Gr	Sonoma	Adult-Gerontology Primary Care Nurse Practi	American Nurses Credentialing Center	05/17/2023	Yes	None	
I	Hunter, Anthony E.,SUDRC I	1801750021	W&R	Empire Recovery Cent	Shasta	Wellness and Recovery	California Substance Use Disorder	08/29/2025	Yes	None	
I	Hussein, Hind BCBA	1396202909	BHP	California Sprout MC 1	Solano	BCBA	Behavior Analyst Certification Board	10/23/2023	Yes	None	
R	Hutchings, Donovan K.,DC	1326127747	SPEC	Churn Creek Chiroprac	Shasta	Chiropractic	None		No	None	
I	Hydinger, Carolynn BCBA	1558517532	BHP	Trumpet Behavioral He	Solano	BCBA	Behavior Analyst Certification Board	05/31/2024	Yes	None	
I	Inouye, Meggie K.,PPCNP-BC	1205244332	PCP	Tahoe Forest MultiSpe	Nevada	Pediatric Primary Care Nurse Practitioner	American Nurses Credentialing Center	06/06/2014	Yes	None	
I	Jagur, Parminder P.,DPM	1083053342	SPEC	One Community Health	Yolo	Podiatry	None		Yes	Admitting Ag	None
R	Jain, Vijay K.,MD	1407938632	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Internal Medicine	06/17/1980	Yes	Admitting Ag	None
I	James, Amanda B.,NP	1831295484	SPEC	Providence Medical Gr	Humboldt	Nurse Practitioner	None		No	None	
I	Johl, Harpreet MD	1053423202	PCP	Harmony Health Medic	Sutter	Family Medicine	ABMS of Family Medicine	07/10/2004	Yes	Adventist He	Active
R	Kennedy, Christie L.,FNP-BC	1558777292	PCP	OLE Health	Solano	Family Nurse Practitioner	American Nurses Credentialing Center	10/05/2015	Yes	None	
R	Khambatta, Shanaz F.,DO	1760587570	PCP	NBHG: Center for Prim	Solano	Family Medicine	AOB-Family Medicine	10/25/2002	Yes	NorthBay Me	Active
R	Kim, Eric E.,MD	1578660916	PCP	Adventist Health Clear	Lake	Internal Medicine	Meets MPCR #17, Verified Residency on AMA/AOIA		No	Adventist He	Affiliate
I	Kirby, Loretta L.,SUDCC	1356994206	W&R	Recover Medical Group	Solano	Wellness and Recovery	California Substance Use Disorder	11/01/2024	Yes	None	
I	Kolodin, Paige BCBA	1558939421	BHP	Trumpet Behavioral He	Solano	BCBA	Behavior Analyst Certification Board	09/16/2025	Yes	None	
I	Kozyk, Ganna PA-C	1225893720	PCP	Manzanita Medical Clin	Placer	Physician Assistant Certified	National Commission on Certification of Physician Assistants	12/04/2024	Yes	None	
I	Kremer, Lisa B.,MD	1144262213	SPEC	Sonoma County Indian	Sonoma	Rheumatology	ABMS of Internal Medicine	11/19/1997	Yes	Sutter Santa	Active
I	Lake, Elizabeth BCBA	1033702287	BHP	Trumpet Behavioral He	Solano	BCBA	Behavior Analyst Certification Board	12/12/2022	Yes	None	
I	Lapid, Yu-Chi L.,MD	1750904660	SPEC	East Bay Nephrology M	Solano	Internal Medicine	American Board of Internal Medicine	08/12/2025	Yes	Sutter Solan	Active Prc
I	Lapp, Sarah BCBA	1083112866	BHP	Trumpet Behavioral He	Solano	BCBA	Behavior Analyst Certification Board	12/16/2025	Yes	None	
I	LaRose, Kelly J.,Doula	1871452755	SPEC	La Rose Doula Service	Humboldt	Doula	None		Not Applical	None	
I	Larson, Quenlyn J.,CPNP-PC	1518050897	PCP	Pediatric Medical Asso	Sacramen	Pediatric Primary Care Nurse Practitioner	Pediatric Nursing Certification Board	07/22/2002	Yes	None	
I	Lattyak, Bruce V.,MD	1629245238	SPEC	Bruce V Lattyak, M.D. I	Nevada	Dermatology	None		No	Sierra Nevac	Active
R	Lau, Cynthia P.,FNP-C	1184291924	SPEC	West Coast Kidney	Solano	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	04/28/2022	Yes	None	
R	Lee, May FNP-C	1174237127	SPEC	West Coast Kidney	Solano	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	12/13/2022	Yes	None	
R	Lee, Peter A.,MD	1982857462	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Internal Medicine	11/04/2010	Yes	San Ramon	Active
I	Leeper, Connie C.,MD	1194091165	PCP	One Community Health	Yolo	Family Medicine	ABMS of Family Medicine	07/01/2015	Yes	Admitting Ag	None
I	Lewandowski, Chelsea BCBA	1801310784	BHP	Maxim Healthcare Sevi	Yolo	BCBA	Behavior Analyst Certification Board	11/30/2017	Yes	None	
I	Lindstedt, Rebecca S.,RD	1902442312	BHP	Sierra Nevada Specialt	Solano	Registered Dietitian	Commission of Dietetic Registration	06/06/2013	Yes	None	
I	Lo, Muaj C.,MD	1487644985	PCP	Mendocino Coast Clinic	Mendocinc	Family Medicine	ABMS of Family Medicine	07/27/2006	Yes	Admitting Ag	None
I	Lock, Judy L.,FNP-BC	1235354945	SPEC	Active Life Wound Clini	Yolo	Family Nurse Practitioner	American Nurses Credentialing Center	07/24/2010	Yes	None	
I	Lopez, Daniel P.,MD	1619025426	SPEC	Mendocino Community	Mendocinc	Obstetrics and Gynecology	ABMS of Obstetrics and Gynecology	12/11/1992	Yes	Admitting Ag	None
I	Lossy, Panna S.,MD	1679670673	PCP	Alliance Medical Cente	Sonoma	Family Medicine	ABMS of Family Medicine	07/11/1997	Yes	Admitting Ag	None
I	Lowdermilk, Mary Frances T.,MD	1245453315	PCP	Rolling Hills Clinic - PC	Tehama	Family Medicine	ABMS of Family Medicine	11/19/2011	Yes	Admitting Ag	Active
R	Lucarelli, Steve CADC-CS	1578908315	W&R	Visions of the Cross/ W	Shasta	Wellness and Recovery	California Consortium of Addiction Programs Professionals	05/30/2013	Yes	None	
R	Lucarelli, Tianna M.,SUDCC III	1629602826	W&R	Visions of the Cross/ W	Shasta	Wellness and Recovery	California Substance Use Disorder	04/06/2024	Yes	None	
I	Luitwieler, Shelbie BCBA	1295230126	BHP	Aura Behavioral Health	Solano	BCBA	Behavior Analyst Certification Board	05/31/2019	Yes	None	
R	Luu, Michael C.,DO	1235244146	SPEC	Luu Medical Group	Solano	Pulmonary Diseases	Previously Board Certified	11/03/2004	Yes	Sutter Solan	Active
R	Macaraeg, Lauren E.,MD	1730612532	SPEC	West Coast Kidney	Marin	Nephrology	ABMS of Internal Medicine	11/10/2022	Yes	Sutter Health	Courtesy
R	MacArthur Clark, Sophie MD	1689135543	PCP	Sutter Lakeside Comm	Lake	Family Medicine	ABMS of Family Medicine	08/15/2022	Yes	Sutter Lakes	Active
I	Macias, Carissa BCBA	1649740887	BHP	ACES 2020 LLC	Solano	BCBA	Behavior Analyst Certification Board	01/05/2026	Yes	None	
I	Macon, Tarryn BCBA	1821514522	BHP	Trumpet Behavioral He	Solano	BCBA	Behavior Analyst Certification Board	06/16/2021	Yes	None	
I	Malaeb, Rommy PA-C	1710840418	PCP	Providence Medical Gr	Sonoma	Physician Assistant Certified	National Commission on Certification of Physician Assistants	11/25/2025	Yes	None	
I	May, Sue C.,CADC_CAS	1770762072	W&R	Drug Abuse Alternative	Sonoma	Wellness and Recovery	California Consortium of Addiction Programs Professionals	05/17/2018	Yes	None	
I	McCrory, Devon BCBA	1285753350	BHP	Maxim Healthcare Serv	Solano	BCBA	Behavior Analyst Certification Board	03/30/2021	Yes	None	

App. T	Full Name	NPI Number	Provider Type	Name/Street	County Na	Specialty Description	Board Name	Initial Cert Date	Board Certif	Hospital Nan	Staff Cat
R	Mehandru, Leena MD	1427096452	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Internal Medicine	11/04/1992	Yes	San Ramon	Active
R	Meng, Lingjin MD	1730574575	PCP	Santa Rosa Communit	Sonoma	Internal Medicine	ABMS of Internal Medicine	08/28/2019	Yes	Admitting Ag	None
R	Micks, Elizabeth A.,MD	1144405119	SPEC	Open Door Community	Humboldt	Obstetrics and Gynecology	ABMS of Obstetrics and Gynecology	12/07/2012	Yes	Mad River C	Active
R	Miller, Heather BCBA	1487368767	BHP	Multiplicity Therapeutic	Sonoma	BCBA	Behavior Analyst Certification Board	12/23/2022	Yes	None	
R	Miyawaki, Lloyd T.,MD	1497737464	SPEC	Marin Cancer Care Inc.	Marin	Radiation Oncology	ABMS of Radiology	06/03/1998	Yes	Marin Health	Active
R	Moeller, Ruth A.,FNP-C	1912441460	PCP	Modoc Medical Clinic	Modoc	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	11/08/2016	Yes	None	
I	Mooney, Tiffani Doula	1033851027	SPEC	Tiffani's Doula Services	Solano	Doula	None		Not Applical	None	
I	Moore, Reece RADT	1548142052	W&R	Drug Abuse Alternative	Sonoma	Wellness and Recovery	California Consortium of Addiction Programs Professionals	07/25/2025	Yes	None	
R	Mouratoff, John G.,MD	1538266218	SPEC	East Bay Nephrology M	Solano	Nephrology	ABMS of Internal Medicine	11/03/1999	Yes	Alta Bates M	Active
R	Mullen-Dewitt, Laura A.,LM	1386611366	SPEC	Capital OB/GYN, Inc.	Yolo	Licensed Midwife	None		No	None	
R	Murphy, Michael N.,MD	1720081490	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Internal Medicine	11/03/1999	Yes	John Muir He	Courtesy
R	Mysore, Prarthana N.,PA-C	1215129689	SPEC	Shriners Hospitals for C	Yolo	Physician Assistant Certified	National Commission on Certification of Physician Assistants	06/14/2007	Yes	None	
I	Nadimi, Ardeshir E., MD	1992190417	SPEC	Yuba City Dermatology & Skin Cai		Dermatology	ABMS of Dermatology	10/24/2020	Yes	Admitting Ag	None
I	Nelson, Randi B., MD	1215247895	PCP	Stallant Health and We	Del Norte	Pediatrics	ABMS of Pediatrics	10/24/2013	Yes	Admitting Ag	Agreement
I	Nguyen, Tram BCBA	1013558584	BHP	Kyo Autism Therapy LL	Marin	BCBA	Behavior Analyst Certification Board	12/16/2025	Yes	None	
I	Nichols, Tracie L.,LAc	1730045444	Allied	Ritual Acupuncture Clir	Solano	Acupuncture	None		No	None	
I	Nisperos, Lara Mae BCBA	1194293514	BHP	Maxim Healthcare Serv	Placer	BCBA	Behavior Analyst Certification Board	03/09/2022	Yes	None	
I	Norton, Kyndel BCBA	1811541634	BHP	Trumpet Behavioral He	Solano	BCBA	Behavior Analyst Certification Board	07/26/2023	Yes	None	
I	Oesterreicher, Jamie BCBA	1972073732	BHP	Kyo Autism Therapy LL	Yolo	BCBA	Behavior Analyst Certification Board	12/29/2025	Yes	None	
I	Onofrei, Rares C.,LAc	1285323360	Allied	Marin Community Clinic	Marin	Acupuncture	None		Yes	None	
I	Onwere, Armstrong D.,NP	1568243509	SPEC	Parkhill Health Inc dba	Solano	Urgent Care			No	None	
I	Osorio, Erick BCBA	1841761327	BHP	Kyo Autism Therapy, LL	Solano	BCBA	Behavior Analyst Certification Board	01/20/2026	Yes	None	
R	Palmieri, Tina L.,MD	1194709444	SPEC	Shriners Hospitals for C	Yolo	Surgery	ABMS of Surgery	03/23/1994	Yes	Shriners Hos	Active
I	Parks, Nicole BCBA	1568800175	BHP	California Sprout MC 1	Solano	BCBA	Behavior Analyst Certification Board	09/30/2012		None	
R	Parsells, Jodi K.,CADC II	1770021412	W&R	Humboldt County Prog	Humboldt	Wellness and Recovery	California Consortium of Addiction Programs Professionals	03/26/2019	Yes	None	
I	Patel, Iryna MD	1790168441	SPEC	Sierra Nevada Specialt	Nevada	Nephrology	ABMS of Internal Medicine	11/18/2020	Yes	Admitting Ag	None
R	Pavia, Danielle BCBA	1134640188	BHP	Aura Behavioral Health	Yolo	BCBA	Behavior Analyst Certification Board	05/31/2018	Yes	None	
I	Pearmain, Patrick SUDRC I	1457237349	W&R	Hilltop Recovery Servic	Lake	Substance Use Disorder Registered Counsel	California Substance Use Disorder	08/05/2025	Yes	None	
R	Phillips, Irving J.,MD	1457707929	PCP	CommuniCare Ole - Da	Yolo	Pediatrics	ABMS of Pediatrics	10/15/2020	Yes	Sutter Davis	Active
R	Phillips, Jonathan RADT	1205549490	W&R	Archway Recovery Ser	Solano	Wellness and Recovery	California Consortium of Addiction Programs Professionals	01/30/2023	Yes	None	
I	Pirouz, Anthony PA-C	1366833923	PCP	Redwoods Rural Healtl	Humboldt	Physician Assistant Certified	National Commission on Certification of Physician Assistants	02/05/2015	Yes	None	
R	Poen, Joseph C.,MD	1972585941	SPEC	Marin Cancer Care Inc.	Marin	Radiation Oncology	ABMS of Radiology	06/10/1993	Yes	Marin Health	Active
I	Pope, Leslie A.,FNP-C	1285193714	SPEC	Obstetrics & Gynecolog	Shasta	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	05/30/2019	Yes	None	
R	Powers, Jessica F.,MD	1538361415	SPEC	NBHG: NorthBay Canc	Solano	Hematology	ABMS of Internal Medicine	11/11/2009	Yes	NorthBay Me	Active
I	Premo, Shurene L.,ACSW	1093430696	W&R	Recover Medical Group	Solano	Wellness and Recovery	None		No	None	
R	Previc, Stephanie T.,FNP-BC	1447876602	PCP	Santa Rosa Communit	Sonoma	Family Nurse Practitioner	American Nurses Credentialing Center	05/30/2020	Yes	None	
R	Pribyl, Shea M.,DO	1639336050	SPEC	Adventist Health Physic	Napa	Thoracic & Cardiac Surgery	ABMS of Thoracic Surgery	06/08/2018	Yes	NorthBay Me	Active Att
I	Pulido, Lucero BCBA	1083175798	BHP	Spectrum Analytic Con	Placer	BCBA	Behavior Analyst Certification Board	08/05/2024	Yes	None	
I	Quigley, Robert F.,DO	1104907674	SPEC	Sierra Nevada Specialt	Nevada	Nephrology	ABMS of Internal Medicine	11/20/2007	Yes	Admitting Ag	None
R	Quinones, Ronda S.,SUDCC II	1770038085	W&R	Ford Street Project	Mendocino	Wellness and Recovery	California Substance Use Disorder	03/25/2018	Yes	None	
I	Ramey, Chrona BCBA	1982152567	BHP	Kids Konnect ABA The	Modoc	BCBA	Behavior Analyst Certification Board	12/09/2021	Yes	None	
I	Randhawa, Manjinder S.,FNP-C	1104410430	PCP	Arbuckle Health Clinic	Placer	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	09/01/2020	Yes	None	
I	Rangarajan, Vineetha DO	1295363752	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Internal Medicine	10/23/2025	Yes	Eden Hospit	Provisiona
R	Rao, Nikhil G.,MD	1275737850	SPEC	Rohnert Park Cancer C	Sonoma	Radiation Oncology	ABMS of Radiology	06/02/2009	Yes	Sutter Santa	Active
R	Rao, Seema S.,MD	1275714495	SPEC	Seema S Rao MD	Sonoma	SNFist	None		No	Admitting Ag	None
R	Reed, John B.,MD	1528177706	SPEC	Retinal Consultants Me	Yolo	Ophthalmology	ABMS of Ophthalmology	06/07/1998	Yes	Admitting Ag	None
I	Reed, Nicole BCBA	1508242272	BHP	Advance Kids	Placer	Board Certified Behavior Analyst	Behavior Analyst Certification Board	05/31/2015	Yes	None	
R	Rice, Geoffrey L.,MD	1194776948	SPEC	Adventist Health Ukiah	Mendocino	Ophthalmology	ABMS of Ophthalmology	06/02/1987	Yes	Ukiah Valley	Active
R	Richardson, Nealetta P.,CADC II	1932585767	W&R	MedMark Treatment Ce	Solano	Wellness and Recovery	California Consortium of Addiction Programs Professionals	09/21/2017	Yes	None	
I	Rife, Lillian BCBA	1033711650	BHP	Maxim Healthcare Serv	Solano	BCBA	Behavior Analyst Certification Board	09/09/2021	Yes	None	
I	Rocco, Nicholas R.,MD	1538508379	SPEC	Oroville Medical Clinic	Butte	Urology	ABMS of Urology	02/28/2023	Yes	Oroville Hos	Provisiona
I	Roller, Katherine MD	1093755563	PCP	NBHG: Center for Prim	Solano	Family Medicine	ABMS of Family Medicine	07/10/1998	Yes	Admitting Ag	None
R	Rosales, Gustavo A.,MD	1548306954	PCP	Elica Health Centers - A	Placer	Pediatrics	Meets MPCR #17, Verified Residency on AMA/AOIA		No	Admitting Ag	None
R	Rushton, Robert B.,MD	1376503839	PCP	Medical Offices of Robe	Mendocino	Family Medicine	Meets MPCR#17, Previously Board Certified in FM, IM, or PEI	07/09/1982	No	Adventist - U	Active
I	Sadovich, Kimberly BCBA	1336779156	BHP	Montera Health Californ	Yolo	BCBA	Behavior Analyst Certification Board	11/30/2019	Yes	None	
R	Schneider, David M.,MD	1104885672	PCP	Santa Rosa Communit	Sonoma	Family Medicine	ABMS of Family Medicine	07/14/1989	Yes	Sutter Santa	Active
R	Scott, Evan BCBA	1629500038	BHP	Momentum Behavior S	Sonoma	BCBA	Behavior Analyst Certification Board	02/28/2017	Yes	None	
R	Sevilla, Arturo SUDCC	1538791603	W&R	Empire Recovery Cent	Shasta	Wellness and Recovery	California Substance Use Disorder	12/18/2025	Yes	None	
I	Shaw, Megan M.,Doula	1265390488	SPEC	Pneuma Bloom	Humboldt	Doula	None		Not Applical	None	
I	Sherry, Larissa BCBA	1720580152	BHP	Advance Kids	Yolo	BCBA	Behavior Analyst Certification Board	11/30/2019	Yes	None	
R	Siddiqui, Javeed MD	1770563967	SPEC	Telehealth Specialty Me	Placer	Infectious Disease	Meets MPCR#17, Previously Board Certified in FM, IM, or PEI	11/03/2004	No	Admitting Ag	None
R	Sira, Anca M.,LAc	1710111844	SPEC	AMA Wellness Center	Shasta	Acupuncture	None		No	None	
I	Smeloff, Maya N.,LAc	1043797962	Allied	One Community Health	Yolo	Acupuncture	None		No	None	
R	Smith, Chelsea A.,DPM	1407095276	SPEC	Oroville Family Medicin	Butte	Podiatry	None		No	Adventist He	Affiliate
I	Smith, Maggie BCBA	1518448786	BHP	ACES 2020, LLC	Placer	BCBA	Behavior Analyst Certification Board	03/04/2022	Yes	None	
R	Snodgrass, Marci L.,MD	1164407839	PCP	CommuniCare Ole - Da	Yolo	Family Medicine	ABMS of Family Medicine	07/10/1998	Yes	Admitting Ag	None
R	Stange, Carla J.,FNP-BC	1780769166	PCP	Adventist Health Ukiah	Mendocino	Family Nurse Practitioner	American Nurses Credentialing Center	01/19/2024	Yes	None	
I	Starr, Kenneth G.,MD	1861431595	SPEC	Drug Abuse Alternative	Sonoma	Addiction Medicine	ABMS of Preventive Medicine	01/01/2019	Yes	Admitting Ag	None
I	Stifle, Jordan L.,BCBA	1770104721	BHP	Advance Kids	Placer	BCBA	Behavior Analyst Certification Board	12/23/2025	Yes	None	
I	Strong, Colby A.,PA	1609733385	PCP	Stallant Health and We	Del Norte	Physician Assistant	National Commission on Certification of Physician Assistants	11/18/2025	Yes	None	

App. T	Full Name	NPI Number	Provider Type	Name/Street	County Na	Specialty Description	Board Name	Initial Cert Date	Board Certif	Hospital Nan	Staff Cat
I	Subijano, Rolando D.,FNP-C	1467066209	SPEC	West Coast Kidney	Solano	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	07/09/2020	Yes	None	
I	Swartz, Katrina K.,PNP	1417392267	SPEC	Shriners Hospitals for C	Yolo	Pediatric Surgery			No	None	
R	Tito, Elizabeth P.,MD	1629092309	SPEC	Adventist Health Physic	Napa	Surgery	ABMS of Surgery	09/13/1999	Yes	Adventist He	Provisiona
I	Tobler, Clark J.,FNP-BC	1619406287	SPEC	Epic Orthopedics	Shasta	Family Nurse Practitioner	American Nurses Credentialing Center	11/17/2016	Yes	None	
I	Torres, Christine Doula	1982150546	SPEC	Raya Health	Solano	Doula	None		Not Applical	None	
I	Triana, Nina BCBA	1184131781	BHP	Advance Kids	Placer	BCBA	Behavior Analyst Certification Board	11/30/2017	Yes	None	
R	Trotter, Marvin G.,MD	1720027436	PCP	Adventist Health Ukiah	Mendocinc	Internal Medicine	ABMS of Internal Medicine	09/15/1982	Yes	Adventist - U	Active
I	Tryba, Alana BCBA	1619600137	BHP	Center for Social Dynar	Solano	BCBA	Behavior Analyst Certification Board	09/27/2025	Yes	None	
R	Turner, Terri L.,DO	1366522831	PCP	Lake County Tribal Hea	Lake	Internal Medicine	Meets MPCR #17, Verified Residency on AMA/AOIA	08/21/2002	No	Admitting Ag	None
I	Valdez, Anthony FNP-C	1568015824	PCP	Open Door Community	Humboldt	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	02/18/2025	Yes	None	
R	Valika, Aziz K.,MD	1992910954	SPEC	West Coast Kidney	Solano	Nephrology	ABMS of Internal Medicine	10/02/2014	Yes	John Muir Mc	Active
I	Vega, Briana J.,Doula	1184434078	SPEC	Graceful Roots Birth Se	Solano	Doula	None		Not Applical	None	
I	Villa, Jackelyn BCBA	1588165740	BHP	Montera Health Californ	Yolo	BCBA	Behavior Analyst Certification Board	04/11/2022	Yes	None	
I	Vukadinovic, Okiemute H.,AGNF	1316677495	SPEC	Wound MD PC	Solano	Adult-Gerontology Primary Care Nurse Practi	American Academy of Nurse Practitioners Certification Board	03/16/2022	Yes	None	
R	Wadham, Anne C.,PA-C	1821053984	BOTH	Providence Medical Gr	Humboldt	Physician Assistant Certified	National Commission on Certification of Physician Assistants	01/17/1992	Yes	None	
I	Walker, Logan C.,FNP-BC	1215727797	PCP	Dignity Health Solano S	Tehama	Family Nurse Practitioner	American Nurses Credentialing Center	08/16/2025	Yes	None	
R	Walsh, Kathleen H.,FNP-BC	1679792485	PCP	Santa Rosa Community	Sonoma	Family Nurse Practitioner	American Nurses Credentialing Center	07/01/2002	Yes	None	
I	Wariso, Bathsheba A.,MD	1316525686	SPEC	Adventist Health Physic	Sutter	Obstetrics and Gynecology	Confirmed per AMA, AOA, ABFAS or Residency Letter		No	Adventist He	Active
R	Weeks, John A.,MD	1962473074	PCP	Adventist Health Clearl	Lake	Family Medicine	ABMS of Family Medicine	07/08/1979	Yes	Adventist He	Active
I	Weissman, Diane E.,MD	1689668048	PCP	Ole Health	Napa	Family Medicine	ABMS of Family Medicine	07/14/2000	Yes	Admitting Ag	None
I	Weninger, Mary BCBA	1053789966	BHP	Spectrum Analytic Con	Placer	Board Certified Behavior Analyst	Behavior Analyst Certification Board	03/31/2009	Yes	None	
I	Wennerholm, Nicholas BCaBA	1861356057	BHP	Humboldt Neurohealth	Humboldt	BCABA	Behavior Analyst Certification Board	07/31/2025	Yes	None	
I	Williams, Michele RADT	1578134458	W&R	Shasta County Alcohol	Shasta	Wellness and Recovery	California Consortium of Addiction Programs Professionals	10/28/2025	Yes	None	
I	Williamson, Caleb BCBA	1013875418	BHP	Williamson Behavioral	Humboldt	BCBA	Behavior Analyst Certification Board	01/08/2026	Yes	None	
R	Wilson, Sandra A.,LMFT	1023168259	W&R	Visions of the Cross/ W	Shasta	Wellness and Recovery	None			None	
I	Winkelmann, Richard R.,DO	1720427024	SPEC	Yuba City Dermatology	Sutter	Dermatology	ABMS of Dermatology	07/26/2018	Yes	Admitting Ag	None
I	Woodmansee, Dylan D.,FNP-C	1699654996	PCP	Feather River Tribal He	Butte	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	06/30/2025	Yes	None	
R	Woolf, Jennifer A.,FNP-C	1528573227	PCP	Redding Rancheria Trit	Shasta	Family Nurse Practitioner	American Academy of Nurse Practitioners Certification Board	07/18/2017	Yes	None	
I	Wright, Mia C.,MD	1639639008	PCP	Peach Tree Healthcare	Yuba	Family Medicine	ABMS of Family Medicine	07/04/2022	Yes	Admitting Ag	None
I	Wu, Evelyn K.,LAc	1730891029	Allied	Ritual Acupuncture Clir	Solano	Acupuncture	None		No	None	
I	Yaghoobians, Pauline BCBA	1619791050	BHP	California Sprout MC 1	Solano	BCBA	Behavior Analyst Certification Board	11/06/2024	Yes	None	
R	Yinger, Kent E.,MD	1093815110	SPEC	Redwood Orthopaedic	Sonoma	Orthopaedic Surgery	ABMS of Orthopaedic Surgery	07/11/2003	Yes	Sutter Santa	Active
I	Young, Jessy M.,AGPCNP-BC	1194501908	SPEC	Providence Medical Gr	Sonoma	Adult-Gerontology Primary Care Nurse Practi	American Nurses Credentialing Center	09/22/2023	Yes	None	
R	Young, Michael T.,DO	1023174042	SPEC	Adventist Health Ukiah	Mendocinc	Pain Management & Rehabilitation	None		No	Adventist - U	Active
I	Young, Rachael BCBA	1346607991	BHP	California Sprout MC 1	Solano	BCBA	Behavior Analyst Certification Board	02/29/2016	Yes	None	
I	Zertuche, Jerrod BCBA	1952752024	BHP	California Sprout MC 1	Solano	BCBA	Behavior Analyst Certification Board	05/31/2016	Yes	None	

HQIP Six-Month Measure Proposal

HQIP 2026 Six-Month Bridge Measurement Set (July 1 – December 31, 2026)

Providers have the potential to earn a total of 100 points in six domains 1) Readmissions; 2) Advanced Care Planning; 3) Clinical Quality; 4) Patient Safety; 5) Operations/Efficiency; 6) Patient Experience. Individual measure values will be assigned for the final and approved measurement set.

Key: Proposed for extension || Proposed for removal or postponement

2025-26 Measures	2026 Six-Month Bridge Set Recommendations
Risk Adjusted Domain	**Risk Adjusted Domain**
1. Risk Adjusted Readmissions (RAR)	1. Risk Adjusted Readmissions (RAR)
2. 7-Day Follow-up Clinical Visit (RAR)	2. 7-Day Follow-up Clinical Visit (RAR)
Palliative Care Domain	**Palliative Care Domain**
3. Palliative Care Capacity	3. Palliative Care Capacity
Clinical Domain	**Clinical Domain**
4. Elective Delivery Before 39 Weeks	4. Elective Delivery Before 39 Weeks
5. Exclusive Breast Milk Feeding Rate	5. Exclusive Breast Milk Feeding Rate
6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate	6. Nulliparous, Term, Singleton Vertex (NTSV) Cesarean Rate
7. Vaginal Birth After Cesarean (VBAC)	7. Vaginal Birth After Cesarean (VBAC)
8. Expanding Delivery Privileges	**8. Expanding Delivery Privileges**
9. Doula Support	**9. Doula Support**
10. Increasing Mammography Capacity	10. Increasing Mammography Capacity
11. Vaccines For Children Enrollment	**11. Vaccines For Children Enrollment**
Patient Safety Domain	**Patient Safety Domain**
12. CHPSO Patient Safety Organization Participation	12. CHPSO Patient Safety Organization Participation
13. Substance Use Disorder Referral, Medication Assisted Treatment (MAT)	13. Substance Use Disorder Referral, Medication Assisted Treatment (MAT)
Operations / Efficiency Domain	**Operations / Efficiency Domain**
14. QI Capacity	**QI Capacity**
15. Hospital Quality Improvement Platform	14. Hospital Quality Improvement Platform
Patient Experience Domain	**Patient Experience Domain**
16. Cal Hospital Compare-Patient Experience	**Cal Hospital Compare-Patient Experience**
17. Health Equity	**Health Equity**

Programmatic Changes:

Due to a new federal regulation that went into effect at the end of 2025, the Hospital Quality Incentive Program must transition to a calendar year program by January 2027. Therefore, the proposed changes below pertain to the proposed abbreviated six-month bridge measurement set covering the period of July 1, 2026, through December 31, 2026. There are no new measures proposed for this set, but several are proposed for removal for this six-month period.

In general, all the reporting timelines for any measures included in this set have been adjusted to correlate to the six-month period. Those revisions are not presented here. What follows are the proposed measure removals with their rationales.

A. Revisions to Existing Measures:

1. **Measure 8: Expanding Delivery Privileges:**
   It is proposed that this measure **remains** in the six-month set at the Phase Two level and move to Phase 3 in the 2027 measurement year. While many hospitals have expanded privileges during the 2025-26 measurement year, this six-month extension will give those hospitals that did not expand this year to expand privileges before moving to Phase 3, which will require contracting and hiring of the providers.

Specifications

In this second phase of measure implementation, hospitals are now required to work toward actively recruiting, granting privileges, and demonstrating evidence of family physicians' and nurse midwives' clinical activity.

Measure Requirements

This multi-phase measure began with ***Phase One*** in the 2024-25 measurement year, which asked hospitals to develop by-laws and/or policy and procedure to expand delivery privileges to midwives and family physicians. With ***Phase One*** completed in 2024-25, this measure moved into ***Phase Two*** for the 2025-26 HQIP Measurement Year starting July 1, 2025.

Phase Two Requirement: Hospitals that have developed by-laws and/or policy and procedure allowing midwives and family physicians to hold delivery privileges, must now show evidence that they are actively recruiting and/or share their provider privileges list of midwives and family physicians who have been granted delivery privileges.

Hospitals with existing family physicians and midwives privileged to perform deliveries will get full credit so long as these clinicians remain active delivering babies in the hospital

2. Measure 9: Doula Support

It is proposed to extend the deadline for the Doula Support measure to December 31, 2026, with the same measure specifications as last year. The plan will be to move into Phase 2 of the measure during the 2027 measurement year at which time hospitals will need to demonstrate recruitment or use of doulas in the hospitals.

Specifications

This measure will be implemented over multiple years, with **Phase One** starting with the 2025-26 measurement year. In future years, hospitals will be required to work toward actively recruiting and allowing doulas to provide support during labor and delivery.

Measure Requirements

Hospitals will develop policy and/or procedures that allow doulas to support birthing parents in the hospital during labor and delivery.

In future years, we anticipate a second phase of this measure to include evidence that doulas are being utilized in labor and delivery

Hospitals with existing bylaws and/or written policies that allow doulas to provide support during labor and delivery will get full points for the measure.

3. Measure 11: Vaccines For Children (VFC) Enrollment

It is proposed to extend the Vaccines For Children (VFC Enrollment) measure through this period, which will allow additional time for hospitals to enroll in the program. The plan is for this measure to be removed in 2027.

Measure Specification:

HQIP birthing hospitals can save cost and positive impact their newborn population by enrolling in the 'no cost" Vaccination For Children program through CDPH. Partnership's HQIP birthing hospitals will be eligible to receive points by successfully enrolling in the CDPH's VFC program by the end of the measurement year.

Exclusions

Very Small sized hospitals with less than 25 Licensed General Acute beds are excluded from participation in this measure. This measure will not be applicable to hospitals who already enrolled during the 2025-26 measurement period.

B. Removal of Existing Measures for 2025-26

1. **Quality Improvement Capacity:**
   This measure is designed to provide a free full day Hospital Quality Symposium each measurement year for our participating hospitals. At which, hospital quality and executive staff can stay up to date on quality topics at large and at Partnership. It is proposed to remove this measure from the six-month bridge set because hospitals have already attended Partnership's Hospital Quality Symposium for the 2025-26 measurement year, and it would be redundant to host another event. The plan is for this measure to be part of the full 2027 calendar year HQIP.

2. **California Hospital Compare:**
   This measure is intended to encourage hospitals to provide excellent patient experience and Partnership's scoring of the measure relies upon California Hospital Compare's scores, which are updated annually. It is proposed to remove this measure for this six-month bridge set as the scores for the 2025-26 measurement year would have just been delivered meaning there would be no new information to score the hospitals. The plan is to return this measure to the full 2027 calendar year HQIP.

3. **Health Equity:**
   It is proposed to remove the Health Equity measure from the six-month bridge set because the hospitals would have just submitted their annual report to Partnership in August of 2026. It is also recommended to remove this measure because CMS removed its requirement for a Commitment to Health Equity Attestation, which is what this measure was based upon. The plan is to develop a new Health Equity measure for the full 2027 calendar year HQIP.

Palliative Care Quality Incentive Program
Summary of Proposed 2027 Measures

Key:

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

2026 Measures	2027 Recommendations
Utilization	
1. Avoiding Hospitalization & Emergency Room Visits • $240 PMPM if no inpatient or ED use per calendar month	**1. Avoiding Hospitalization & Emergency Room Visits** • $240 PMPM if no inpatient or ED use per calendar month *CHANGE:* *No recommended changes*
Quality	
2. Completion of POLST • $120 PMPM once a signed POLST is completed **3. Completion of a Standardized Patient Symptom Assessment** • $120 PMPM if two (2) standardized patient symptom assessments are completed, with all essential data elements included. Thresholds: • ≥ 70% of data elements entered on assessments = Full points ($120 PMPM) • 50-69% of data elements entered on assessments = Partial points ($60 PMPM)	**2. Completion of POLST** • $120 PMPM once a signed POLST is completed **3. Completion of a Standardized Patient Symptom Assessment** • $120 PMPM if two (2) standardized patient symptom assessments are completed, with all essential data elements included. Thresholds: • ≥ 70% of data elements entered on assessments = Full points ($120 PMPM) • 50-69% of data elements entered on assessments = Partial points ($60 PMPM) *CHANGE:* *No recommended changes*